FINANCIAL SECTION

MESSAGE FROM THE CHIEF FINANCIAL OFFICER

The Department of Health and Human Services (HHS or the Department) is one of the largest, most complex financial organizations in the world. This *Agency Financial Report* represents our accountability report for FY 2012. We will issue the *FY 2012 Annual Performance Report*, the *Congressional Budget Justification* and the *Summary of Performance and Financial Information* in February, 2013.

Through collaboration, our CFO community manages financial accountability, transparency, compliance and risk across the Department by maximizing resources to drive results. We are vigilant in using taxpayer resources wisely to carry out the Department's mission to enhance the health and well-being of Americans.

During 2012, we continued in our role as stewards of the public trust and worked together collaboratively to address our challenges. For example:

- Our CFO executives continued to work together as a community to improve financial reporting and systems, reflecting management's commitment to maintain full financial accountability, transparency and effective stewardship.
- We continued to refine our reporting processes and successfully performed our annual, internal control assessment as required by OMB Circular A-123, *Management's Responsibility for Internal Control*. We present the Secretary's annual Statement of Assurance in the Management's Discussion and Analysis section of this report, which reflects the results of our assessment and planned corrective actions.
- We successfully sustained and took steps to improve our standards for reporting and management controls. We implemented the Enterprise Financial Business Intelligence System, which will offer improved management reporting and business analytic tools for strategic decision makers. We also implemented policies designed to reduce system and security risks. We continue work to monitor and reduce system and security risks.

This year we obtained a clean opinion on our consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position and the Combined Statement of Budgetary Resources. However, the auditors did not express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. These statements were developed using information from the annual report of the Medicare trust funds, reflect current law, and, are prepared in accordance with the standards issued by the Federal Accounting Standards Advisory Board. Please refer to the Financial Section of this *Agency Financial Report* for further information.

I want to thank our employees and partners. This report and the accomplishments it describes, is a reflection of their extraordinary dedication to our mission. Together, we look forward to taking our ambitious agenda for the future into 2013.

/Ellen G. Murray/
Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 15, 2012

REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

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

FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2012 (A-17-12-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2012 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young LLP (Ernst & Young), to audit the HHS (1) consolidated balance sheet as of September 30, 2012 and 2011, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the years then ended; and (3) the statement of social insurance as of January 1, 2012, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the *Government Auditing Standards,* issued by the Comptroller General of the United States; and the Office of Management and Budget (OMB) Bulletin 07-04, as amended, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2012 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with accounting principles generally accepted in the United States of America. As presented in note 23 to the financial statements, with respect to the estimates for the Centers for Medicare & Medicaid Services (CMS) Social Insurance Program as of January 1, 2012 and 2011, management has noted that actual future costs for Medicare are likely to exceed those projections estimated under

the Patient Protection and Affordable Care Act (P.L. No. 111-148) and other current law. As a result, Ernst & Young was unable to obtain sufficient evidential matter for the amounts presented in the statements of social insurance as of January 1, 2012, 2011, and 2010, and the related statements of changes in social insurance amounts for the periods ending January 1, 2012 and 2011, to enable them to express an opinion on whether the statements were presented fairly. Ernst & Young provided unqualified opinions on the statements of social insurance as of January 1, 2009 and 2008.

Ernst & Young also noted two matters involving internal controls with respect to the financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young identified a material weakness in HHS's financial management information systems and a significant deficiency in its financial reporting systems, analyses, and oversight:

- *Financial Management Information Systems*—Ernst & Young noted continued improvement in the controls within HHS's infrastructure that support information technology (IT) and the financial application systems. HHS's operating divisions have made efforts to address the existing needs for governance, processes and practices, and the security of IT application configuration integrity for financial systems. Ernst & Young also noted the use of IT system tools to prevent users having access rights that are inconsistent with segregation of duties and to limit IT access to individuals with the need and appropriate approvals to view or change information. Even with these improvements, Ernst & Young noted a concerted effort is still necessary to remediate remaining long outstanding deficiencies to a level that supports reliance on the controls within the financial systems. The deficiencies found continue to constitute a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2012 audit, Ernst & Young noted continued progress in improving financial management processes. While the steps taken have improved financial reporting processes, HHS's financial management systems are still not in compliance with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208). The audit identified internal control weaknesses in financial systems and processes, including the lack of integrated financial management systems and insufficient analysis of certain significant accounts that impaired HHS's ability to report timely financial information. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2012, HHS's management declared a violation to certain provisions of the Anti-Deficiency Act (31 U.S.C. § 1341) and OMB Circular A-11. Currently, HHS is investigating several additional potential violations of that Act. HHS is not currently in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) as amended by the Improper Payments Elimination and Recovery Act of 2010 (P.L. No. 111-204) and section 6411 of the Patient Protection and Affordable Care Act. As

noted above, Ernst & Young concluded HHS also did not comply with the Federal Financial Management Improvement Act of 1996.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 07-04, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation including those related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2012 Agency Financial Report.*

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

For fiscal year 2012, CMS management revised its methodology for the Medicare fee-for-service improper payment estimate to adjust for the effects of the receipt of late documentation and denied claims overturned on appeal and the impact of rebilling certain Part A claims that had been considered errors as Part B claims. CMS modified the improper payment reporting period by 6 months (from calendar year 2011 to July 1, 2010, through June 30, 2011) so it could report the actual impact of appeals and the receipt of late documentation for the Medicare fee-for-service program. In the past, CMS has used an estimate for this amount. In addition, CMS adjusted the Medicare fee-for-service error rate to account for the impact of allowing providers to resubmit Part A inpatient claims that should have been provided on an outpatient basis as Part B services. CMS believes that making these adjustments to its methodology will result in a more accurate reflection of the actual incidence of improper payments in the program. We have not yet had time to review the adjusted data and related methodology. Under the Improper

Page 4 – The Secretary

Payments Elimination and Recovery Act, we are required to issue a report on compliance with the Improper Payments Information Act of 2002 and as part of that report will assess the accuracy and completeness of HHS's improper payment reporting.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-12-00001.

/Daniel R. Levinson/

Attachment

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and Chief Financial Officer

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

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Report of Independent Auditors

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2012 and 2011, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the statements of social insurance as of January 1, 2009 and 2008. We were engaged to audit the statements of social insurance as of January 1, 2012, 2011 and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2012 and 2011. These financial statements are the responsibility of HHS' management. Our responsibility is to express an opinion on these financial statements based on our audits.

Except as discussed in the following paragraphs with respect to the accompanying statements of social insurance as of January 1, 2012, 2011 and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2012 and 2011, we conducted our audits in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of HHS' internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of HHS' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 22 to the financial statements, the statement of social insurance presents the actuarial present value of the Centers for Medicare and Medicaid Services' (CMS) Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income

to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates, and as discussed below, significant additional variability has been introduced by the passage of recent legislation as well as issues regarding the sustainability of the underlying assumptions under current law.

As further described in Note 23 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2012, 2011 and 2010, management has reflected in the projections of the program the direct impact, but has not fully reflected the secondary impacts of productivity adjustments (reductions in anticipated rates of increase) and reductions in Medicare payment rates for physician services mandated in the Patient Protection and Affordable Care Act (ACA) and current law. Prior legislation mandating reductions in provider payments has been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long-term sustainability of the social insurance program. As a result of these limitations, we were unable to obtain sufficient evidential matter for the amounts presented in the statements of social insurance as of January 1, 2012, 2011 and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2012 and 2011.

Because of the matters discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2012, 2011 and 2010and the related changes in the social insurance program for the periods ended January 1, 2012 and 2011.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2012 and 2011, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its

social insurance program as of January 1, 2009 and 2008, in conformity with US generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 14, 2012, on our consideration of HHS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

US generally accepted accounting principles require that the Management's Discussion and Analysis, Required Supplementary Stewardship Information, and Required Supplementary Information as identified on HHS' Agency Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Our audits were conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS' basic financial statements. The Other Accompanying Information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has not been subjected to the auditing procedures applied in the audits of the basic financial statements and, accordingly, we do not express an opinion or provide any assurance on it.

/Ernst & Young LLP/

November 14, 2012

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Report on Internal Control over Financial Reporting Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited the financial statements of the U.S. Department of Health and Human Services (HHS or the Department) as of and for the year ended September 30, 2012, and we were engaged to audit the statement of social insurance as of January 1, 2012, and the related statement of changes in social insurance amounts for the period ended January 1, 2012, and have issued our Report of Independent Auditors, thereon dated November 14, 2012. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2012 and the related statement of changes in social insurance amounts for the period ended January 1, 2012. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

Management of HHS is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered the Department's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control over financial reporting.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all deficiencies, significant deficiencies or material weaknesses have been identified. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 07-04, as amended. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to ensuring efficient operations. However, we

identified a deficiency in internal control that we considered to be a material weakness and another deficiency that we considered to be a significant deficiency.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. We consider the deficiency related to Financial Management Information Systems to be a material weakness.

A *significant deficiency* is a deficiency or a combination of deficiencies in internal control that, in our professional judgment, is less severe than a material weakness, yet is of sufficient importance to merit attention by those charged with governance. We consider the deficiency related to Financial Reporting Systems, Analyses, and Oversight to be a significant deficiency.

Material Weakness

Financial Management Information Systems

HHS continued to make strides during fiscal year (FY) 2012 to improve the controls within its supporting Information Technology (IT) infrastructure and financial application systems. We noted attention among the HHS operating divisions (OPDIVs) to address the existing needs for governance, processes & practices, and securing the integrity of IT application configuration for financial systems. In addition, there was attention in information security areas. We identified tools were being put into place to prevent users having access rights that are inconsistent with segregation of duties, and to limit IT access to individuals with the need and appropriate approvals to view or change information.

However, a concerted effort is still necessary to remediate remaining long outstanding deficiencies to a level that supports reliance on controls within these systems. Consistent processes, accountability, ownership, and coordination among system owners, IT operations, and OPDIVs, are challenging given the size of the Department, the number of different applications comprising the Departmental financial systems, and the disaggregated control structure within the Department. We have observed plans to remediate most of the deficiencies remaining in the significant systems, including the three primary general ledger applications – Unified Financial Management System (UFMS), Healthcare Integrated General Ledger Accounting System (HIGLAS), and National Institutes of Health (NIH) Business System (NBS). However, the

contributing factors noted above may cause these remediation plans to remain a multi-year process.

The remaining deficiencies noted in our testing throughout FY 2012, as summarized below, continue to constitute a material weakness in internal control. HHS management has identified financial management information systems as a material weakness as a result of its OMB Circular A-123 and FMFIA assessments discussed within the Management Discussion and Analysis of the Department's FY 2012 Agency Financial Report.

Non-Centers for Medicare & Medicaid Services (CMS) OPDIV Financial Information Management Systems

The security management program, as required by the Federal Information Security Management Act of 2002 (FISMA), provides a framework to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to provide for the overall effectiveness of security measures. Without a fully integrated security management program, design and implementation of security controls may be inadequate; user roles and responsibilities may be unclear; and management, operational and technical controls may be inconsistently implemented. Such conditions will lead to insufficient protection of sensitive or critical resources. As part of our audit of significant financial management processes and accounts, we assessed applicable controls within key financial management systems, including HHS' financial accounting, grant, payroll, acquisition and financial reporting systems. Our procedures identified the following issues:

- Patch Management – The Department does not have an effective process for timely implementation of critical system patches. Some OPDIVs do not have an effective process for timely identification, tracking, and remediation of critical system vulnerabilities.

- Identity and Access Management – The Department needs to standardize identification and access management procedures to provision, recertify and de-provision user accounts. Additionally, background investigations should be completed and favorably adjudicated for personnel prior to allowing access to sensitive Departmental systems and networks.

- Remote Access Management – The Department has not fully implemented adequate security controls over remote access to the HHS networks. We found deficiencies related to policies and procedures and virtual private network (VPN) user account maintenance.

- Plan of Action and Milestones (POA&M) – The Department's security management has not fully implemented an effective POA&M process to ensure that all fields for each POA&M record are entered and updated on a timely basis and that all POA&M records are resolved and closed in a timely manner.

Non-CMS OPDIV Application Security Management

Elements of sound configuration management (CM) programs ensure that only authorized and fully tested software is placed in operation, software and hardware are updated, information systems are monitored, patches are applied to systems to protect against known vulnerabilities, and emergency changes are documented and approved. These controls, which limit and monitor access to powerful programs and sensitive files associated with computer operations, are important in providing reasonable assurance that access controls and the operations of systems and networks are not compromised. For the majority of the significant financial applications, the framework of a sound CM program exists; however, the CM program had not fully matured nor been integrated. The following CM-related issues and others were noted for Application Security Management:

- Infrastructure Change Management – Change management exceptions were identified at the NIH Centers for Information Technology (CIT). More specifically, CIT did not configure certain UNIX and Windows settings to the baseline configuration standards, including certain password settings. For UNIX, CIT has implemented Tripwire to detect changes to critical system files; however, system owners have not implemented a process document that the monitoring and evaluation of the results was accomplished.

- Segregation of Duties (SoD) – Access assignments were excessive for UFMS, NBS, Information for Management, Planning and Coordination (IMPACII), HHS Consolidated Acquisition Solution System (HCAS), Grants Administration, Tracking and Evaluation System (GATES), Enterprise Human Resources and Payroll System (EHRP), and Consolidated Financial Reporting System (CFRS) systems and did not provide an adequate segregation of duties. Assignment conflicts represent instances whereby access assigned may have allowed users to perform conflicting responsibilities without intervention by other users or approvers. In addition, for UFMS, HCAS, GATES, and EHRP applications, developer(s) had full access to both development and production system.

- Segregation of Duties Review – Process Owners have not completely identified segregation of duty conflicts that can exist for UFMS, NBS, IMPACII, HCAS, and EHRP and the roles and users with these conflicts. Known, authorized users have access to transactions or activities that cause segregation of duty conflicts, but are not supported by documented business needs. The Department has not documented or retained

consistent evidence of monitoring of control effectiveness and corrections to any SoD exceptions noted for UFMS, NBS, IMPACII, HCAS, GATES, and EHRP.

- Application Change Management – Change management processes for UFMS, NBS, HCAS, GATES, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. In addition, management is in the process of working with business and IT personnel to determine the monitoring process for application, database, report, and configuration changes.

- GrantSolutions – This system was implemented using the commercial cloud service provider. However, the Department did not follow the components of the National Institute of Standards and Technology (NIST) SP 800-37 R1, "Guide for Applying the Risk Management Framework to Federal Information Systems," and did not perform a complete self-assessment of controls in the current GrantSolutions production system.

- Audit Logging and Monitoring – IMPACII system auditing procedures do not include the monitoring and review of privileged access commands. This is not in compliance with HHS policy.

Non-CMS OPDIV Recommendations:

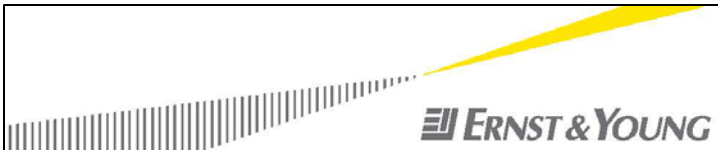
HHS should continue the focus achieved in FY 2012 to remediate the remaining deficiencies. The following are some specific recommendations to consider:

- Continue to identify, assess, modify, and monitor SoD to ensure least privilege access is granted to system users for all systems listed above. Here are the specific recommendations for UFMS/HCAS, NBS, GATES, and EHRP:

    - For UFMS/HCAS, management has implemented Standard Operating Procedures (SOP) which outlines how SoD conflicts are to be evaluated, documented, and reviewed. Results of SoD reviews and any subsequent actions should be clearly completed and documented. System owners should collaborate with Financial Enterprise Systems Management (FESM) and the UFMS user community to re-design roles with known SoD conflicts.

    - For NBS, management should continue to resolve "Intra" conflicts where the focus is on SoD conflicts within a role and the "Inter" conflicts where users have been assigned multiple roles, which creates the conflicts.

    - For EHRP, management should continue to develop the SoD matrix that is in-



process and distribute the SoD matrix for use during the updated SoD review process. Incorporate the completed SoD matrix into the user provisioning process.

- For GrantSolutions, management should perform a complete NIST-based self-assessment of the current production system, and evaluate and follow required components of the NIST SP 800-37 R1, "Guide for Applying the Risk Management Framework to Federal Information Systems." As SoD has been an area of weakness for the Department, as users transition from GATES to GrantSolutions, SoD considerations such as role-based security and least privileged access should be addressed. A SoD matrix and user monitoring and corrective processes, such as those that exist in GATES, should also be included.

- Continue to test, track, and authorize all system changes planned for release into the production environment. For example, for UFMS, the system owner should collaborate with FESM, Information Security Branch (ISB), and business process owners to develop and implement a policy and procedure outlining key activities and events within UFMS to be monitored on a regular basis. These key activities and events would include: (1) frequency of monitoring, (2) the assignment of responsibilities, and (3) the appropriate documentation needed to support them. This policy should be in accordance with and address HHS information security controls and applicable guidance. For NBS, management should also implement a tool that produces a system-generated list of when changes are made to specific areas.

- Enhance the configuration process, including putting an enhanced focus on consistently executing detective reviews, the review of changes indicated by Tripwire, and monitoring of system configuration baselines.

- Establish a consistent vulnerability management program based on the vulnerability management tool for each OPDIV, and operational processes that will allow the Department to effectively secure and operate the various IT operating systems such as Windows, UNIX, databases, and network devices.

- Continue to review and verify that user access to critical financial applications is properly granted and to recertify or remove access on a periodic basis. More specifically, CIT should configure certain UNIX and Windows settings to the baseline configuration standards, specifically certain password settings.

- Require suitability background investigations to be completed and favorably adjudicated for personnel prior to allowing access to sensitive Departmental systems and networks.

ERNST & YOUNG

CMS Information Systems Controls

The nature, size and complexity of the operations of the CMS necessitate that their IT sub-systems are different than that of the other OPDIVs within the Department and serve to complicate their internal controls over the IT systems. CMS manages national health care related programs, including Medicare, the largest health care program; other programs include Medicaid, and the Children's Health Insurance Program (CHIP). CMS' Central Office provides overall direction for these programs using a variety of information systems.

CMS manages the Medicare fee-for-service program under a decentralized business model by geographically dispersed contractors using complex and extensive information systems operations. These operations support a number of Medicare fee-for-service application systems that are intended to assure consistency in administering the Medicare fee-for-service activities, in addition to processing, accounting for, and reporting Medicare fee-for-service expenditures and related assets and liabilities. Similar to the overall process of program management, CMS controls the principal Medicare data processing needs by contracting the operations of three separate Electronic Data Centers (EDCs).

Other important financial systems are managed by a combination of employees and contractors at the CMS Central Office including the HIGLAS, the Financial Accounting and Control System (FACS), the Medicare Advantage and Prescription Drug System (MARx), the Medicaid Budget & Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), and the National Claims History (NCH).

CMS maintains a Business Partners Systems Security Manual (BPSSM) based on federal guidelines to direct the information security and assurance activities at the Medicare fee-for-service contractors. Monitoring compliance with the BPSSM is accomplished through CMS' ongoing Security Authorization (SA) program. Each contractor is required to maintain a System Security Plan (SSP) developed in accordance with the BPSSM that outlines the contractor's plan for maintaining a secure environment for CMS' systems.

CMS principally monitors its Medicare fee-for-service contractors' compliance with its standards through federal processes, including (1) annual evaluations of the implementation of information security requirements outlined in Section 912 of the *Medicare Modernization Act of 2003*, (2) Reports issued annually on the controls Medicare Administrative Contractors (MACs) placed in operation and tested to conclude on the operating effectiveness issued by independent auditors in accordance with the American Institute of Certified Public Accountants (AICPA)'s Statement on Standards for Attestation Engagements (SSAE) No. 16, *Reporting on Controls at a Service Organization;* and (3) other monitoring procedures, such as FISMA, annual reviews in accordance with the OMB No. A-123, *Management's Responsibility for Internal Control*, ongoing contractor management assessments and regular reviews of computer security

configurations submitted by the MACs and EDCs, and other assessments performed by the Office of Inspector General (OIG).

CMS is also subject to various Federal information security and application software management guidelines. Primary guidance is provided by the NIST.

CMS is challenged in maintaining computer security by a number of key factors including:

- The very large number of users required to have access to CMS systems in order to process claims and otherwise serve the Medicare, Medicaid and other health beneficiaries in a timely and effective manner.
- The decentralized business control structure wherein program executives are tasked with responsibility with managing the operations and controls over many business functions including compliance with computer security standards designed by the computer security office at CMS headquarters.
- The use and reliance upon contractors to accomplish most business functions, including operation of the computer systems. In many cases the degree of computer security is dependent upon a contractor's interpretation of and adherence to CMS security policies.

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on their internal controls dated November 9, 2012. In that report, we outlined details of deficiencies noted and made recommendations for improvement in the monitoring of IT contractor compliance with computer security policies, the prevention of and monitoring for inconsistencies in access rights allowing a potential lack of segregation of duties in certain areas and controls over system access and monitoring of unauthorized system access. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting.

CMS OPDIV Recommendations:

We recommend that continued emphasis be placed on improvements in monitoring contractor compliance with CMS Security Policies. We noted that our specific current year findings related to system access and monitoring of segregation of duties policies have been addressed but recommend that those issues be further reviewed for root causes and that necessary policy revisions be implemented to reduce the probability that similar issues might arise. More detailed recommendations related to our specific findings are included in our CMS Report on Internal Control.

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Significant Deficiency

Financial Reporting Systems, Analyses, and Oversight

Over the past four years, HHS has implemented new processes, upgraded its various legacy systems, improved communication, developed new guidance, and provided training to its personnel to address significant long-standing issues. We noted continued progress in financial management processes as a result of our FY 2012 audit; however, HHS and its OPDIVs management's review and the results of our testing of internal control continued to identify internal control deficiencies in financial systems and processes for producing financial statements, including lack of integrated financial management systems and insufficient analysis of certain significant accounts. In many cases, the progress noted above and related processes continued to be developed throughout FY 2012 and will require additional refinements in FY 2013. Within the context of the approximately $900 billion in departmental net outlays, the ultimate resolution of such amounts is not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that must continue to be resolved.

Lack of Integrated Financial Management System

In FY 2004, HHS began its implementation of a commercial web-based, off-the-shelf product modified to replace five legacy accounting systems and numerous subsidiary systems with one modern accounting system with three components. The three components include:

- HIGLAS - developed to support the financial activities of the CMS and its Medicare contractors by integrating the CMS contractors' standard claims processing system and eventually replace the CMS current mainframe-based financial system with a web-based accounting system (currently, the web-based accounting system has been placed "on top" of the current mainframe-based financial system). Based on the ability to generate financial statements, CMS named HIGLAS as its official financial management system of record. Although initiated in FY 2005, full implementation is not expected until FY 2013.
- NBS - developed to support the financial activities at NIH. NIH completed certain aspects of its implementation in FY 2008 with more ancillary modules expected to be implemented over the next three to five years.
- UFMS - developed to support the financial activities at the remaining OPDIVs with full implementation completed in FY 2008. Certain processes to refine the implementation and address systemic issues are ongoing.

Although progress to fully implement the new financial systems is underway, HHS' financial management systems are not compliant with the Federal Financial Management Improvement

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Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with federal financial management systems requirements. More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems and compliance with the United States Standard General Ledger (USSGL) at the transaction level and applicable Federal accounting standards. The lack of an integrated financial management system, not expected to be fully integrated until FY 2013 and beyond, continues to impair HHS' and its OPDIVs' abilities to adequately support and analyze account balances reported in a timely fashion. Specific deficiencies noted include the following:

- Although significant progress was made with the implementation of the CFRS during FY 2011, over 8,000 manual journal vouchers (JVs) in excess of $1.0 trillion in absolute value were required to be recorded in UFMS and NBS to post certain types of transactions - including transactions to record certain proprietary and budgetary entries, record accruals, perform adjustments between governmental and nongovernmental accounts, perform adjustments to agree budgetary to proprietary accounts, perform other reconciliation adjustments at period-end, and correct errors identified related to configuration issues within UFMS and NBS. These entries are postings to UFMS and NBS to record both the proprietary and budgetary effects of certain financial activities for which the financial system may not be configured properly to post automatically. For UFMS, we found that manual entries consisted of the following:

    - Approximately 65% or $660 billion represent either reversals of entries or manual JVs which have been or are about to be automated: These entries represent Intra-departmental delegations of Authority (IDDAs) and grant accruals adjustments for incurred but not reported costs and block grants. Of the $660 billion, over $400 billion represent reversals of prior transactions.

    - Approximately 20% or $186 billion are due to corrections or adjustments made to the general ledger identified as a result of the monthly financial reporting analyses and various detect internal controls.

    - The remaining 15% or $150 billion are due to normal business process, such as continuing resolution entries, Common Account Number (CAN) realignments and accruals for the monthly financial reporting.

  For NBS, we found a different mix of manual entries which can be broken down as follows:

- Approximately 30% or $12 billion are required to be posted outside the NBS for the fiscal year in order for the quarterly financial statements to be accurate. The adjustments were recorded outside the system in order to address such entries as proprietary account closing, adjust for unbilled amounts not billed internally, and record information which was received after the system closed. Included in the $12 billion are nearly $2 billion of Department level adjustments related to the reclassification of the NIH grant accrual.

- Approximately 60% or $25 billion in manual entries are broken out between normal business processes and other general ledger adjustments.
  - Of the $25 billion, approximately $12 billion represent either reversals of entries or manual JVs loaded from excel spreadsheet templates directly to the general ledger to record PMS grant advances and accrual adjustments for incurred but not reported costs.
  - Nearly $9 billion are related to intra-NIH activity, such as the Central Service assessments and fee transactions for recording activity between the institutes and centers, as well as institute and centers CAN realignments and adjustments.
  - The remaining $4 billion are related to activity for inter-agency agreements and program evaluation obligations and billings, capitalization of internal software and other accruals for the quarterly financial reporting, such as environmental and custodial liabilities.

- Furthermore, 10% or $4 billion are related to the movement of activity due to the resolution of one institute, National Center for Research Resources, and the creation of the new institute, National Center for Complementary and Alternative Medicine, during FY 2012.

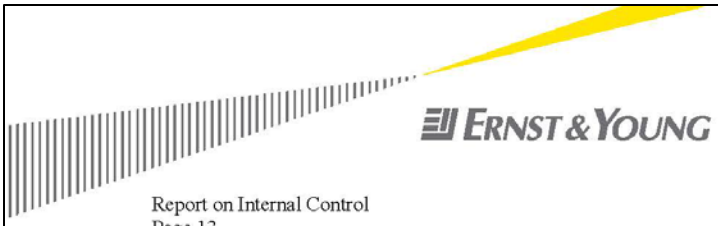
Although these entries are required to be posted to the general ledger in order for the financial statements to be accurate and internal controls over manual vouchers were found to be operating effectively, including supervisory reviews and properly maintained documentation to support each entry, many of these entries should be configured as routine systematic entries within the systems. HHS' management indicated that it has developed corrective actions to reduce the number of manual entries in future years. For NBS financial statement closing entries, although the entry is recorded in NBS for financial statement preparation purposes, the entry may be recorded in aggregate and reversed until such time that either the routine process captures the activity or the entries are carried forward to the next reporting period.

- As CMS continues their efforts to implement a web-based accounting system, HIGLAS, which will integrate the CMS contractors' standard claims processing system and

eventually replace FACS, CMS continues to address certain challenges. Although CMS is preparing financial statements using HIGLAS, the majority of the financial transactions and journal vouchers are recorded with the current mainframe-based financial system. As a result, full functionality of HIGLAS has not been implemented; however, CMS will transition and further implement HIGLAS in fiscal year 2013. CMS will need to fully understand the capability of HIGLAS to consolidate the financial data from the Medicare contractors and Central Office. In addition, there is no letter of credit or cash management module that currently exists within HIGLAS at Central Office that monitors the MACs' draws. The MACs' accounts receivable balances are recorded at Central Office through the manual journal voucher process. Further, there are a number of system interventions and manual adjustments or reconciliations to properly categorize the information within the financial statements, as required by OMB A-136. Finally, all MACs have implemented HIGLAS, except for the Durable Medical Equipment (DME) MACs. For these contractors the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

- As discussed in further detail above, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

- Within a decentralized complex organization like HHS, a single integrated financial system with strong internal controls is required for up-to-date accurate financial information needed for certain decision-making responsibilities. Many of the OPDIVs within HHS have their own financial management systems with individual data structures. Accordingly, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. With the implementation of CFRS, certain program, financial, and budgetary consolidated and OPDIV information is pulled into a common system on a quarterly basis; however, more timely and standard information is necessary to respond to congressional requests and for decision-making purposes. In certain cases, the department is required to use surveys or data calls to the OPDIVs or to the specified programs to obtain information for specific requests. There is no current plan to further consolidate financial management systems. Management indicated that with the expansion of certain aspects of CFRS and its future implementation of the Oracle Business Intelligence system, which started in FY 2012, it is working to improve upon its readily available information to support information analysis and to address potential requests from Congress, OMB, the President, and other entities.



Resource limitations and other priorities were noted as causes for delays in upgrading certain system and financial internal control processes limiting HHS' ability to comply with requirements under FFMIA. HHS will need to continue to review its available resources as resources become even more restrained with potential further budget cuts expected in FY 2013 and future years.

Financial Analysis and Oversight

Because deficiencies continue to exist in the financial management systems, management must compensate for the deficiencies by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner. Our review of internal control disclosed a series of deficiencies that impact HHS' ability to report accurate financial information on a timely basis. Consistent with prior years, during FY 2012, we found that certain controls were not consistently performed to ensure differences were properly identified, researched, and resolved in a timely manner, and that account balances were complete and accurate. We noted the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required:

Department/Operating Division Periodic Analysis and Reconciliation
When deficiencies exist in financial systems, as discussed above, management must compensate by implementing and strengthening other manual or compensating controls to ensure that errors and irregularities are detected in a timely manner. These manual and compensating controls would include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, and aging of accounts. During our audit, we found that certain controls still required further improvements. The following represent specific areas we noted that need enhanced periodic reconciliation and analysis procedures:

- Fund Balance with Treasury (FBWT) – As reported in prior years, on a monthly basis, HHS is responsible for reconciling approximately 500 Treasury appropriation symbols. As of September 30, 2012, the general ledger and Treasury's records differed by more than an approximate absolute value of $440 million. This primarily relates to differences that were not adequately researched and cleared from the Suspense Account Reconciliation. Additionally, management was not fully compliant with the U.S. Treasury FBWT Suspense Waiver according to all terms and conditions. Certain disbursements were not related to allowable transactions within the waiver, and differences in the Suspense Account Reconciliation were not properly cleared within the 60 days required time frame.
- Departmental Review of OPDIV Financial Statements—We noted that although desk officers have been assigned the responsibility of reviewing specific OPDIV financial reporting, the desk officers do not consistently review the supporting documentation to

ensure that the submissions are accurate or fully supported. In our review of the OPDIV level financial statements, we identified approximately $1.3 billion in differences that could not be identified or were not identified on a timely basis.

- Intra-governmental Transactions—For FY 2012, HHS has not properly classified trading partners and failed to report intergovernmental transactions using the appropriate USSGL account number as prescribed by the Treasury Financial Manual. In addition, a formal process has not been consistently applied between the trading partners to settle and report transactions. This issue is apparent at the intra-HHS reporting level, where the CFRS system has reported the absolute value of unresolved intra-HHS differences from each reciprocal category in excess of $962 million. This activity has been identified as "Federal" within HHS, but the trading partners have not resolved the differences. This does not follow the HHS elimination policy.

- Payroll —HHS has over 70,000 employees, whose pay, totaling in excess of $9.5 billion in FY 2012, was processed through a series of computer systems and internal controls. During FY 2012, we noted certain control issues related to payroll which resulted in an inappropriate withholding of employees' pay, inconsistencies in payroll systems, lack of supporting documentation and deficiencies related to IT security, specifically relating to access and segregation of duties within certain payroll-related systems. HHS has indicated that it is working to resolve certain control issues by strengthening IT security and manual controls. Additionally, HHS is considering transitioning its current legacy payroll systems to a new fully integrated system to improve its controls; however, the transition will not be fully implemented until FY 14.

Policies and Procedures

During our internal control documentation and testing phases, we noted that, although various internal control processes had been changed or updated, the Department had not completed its updating of procedural manuals to ensure sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. For example, we noted that certain policies and procedures were inconsistent with actual processes used or contained programs that no longer were performed by HHS. Additionally, we noted that HHS utilizes several different means of providing guidance to its personnel; however, the guidance is located at different intranet locations and may be at different stages of updating, thus, making it very confusing for the personnel to locate the most up-dated guidance. It is our understanding that the Department and its OPDIVs are currently updating all financial management procedures.

Finally, as part of the accounting centers' monthly processes, the Department has instituted a policy whereby the accounting centers certify the status of completing required periodic reconciliations. For each required reconciliation, the preparer and approver sign off and provide

a date of completion. On a monthly basis, the document is forwarded to the Department. No supporting documentation is required to be provided as part of the submission. Our review of the OPDIVs' submissions and the supporting documentation maintained at the OPDIVs identified inconsistencies in the procedures performed, the reports utilized, and the results provided among the various OPDIVs. Additionally, we noted that although the financial statements are submitted to OMB on the 21st day after the end of the quarter, the Department's policy did not require reconciliations to be completed and certified until the end of the month.

Medicaid Oversight

The Medicaid program is designed to reimburse the various state programs for the federal share of claim payments. CMS' Center for Medicaid and CHIP Services (CMCS) approves each state's budget (the authorized amount) on a quarterly or annual basis. The state draws against its authorized amounts, funds representing the federal share of claims paid. The state has to support its draws by supplying CMS with a certified report of actual expenditures. The certification of the actual expenditures by the states, the review by CMS and determination of any adjustments required to the draws, is to occur within the succeeding two quarters (180 days). The grant awards are reconciled on an annual basis and any over or under draws by the states are included in accounts receivable or payable on CMS financial statements.

In recent years, as CMS has separately identified and reconciled the states' annual funds, there has been a increase in the number of adjustments, which have become more difficult to resolve timely, highlighting the weaknesses of their oversight of the program expenditures. As of September 30, 2012, a $950 million accounts receivable and a $1.4 billion accounts payable balance were recorded in the CMS financial statements related to the Medicaid program, some of which dates back to FY 2009 and prior. Although the FY 2011 grant finalizations were performed more consistently and timely for the states in 2012, our analyses of this process still identified the following deficiencies in the Medicaid program:

- In the first quarter of FY 2012, CMS did not have the appropriate funding in one Treasury account to fund specific grant awards. Although the funding was available in the other Medicaid Treasury account, steps required to make the funds available were not executed in a timely fashion due to insufficient communications within CMS, a miscalculation for carry-forward and recovery amounts for the Medicaid budget authority and inadequate controls to timely identify the need for the funding. As a result, on November 30, 2011, specific states were notified of the lack of funding and negative grant awards were issued for $720 million to de-obligate the funds. On December 5, 2011, after the corrections in funding had been made, funds were re-obligated, and grant awards were reissued, to the states.

- There is not a timely settlement of the receivables and payables with the state after the annual grant award has been finalized, as certain amounts recorded in the prior year have yet to be resolved (either collected or paid). The states make adjustments or transfers

within their Payment Management System (PMS) accounts and appropriate documentation is not provided to CMS to validate and authorize the changes.

- The grant closeout process within the PMS is not performed timely nor are the grants simultaneously closed out within PMS when finalized. The states have two years to report the Medicaid claims expenditures. In certain cases, the balances have remained outstanding or unresolved for three years. The states have access to draw or transfer funds from open PMS accounts, even the accounts that CMS has finalized the grant award.

- Accounts receivable and payable balances were not identified timely in finalizing actual state certified expenditures nor are these balances recorded in detail within a Medicaid receivable or payable subsidiary ledger.

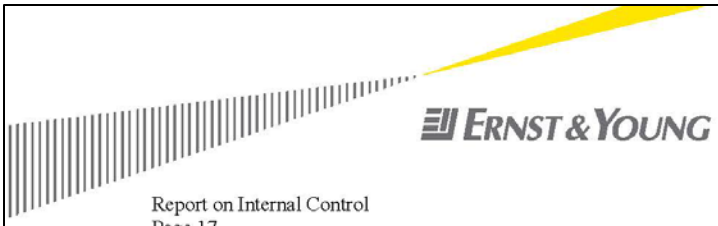
- CMS does not analyze the changes in the accounts receivable and payable balances to identify and monitor the current period activity nor are the impacts of the issued deferrals on the balances identified, documented or resolved timely. Some deferral balances have been outstanding for more than three years.

During FY 2012, an OIG report revealed that a state may have charged a rate to the Federal government for care at institutions for the developmentally disabled that may not have met the Federal requirement that payment for services be consistent with efficiency and economy. Use of a rate that meets the Federal requirement may have saved the Federal Medicaid program approximately $701 million in FY 2009. This report demonstrates another broad deficiency in the design of CMS' controls over the program. The design of the program controls rely upon the states provision of oversight for the providers of the required services to the beneficiaries. In certain cases, as was the case studied in the OIG report, the state was providing the services itself. In such an example, at least one expected level of state oversight was missing and additional oversight procedures should have been performed by CMS.

CMS needs to strengthen the Medicaid program oversight controls that will serve to prevent, detect and resolve errors timely and to deter fraud, waste and abuse of federal government resources. Strong oversight of the Medicaid program will facilitate an efficient and effective delivery of the program and allow continued focus on the mission of the Medicaid program. In strengthening the oversight and monitoring of the program, CMS should further enhance their coordination and collaboration of divisions within CMS and its data analyses capability.

Financial Management Controls at CMS

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on their internal controls dated November 9, 2012. In that report, we outlined details of deficiencies noted and made recommendations for improvement in their



financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies and those related to Medicaid oversight, business partner risk management, and Statement of Social Insurance (SOSI) noted elsewhere in this letter to be a significant deficiency for the CMS internal control over financial reporting. Our observations related to financial management controls included:

- The vulnerability to delays in handling the financial management implications of business issues brought about by the timing of preparation and quality of position papers supporting conclusions on critical accounting matters.

- Improvements that could be made to estimation accruals such as the contingent liability and Medicaid Entitlement Benefits Due and Payable (EBDP). In particular CMS annual estimate of the liability would be enhanced by the development of a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability.

- The potential for further improvement in financial controls can be made through the development of robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations.

- During our internal control testing, we noted several areas where the effectiveness of the related review processes and accounting monitoring procedures could be improved. For example, we found a $126 million difference identified during the audit of the State Plan Amendment accrual, untimely review of the Medicare FFS and Medicaid/CHIP regional office reports, and a lack of segregation of duties maintaining and reconciling the accounts receivable subsidiary ledgers.

Business Partner Risk Management at CMS

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Part C and Part D programs. In our internal control report related to our financial statement audit of CMS noted above, we continued to identify areas where improvements could be made in the overall control over and relationships with these third-party contractors referred to herein as "contractors."

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the MACs to develop and follow objectives established by CMS. Through the established procedures, the MACs are required to a) periodically certify to the completeness and accuracy of the financial information transmitted, b) document specific objectives and maintain supporting documentation for review and audit, and c) provide monthly shared system reports and related

support for reported amounts. Through its A-123, SSAE 16 and regional office processes, CMS tests and monitors the MACs' compliance with its policies and procedures, established controls and the accuracy of financial reporting.

While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight / monitoring process has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs.

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Statement of Social Insurance

The Statement of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from or on behalf of those same individuals. The presentation assumes the Medicare programs will continue in their current form under current law, albeit with certain economic assumptions that serve to constrain growth of the programs and imply refinements in response to the burden of the programs on economic activity.

In FY 2010, the passage of the Patient Protection and Affordable Care Act (ACA) significantly impacted the projections embodied in the Trustees Report and SOSI. The application of the current law formulation to development of the SOSI projection created significant challenges in applying this legislation. The degree of uncertainty experienced in FY 2010 regarding the projections continued through FY 2012, and as a result, we were unable to assess whether the presentation of the SOSI was fairly presented and fully useful for its intended purpose. Management has noted that the effects of some of ACA's provisions on Medicare are not known and the long-range feasibility of certain of the provisions is doubtful. The Trustees Report and related Actuarial Opinion reflect uncertainty regarding the projections and reflect concerns that certain current law provisions are not sustainable or will, based on prior patterns, likely be modified. The extent to which the current law SOSI projections, as presented, are subject to ongoing uncertainty this year and may not reflect management's reasonable estimate of the ultimate cash flows of the social insurance program, is discussed in the footnotes to the FY 2012 SOSI.

Developing auditable estimates for SOSI that fairly present the financial condition of the Trust Funds may require revisiting provisions of Federal accounting standards and potentially reformulating the assumptions used in SOSI and the Trustees Report to help improve the usefulness of the estimates provided. Certain efforts have been taken within CMS that will assist in narrowing areas of concern, including the appointment of a panel of advisors to assist in reviewing the projections and related assumptions. Although the work of the panel of advisors was not completed timely for the FY 2012 SOSI presentation and Trustees Report development,

certain recommendations made by the panel of advisors regarding the economic model were implemented by the CMS Office of the Actuary (OACT) in the FY 2012 SOSI. As the panel of advisors finalizes its report and recommendations, the completed set of measures will assist CMS during the refinement of future projections and in considering the appropriate response to concerns about the sustainability of current law provisions over the projection period. The investment made by the CMS OACT in formulating alternative illustrative scenarios, coupled with recent activities by the Federal Accounting Standards Advisory Board, may help inform the process and facilitate developing appropriate responses to the unique challenges faced by CMS in developing SOSI projections.

Recommendations

We recommend that HHS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Specifically, we recommend that HHS:

- Continue to focus on the areas of Fund Balance with Treasury reconciliations and related suspense accounts. Further, we recommend that the OPDIVs allocate adequate resources to perform the required account reconciliations and analyses on a timely basis.

- Continue to focus on the area of intra- and inter-governmental transactions to ensure partner codes are identifiable with the transaction and that trading partners are accounting for transactions consistently.

- Continue to strengthen controls over payroll-related processes.

- Continue to devise short-term and long-term resolutions to systematic and integration issues that complicate use of UFMS and NBS. HHS should continue to assess whether systems used to prepare the financial statements are working effectively and have been sufficiently tested prior to year-end reporting dates.

- Continue to offer updated guidance to personnel to ensure consistent application of policies among the various Operating Divisions and Headquarters.

- Advance management initiatives to streamline the processes for responding to financial information requests through implementation of the Oracle Business Intelligence tools and IT system consolidation or standardization to more effectively utilize CFRS to provide for more timely and up-to-date financial and business information.

- Continuously monitor the state Medicaid draws and perform grant oversight activities to ensure that the states do not overdraw funds. CMS should perform the grant closeout process timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority. In addition, the accounts receivable and payable Medicaid balances should be analyzed and validated through the use of a subsidiary ledger.

- Strengthen the Medicaid program oversight controls that will serve to prevent, detect and resolve errors timely and to deter fraud, waste and abuse of federal government resources. With respect to state-operated programs, CMS should perform additional oversight and analysis procedures related to the state costs.

- Developing SOSI projections representing management's reasonable estimate of the cash flows for the programs over a 75-year projection period will continue to be a challenge. In pursuing the ultimate resolution, CMS should obtain and implement the complete set of recommendations made by the panel of advisors to assist in addressing the challenges presented by the passage of ACA. In addition, continue and broaden discussions with key stakeholders and standard-setting bodies, including the Federal Accounting Standards Advisory Board, to co-develop appropriate recommendations for potential revisions to the approaches used in presenting projections for the programs in the Trustees Report and standards applicable to presentation of the SOSI to aid in ensuring that the SOSI projection is meaningful and presents fairly the financial condition of the Trust Funds.

Additionally, we recommend that CMS continue to develop and refine its financial management controls and business partner risk management as a means to improve its accounting, analysis and oversight of financial management activity. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

STATUS OF PRIOR YEAR FINDINGS

In the reports on the results of the FY 2011 audit of the HHS financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

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Material Weakness		
Issue Area	**Summary Control Issue**	**FY 2012 Status**
Financial Management Information Systems	• Non-CMS OPDIV Financial Management Information Systems • Non-CMS OPDIV Application Security Management • CMS Configuration Management • CMS Information Security—Fee- For -Service	Certain progress noted; certain issues need continued focus. Modified Repeat Condition
	Significant Deficiency	
Financial Reporting Systems, Analyses, and Oversight	• Lack of Integrated Financial Management System • Financial Analysis and Oversight • Statement of Social Insurance	Certain progress noted. Certain issues require continued focus. Modified Repeat Condition

We have reviewed our findings and recommendations with HHS management. Management generally concurs with our findings and recommendations and will provide a corrective action plan to address the findings identified in this report. We did not audit HHS' response and, accordingly, we express no opinion on it.

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

/Ernst & Young LLP/

November 14, 2012

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Report on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited the financial statements of the U.S. Department of Health and Human Services (HHS) as of and for the year ended September 30, 2012, and we were engaged to audit the statement of social insurance as of January 1, 2012 and the related statement of changes in social insurance amounts for the period ended January 1, 2012, and have issued our Report of Independent Auditors thereon dated November 14, 2012. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2012 and the related statement of changes in social insurance amounts for the period ended January 1, 2012. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

As part of obtaining reasonable assurance about whether HHS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 07-04, as amended, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA) (P.L.104-208); however, providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS.

The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance with the following laws and regulations or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 07-04, as amended, as described below.

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During fiscal year (FY) 2012, HHS' management declared that the Indian Health Service had violated certain provisions of the Anti-Deficiency Act (31 U.S.C. section 1341 and OMB Circular A-11). Additionally, HHS is currently investigating other potential violations of the Anti-Deficiency Act at the National Institutes of Health, the Administration for Children and Families and other operating divisions.

Additionally, the Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300) as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 (P.L. 111-204) (hereinafter the Acts) require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While it continues to make progress, HHS is currently not in full compliance with the requirements of the Acts. HHS has reported error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF); however, the Medicare Part C component rate is greater than the statutorily required maximum of 10 percent. As for improper payment estimates in the TANF program, HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement due to Section 411 of the Social Security Act which specifies the data elements that HHS may require states to report and Section 417 of the same Act dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS feels that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the Act. In addition, Medicare Part C is not in full compliance with Section 6411 of the Affordable Care Act related to improper payment recovery programs.

Under FFMIA, we are required to report whether HHS' financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger (USSGL) at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed instances in which HHS' financial management systems did not substantially comply with certain requirements as discussed above. We have identified the following instances of noncompliance related to FFMIA:

- Certain subsidiary systems are not integrated with the Unified Financial Management System (UFMS) and are not complemented by sufficient manual preventative and detective type controls. For example, although all Medicare contractors have implemented the Healthcare Integrated General Ledger Accounting System (HIGLAS), the Durable Medical Equipment contractors continue to be heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS. Additionally, CMS continues to address certain challenges with its financial system, including the majority of the financial transactions and journal vouchers are recorded with the current mainframe-based financial system and a number of system interventions and manual adjustments or reconciliations are required to properly categorize information

within the financial statements, as required by OMB A-136. Finally, HHS continues to resolve certain legacy system issues within the National Institutes of Health's (NIH) Business System (NBS). As a result, although progress was made in FY 2012, NIH's NBS continues to have certain transactions which are captured incorrectly as compared to the Treasury Standard General Ledger at the transaction level and require adjustments to the accounting records.

- During fiscal year 2012, thousands of manual journal vouchers were required to be recorded in UFMS/NBS to post certain types of transactions, including budgetary and proprietary, not currently configured correctly within UFMS and for the purpose of developing quarterly financial statements.
- Certain reconciliations and clearance of differences are not completed timely due to the use of ad hoc inquiries and system limitations on matching debits and credits to resolve certain issues.
- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.
- Currently, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. HHS is currently working on implementing Oracle Business Tools to provide access to more timely information to support decision making.

* * * * *

Our Report on Internal Control dated November 14, 2012, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from HHS' management responsible for addressing the noncompliance are provided in their letter dated November 14, 2012. We did not audit management's comments and, accordingly, we express no opinion on them. Additionally, HHS is updating its agency-wide corrective action plan to address FFMIA and other financial management issues.

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

/Ernst & Young LLP/

November 14, 2012

DEPARTMENT'S RESPONSE TO THE REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY 2012 Financial Statement Audit

We would like to thank the Office of Inspector General and your contractors, Ernst & Young LLP, for your efforts on our behalf. We appreciate the professionalism exhibited by your staff and contractors during the audit.

We appreciate the opportunity to comment on the draft reports provided to us. We generally concur with the findings in the Final Report which has been included in this FY 2012 *Agency Financial Report*. In response to your reports, we will prepare corrective action plans to address the identified findings within the next 60 days.

HHS management is committed to working toward resolving these challenges. We look forward to continued collaboration with the Office of Inspector General to improve our stewardship of taxpayer funds.

/Ellen G. Murray/
Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 14, 2012

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services
Consolidated Balance Sheet

As of September 30, 2012 and 2011
(in Millions)

	2012	2011
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 197,348	$ 166,855
Investments, Net (Note 4)	306,381	325,443
Accounts Receivable, Net (Note 5)	820	1,020
Advances (Note 8)	48	29
Total Intragovernmental Assets	504,597	493,347
Accounts Receivable, Net (Note 5)	10,943	10,908
Inventory and Related Property, Net (Note 6)	8,072	6,546
General Property, Plant and Equipment, Net (Note 7)	5,401	5,657
Advances (Note 8)	1,244	16,090
Other Assets	396	332
Total Assets	$ 530,653	$ 532,880
Stewardship PP&E (Note 1)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 659	$ 649
Other Liabilities (Note 13)	1,430	1,100
Total Intragovernmental Liabilities	2,089	1,749
Accounts Payable	425	547
Entitlement Benefits Due and Payable (Note 10)	72,493	80,882
Accrued Grant Liability (Note 12)	3,748	4,485
Federal Employee and Veterans' Benefits (Note 11)	11,008	10,219
Contingencies and Commitments (Note 14)	6,766	3,623
Other Liabilities (Note 13)	2,962	3,412
Total Liabilities	99,491	104,917
Net Position		
Unexpended Appropriations - Earmarked funds (Note 21)	20,418	4,236
Unexpended Appropriations - Other funds	135,768	122,558
Unexpended Appropriations, Total	156,186	126,794
Cumulative Results of Operations - Earmarked funds (Note 21)	267,009	293,362
Cumulative Results of Operations - Other funds	7,967	7,807
Cumulative Results of Operations, Total	274,976	301,169
Total Net Position	431,162	427,963
Total Liabilities and Net Position	$ 530,653	$ 532,880

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

U.S. Department of Health and Human Services
Consolidated Statement of Net Cost
For the Years Ended September 30, 2012 and 2011
(in Millions)

	2012	2011
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 802,301	$ 817,383
Exchange Revenue (Note 16)	(65,078)	(63,686)
CMS Net Cost of Operations	737,223	753,697
Other Segments:		
Administration for Children and Families (ACF)	49,143	54,027
Administration for Community Living (ACL)	1,488	1,569
Agency for Healthcare Research and Quality (AHRQ)	635	553
Centers for Disease Control and Prevention (CDC)	10,380	10,407
Food and Drug Administration (FDA)	3,250	3,144
Health Resources and Services Administration (HRSA)	8,653	8,523
Indian Health Service (IHS)	6,726	5,240
National Institutes of Health (NIH)	31,834	34,406
Office of the Secretary (OS)	3,684	5,033
Program Support Center (PSC)	1,774	1,817
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,480	3,581
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	$ 121,047	$ 128,300
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	497	(82)
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	$ 121,544	$ 128,218
Exchange Revenue (Note 16)	(3,220)	(3,782)
Other Segments Net Cost of Operations	118,324	124,436
Net Cost of Operations (Note 25)	$ 855,547	$ 878,133

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2012
(in Millions)

	2012			
	Earmarked Funds	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 293,362	$ 7,807	$ -	$ 301,169
Budgetary Financing Sources:				
Appropriations Used	231,390	376,985	-	608,375
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	205,006	-	-	205,006
Non-exchange Revenue - Investment Revenue	13,890	2	-	13,892
Non-exchange Revenue - Other	3,417	-	-	3,417
Donations and Forfeitures of Cash and Cash Equivalents	47	-	-	47
Transfers-in/out without Reimbursement	(3,637)	2,232	-	(1,405)
Other (+/-)	-	1	-	1
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	6	-	6
Transfers-in/out Without Reimbursement (+/-)	(3)	2	-	(1)
Imputed Financing	35	633	(158)	510
Other (+/-)	-	(494)	-	(494)
Total Financing Sources	450,145	379,367	(158)	829,354
Net Cost of Operations (+/-)	476,498	379,207	(158)	855,547
Net Change	(26,353)	160	-	(26,193)
Cumulative Results of Operations:	**$ 267,009**	**$ 7,967**	**$ -**	**$ 274,976**
Unexpended Appropriations:				
Beginning Balances	$ 4,236	$ 122,558	$ -	$ 126,794
Budgetary Financing Sources:				
Appropriations Received	250,966	398,108	-	649,074
Appropriations Transferred in/out	-	9	-	9
Other Adjustments	(3,394)	(7,922)	-	(11,316)
Appropriations Used	(231,390)	(376,985)	-	(608,375)
Total Budgetary Financing Sources	16,182	13,210	-	29,392
Total Unexpended Appropriations	20,418	135,768	-	156,186
Net Position	**$ 287,427**	**$ 143,735**	**$ -**	**$ 431,162**

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2011
(in Millions)

	2011			
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**
Cumulative Results of Operations:				
Beginning Balances	$ 317,334	$ 5,049	$ -	$ 322,383
Budgetary Financing Sources:				
Appropriations Used	242,151	405,173	-	647,324
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	192,341	-	-	192,341
Non-exchange Revenue - Investment Revenue	15,736	4	-	15,740
Non-exchange Revenue - Other	2,469	-	-	2,469
Donations and Forfeitures of Cash and Cash Equivalents	56	-	-	56
Transfers-in/out without Reimbursement	(3,809)	2,373	-	(1,436)
Other (+/-)	(1)	(32)		(33)
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	5	-	5
Transfers-in/out Without Reimbursement (+/-)	(4)	23	-	19
Imputed Financing	41	687	(127)	601
Other (+/-)	6	(173)	-	(167)
Total Financing Sources	448,986	408,060	(127)	856,919
Net Cost of Operations (+/-)	472,958	405,302	(127)	878,133
Net Change	(23,972)	2,758	-	(21,214)
Cumulative Results of Operations	**$ 293,362**	**$ 7,807**	**$ -**	**$ 301,169**
Unexpended Appropriations				
Beginning Balances	$ 1,675	$ 140,468	$ -	$ 142,143
Budgetary Financing Sources				
Appropriations Received	245,950	417,471	-	663,421
Appropriations Transferred in/out	-	(294)	-	(294)
Other Adjustments	(1,238)	(29,914)	-	(31,152)
Appropriations Used	(242,151)	(405,173)	-	(647,324)
Total Budgetary Financing Sources	2,561	(17,910)	-	(15,349)
Total Unexpended Appropriations	4,236	122,558	-	126,794
Net Position	**$ 297,598**	**$ 130,365**	**$ -**	**$ 427,963**

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

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2012 and 2011
(in Millions)

	2012		2011	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated Balance, Brought Forward, Oct 1	$ 51,730	$ 71	$ 59,275	$ 50
Recoveries of Prior Year Unpaid Obligations	25,746	-	25,808	-
Other Changes in Unobligated Balance	(4,524)	-	(8,812)	-
Unobligated Balance from Prior Year Budget Authority, Net	72,952	71	76,271	50
Appropriations (Discretionary and Mandatory)	1,191,860	-	1,218,807	-
Borrowing Authority (Discretionary and Mandatory) (Note 17)	-	3,194	-	-
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	20,122	1,636	20,168	37
Total Budgetary Resources	**$ 1,284,934**	**$ 4,901**	**$ 1,315,246**	**$ 87**
Status of Budgetary Resources:				
Obligations Incurred (Note 18)	$ 1,204,154	$ 1,726	$ 1,263,516	$ 16
Unobligated Balance, End of Year:				
Apportioned	71,919	3,134	44,125	44
Exempt from Apportionment	184	-	265	-
Unapportioned	8,677	41	7,340	27
Total Unobligated Balance, End of Year	80,780	3,175	51,730	71
Total Budgetary Resources	**$ 1,284,934**	**$ 4,901**	**$ 1,315,246**	**$ 87**
Change in Obligated Balance:				
Unpaid Obligations, Brought Forward, Oct 1	$ 188,534	$ -	$ 182,540	$ -
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	(10,360)	-	(7,179)	-
Obligated Balance, Start of Year (Net)	178,174	-	175,361	-
Obligations Incurred (Note 18)	1,204,154	1,726	1,263,516	16
Outlays (Gross)	(1,186,188)	(124)	(1,231,433)	(16)
Change in Uncollected Customer Payments from Federal Sources	257	(1,587)	(3,462)	-
Recoveries of Prior Year Unpaid Obligations	(25,746)	-	(25,808)	-
Obligated Balance, End of Year				
Unpaid Obligations, End of Year (Gross)	180,754	1,602	188,534	-
Uncollected Customer Payments from Federal Sources, End of Year	(10,103)	(1,587)	(10,360)	-
Obligated Balance, End of Year (Net)	**$ 170,651**	**$ 15**	**$ 178,174**	**$ -**
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,211,982	$ 4,830	$ 1,238,975	$ 37
Actual Offsetting Collections (Discretionary and Mandatory)	(20,291)	(48)	(17,156)	(37)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	257	(1,587)	(3,462)	-
Budget Authority, Net (Discretionary and Mandatory)	**$ 1,191,948**	**$ 3,195**	**$ 1,218,357**	**$ -**
Outlays, Gross (Discretionary and Mandatory)	$ 1,186,188	$ 124	1,231,433	16
Actual Offsetting Collections (Discretionary and Mandatory)	(20,291)	(48)	(17,156)	(37)
Outlays, Net (Discretionary and Mandatory)	1,165,897	76	1,214,277	(21)
Distributed Offsetting Receipts	(317,777)	-	(322,724)	-
Agency Outlays, Net (Discretionary and Mandatory)	**$ 848,120**	**$ 76**	**$ 891,553**	**$ (21)**

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

U.S. Department of Health and Human Services

Statement of Social Insurance

75-Year Projection as of January 1, 2012 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	(unaudited) 2012	(unaudited) 2011	(unaudited) 2010	2009	2008
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 22 and 23)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 7,929	$ 7,581	$ 7,216	$ 6,348	$ 6,320
SMI Part B	14,431	13,595	12,688	16,323	14,932
SMI Part D	5,866	6,438	6,355	6,144	6,527
Have attained eligibility age (age 65 and over)					
HI	302	262	248	209	202
SMI Part B	2,395	2,122	1,972	1,924	1,785
SMI Part D	694	695	646	595	581
Those expected to become participants					
HI	7,367	7,260	6,944	5,451	5,361
SMI Part B	3,333	3,223	3,077	4,909	4,480
SMI Part D	2,568	2,817	2,714	2,632	2,856
All current and future participants					
HI	15,598	15,104	14,408	12,008	11,883
SMI Part B	20,159	18,940	17,737	23,156	21,197
SMI Part D	9,128	9,950	9,715	9,371	9,964
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 22 and 23)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,919	$ 12,887	$ 12,032	$ 18,147	$ 17,365
SMI Part B	14,303	13,489	12,587	16,342	14,949
SMI Part D	5,866	6,438	6,355	6,144	6,527
Have attained eligibility age (age 65 and over)					
HI	3,369	2,923	2,648	2,958	2,747
SMI Part B	2,646	2,343	2,166	2,142	1,986
SMI Part D	694	695	646	595	581
Those expected to become participants					
HI	2,891	2,546	2,411	4,673	4,506
SMI Part B	3,211	3,108	2,984	4,672	4,262
SMI Part D	2,568	2,817	2,714	2,632	2,856
All current and future participants					
HI	21,179	18,356	17,090	25,778	24,619
SMI Part B	20,159	18,940	17,737	23,156	21,197
SMI Part D	9,128	9,950	9,715	9,371	9,964
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 22 and 23)					
HI	$ (5,581)	$ (3,252)	$ (2,683)	$ (13,770)	$ (12,737)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 22 and 23)					
HI	$ (5,581)	$ (3,252)	$ (2,683)	(13,770)	$ (12,737)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	244	272	304	321	312
SMI Part B	80	71	76	59	53
SMI Part D	1	1	1	1	3
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 22 and 23)					
HI	$ (5,337)	$ (2,980)	$ (2,378)	$ (13,449)	$ (12,425)
SMI Part B	80	71	76	59	53
SMI Part D	1	1	1	1	3

Please note for the entirety of the Statement of Social Insurance:

Totals do not necessarily equal the sum of the rounded components.

Current participants are assumed to be 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.

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

U.S. Department of Health and Human Services
Statement of Social Insurance (Continued)
75-Year Projection as of January 1, 2012 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	(unaudited) 2012	(unaudited) 2011	(unaudited) 2010	2009	2008
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 3,391	$ 3,079	$ 2,866	$ 2,729	$ 2,568
Expenditures	6,709	5,961	5,459	5,695	5,315
Income less expenditures	(3,319)	(2,882)	(2,593)	(2,967)	(2,746)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	28,227	27,615	26,259	28,815	27,778
Expenditures	35,088	32,814	30,974	40,634	38,841
Income less expenditures	(6,861)	(5,199)	(4,715)	(11,819)	(11,063)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(10,180)	(8,081)	(7,308)	(14,786)	(13,809)
Combined Medicare Trust Fund assets at start of period	325	344	381	381	368
Actuarial present value of estimated future income (excluding interest) less expenditures plus Trust Fund assets at start of period	(9,855)	(7,737)	(6,927)	(14,405)	(13,441)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	13,268	13,300	12,735	12,991	12,698
Expenditures	8,669	8,471	8,109	11,976	11,625
Income less expenditures	4,599	4,829	4,626	1,016	1,073
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,581)	(3,252)	(2,683)	(13,770)	(12,737)
Combined Medicare Trust Fund assets at start of period	325	344	381	381	368
Actuarial present value of estimated future income (excluding interest) less expenditures plus Trust Fund assets at start of period	$ (5,256)	$ (2,908)	$ (2,302)	$ (13,390)	$ (12,369)

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be 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.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (unaudited)
Medicare Hospital and Supplementary Medical Insurance
(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare *(Note 24)*					
As of January 1, 2011	$ 43,993	$ 47,245	$ (3,252)	$ 344	$ (2,908)
Reasons for change					
Change in the valuation period	2,011	2,136	(125)	(28)	(153)
Change in projection base	113	(173)	286	9	295
Changes in the demographic assumptions	(1,189)	(1,092)	(97)	-	(97)
Changes in economic and health care assumptions	24	2,570	(2,546)	-	(2,546)
Changes in law	(66)	(219)	153	-	153
Net changes	892	3,221	(2,329)	(19)	(2,348)
As of January 1, 2012	$ 44,885	$ 50,467	$ (5,581)	$ 325	$ (5,256)
HI - Part A *(Note 24)*					
As of January 1, 2011	$ 15,104	$ 18,356	$ (3,252)	$ 272	$ (2,980)
Reasons for change					
Change in the valuation period	634	759	(125)	(34)	(159)
Change in projection base	15	(271)	286	6	292
Changes in the demographic assumptions	(84)	13	(97)	-	(97)
Changes in economic and health care assumptions	(71)	2,475	(2,546)	-	(2,546)
Changes in law	-	(153)	153	-	153
Net changes	494	2,824	(2,329)	(28)	(2,357)
As of January 1, 2012	$ 15,598	$ 21,179	$ (5,581)	$ 244	$ (5,337)
SMI - Part B *(Note 24)*					
As of January 1, 2011	$ 18,940	$ 18,940	$ -	$ 71	$ 71
Reasons for change					
Change in the valuation period	845	845	-	6	6
Change in projection base	152	152	-	2	2
Changes in the demographic assumptions	(339)	(339)	-	-	-
Changes in economic and health care assumptions	623	623	-	-	-
Changes in law	(61)	(61)	-	-	-
Net changes	1,220	1,220	-	8	8
As of January 1, 2012	$ 20,159	$ 20,159	$ -	$ 80	$ 80
SMI - Part D *(Note 24)*					
As of January 1, 2011	$ 9,950	$ 9,950	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	533	533	-	-	-
Change in projection base	(54)	(54)	-	-	-
Changes in the demographic assumptions	(767)	(767)	-	-	-
Changes in economic and health care assumptions	(528)	(528)	-	-	-
Changes in law	(5)	(5)	-	-	-
Net changes	(822)	(822)	-	-	-
As of January 1, 2012	$ 9,128	$ 9,128	$ -	$ 1	$ 1

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

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (unaudited)
Medicare Hospital and Supplementary Medical Insurance
(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare *(Note 24)*					
As of January 1, 2010	$ 41,860	$ 44,543	$ (2,683)	$ 381	$ (2,302)
Reasons for change					
Change in the valuation period	1,952	2,063	(112)	(49)	(160)
Change in projection base	(1,069)	(538)	(531)	11	(519)
Changes in the demographic assumptions	(67)	44	(112)	-	(112)
Changes in economic and health care assumptions	1,299	1,115	185	-	185
Changes in law	19	19	-	1	1
Net changes	2,134	2,703	(569)	(37)	(606)
As of January 1, 2011	$ 43,993	$ 47,245	$ (3,252)	$ 344	$ (2,908)
HI - Part A *(Note 24)*					
As of January 1, 2010	$ 14,408	$ 17,090	$ (2,683)	$ 304	$ (2,378)
Reasons for change					
Change in the valuation period	611	723	(112)	(32)	(143)
Change in projection base	(427)	103	(531)	(1)	(531)
Changes in the demographic assumptions	(151)	(40)	(112)	-	(112)
Changes in economic and health care assumptions	664	479	185	-	185
Changes in law	-	-	-	-	-
Net changes	696	1,265	(569)	(32)	(602)
As of January 1, 2011	$ 15,104	$ 18,356	$ (3,252)	$ 272	$ (2,980)
SMI - Part B *(Note 24)*					
As of January 1, 2010	$ 17,737	$ 17,737	$ -	$ 76	$ 76
Reasons for change					
Change in the valuation period	807	807	-	(16)	(16)
Change in projection base	(552)	(552)	-	12	12
Changes in the demographic assumptions	123	123	-	-	-
Changes in economic and health care assumptions	806	806	-	-	-
Changes in law	19	19	-	1	1
Net changes	1,203	1,203	-	(4)	(4)
As of January 1, 2011	$ 18,940	$ 18,940	$ -	$ 71	$ 71
SMI - Part D *(Note 24)*					
As of January 1, 2010	$ 9,715	$ 9,715	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	534	534	-	(1)	(1)
Change in projection base	(90)	(90)	-	-	-
Changes in the demographic assumptions	(39)	(39)	-	-	-
Changes in economic and health care assumptions	(170)	(170)	-	-	-
Changes in law	-	-	-	-	-
Net changes	234	234	-	-	-
As of January 1, 2011	$ 9,950	$ 9,950	$ -	$ 1	$ 1

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

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

For the years ended September 30, 2012 and 2011

Note 1. Summary of Significant Accounting Policies

Reporting Entity

The Department of Health and Human Services (HHS or the Department) 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* was signed into law, creating a separate Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Organization and Structure of HHS

HHS is comprised of the Office of the Secretary (OS) and eleven other Operating Divisions (OPDIVs) with diverse missions and programs. OS 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 OS, the Program Support Center (PSC) reports on its activity separately because its business activities encompass offering services to other federal agencies and HHS OPDIVs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes comprising a total of 12 responsibility segments. Therefore, references to the CDC responsibility segment include ATSDR. Managers of the responsibility segments report directly to the Department'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 for Community Living (ACL) – formerly 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 the Program Support Center
11. Program Support Center (PSC)
12. Substance Abuse and Mental Health Services Administration (SAMHSA)

HHS partners with other governmental agencies to accomplish its mission. One such partnership is with the Department of Homeland Security (DHS) for the Biodefense Countermeasures Fund. It is reported on HHS financial statements under the OS responsibility segment.

Basis of Accounting and Presentation

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 (U.S.C.) §3515(b), the *Chief Financial Officers Act*, as amended by the *Government Management Reform Act* (GMRA), and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136*, Financial Reporting Requirements* (OMB Circular A-136). These statements have been prepared from HHS' financial records using an accrual basis in conformity with accounting principles generally accepted in the United States (U.S.). 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 (AICPA) 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 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 250 appropriations and fund accounts. The fund accounts include accounts used for suspense, collection of receipts and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheet 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 HHS have not been eliminated from these statements. Supplemental information is accumulated from the OPDIVs' reports, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with accounting principles generally accepted in the United States are based on the selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. 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 the child entity executes 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.

HHS received an exception to the Parent/Child reporting requirements of OMB Circular A-136, as it pertains to the allocation transfer from DHS to HHS for the Biodefense Countermeasures Fund for Fiscal Year (FY) 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

In addition to these funds, HHS allocates funds, as the parent, to the Department of Interior's Bureau of Indian Affairs, Treasury and the Internal Revenue Service. HHS receives allocation transfers, as the child, from the Departments of Agriculture, Justice and State.

Reclassifications and Adjustments

Certain FY 2011 balances have been reclassified to conform to FY 2012 financial statement presentations. The effects are immaterial. Also during 2011, HHS implemented a consolidated reporting solution. As a result, immaterial balances were reclassified in both the Statement of Changes in Net Position and the Statement of Budgetary Resources. In addition, in accordance with OMB Circular A-136, the format of the Statement of Budgetary Resources changed in FY 2012. Therefore, the FY 2011 balances have been presented in the FY 2012 format.

Earmarked Funds

Earmarked funds are financed by specifically identified revenues, often supplemented by other financing sources which remain available over time. Earmarked funds 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.

HHS' major earmarked funds are described in the sections below.

Medicare Hospital Insurance (HI) Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare HI Trust Fund. Medicare contractors are paid by 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. A portion of HHS payments to Medicare Advantage Plans (previously known as Managed Care Plans) is 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 (Ch 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 self-employment 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. The SSA uses the wage totals reported annually 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 HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end-stage renal disease treatment, rural health clinics, laboratory services 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. A portion of HHS payments to Medicare Advantage Plans is 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 Fund. 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 SMI Trust Fund – Part D

The *Medicare Prescription Drug, Improvement and Modernization Act* (*Medicare Modernization Act,* or MMA) established the Medicare Supplementary Medical Insurance Trust Fund – Part D, Prescription Drug Benefit. The Prescription Drug Benefit makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Two types of drug plans are offered by insurance companies and other private companies approved by Medicare: Medicare Prescription Drug Plans, which add coverage to Fee-for-Service (FFS) 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 (RDS). The Low Income Subsidy (LIS) helps those with limited income and resources. The *Affordable Care Act* provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs from 100 percent in 2010 (including the $250 rebate) to 25 percent by 2020.

Medicare Integrity Program

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program and 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, HHS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews and cost report audits. In addition, the Department educates 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

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriation and user fees. The U.S. Constitution prescribes that no money may be expended by an 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 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

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).

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended and 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.

Borrowing Authority

HHS uses indefinite borrowing authority under the *Federal Credit Reform Act*, as amended, for its loan programs. Borrowing authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. Any unobligated borrowing authority does not carry forward to the next fiscal year. HHS has three programs with borrowing authority: the Consumer Operated and Oriented Plan (CO-OP) Loan Program, the Health Center Loan Program and the Health Education Assistance Loan Program.

Direct Loans. Under the *Patient Protection and Affordable Care Act* (ACA), the CO-OP Loan Program was established to provide loans for start-up costs and repayable grants to assist the applicant in meeting State solvency requirements. This provision fosters the creation of qualified, non-profit health insurance issuers who will offer qualified health plans in the individual and small-group markets of each State. These loans will be repaid in a manner consistent with federal requirements and terms and conditions of the loan agreement. In FY 2012, HHS awarded the first loan agreements for both start-up and solvency requirements; however, disbursements have been made for only the start-up costs.

Loan Guarantees. 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 HHS on the defaulted loans. The liabilities for loan guarantees are valued at the present value of the cash outflows from HHS less the present value of related inflows.

HHS reports loans and loan guarantees in accordance with the *Federal Credit Reform Act*. Due to the immateriality of these Direct Loans and Loan Guarantees, the related receivables and liabilities are reported in Other Assets and Other Liabilities, respectively. Budgetary related activity is reported separately within the Statement of Budgetary Resources.

Exchange Revenue

Exchange revenue results when HHS provides a good or service to another entity and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its

programs. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury central accounting system. Regardless of whether they are derived 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 HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results 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 revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

Imputed Financing Sources

In certain instances, HHS' operating costs are paid out of funds appropriated to other federal agencies. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management and certain legal judgments against HHS are paid from the Judgment Fund maintained by the Treasury. When costs are identifiable to HHS and directly attributable to HHS' operations and are paid by other agencies, HHS recognizes these amounts as imputed costs within 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 either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is 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 incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies. The more prominent of these relationships are with SSA and the Treasury. SSA determines eligibility for Medicare programs and also deducts Medicare Part-B premiums from Social Security benefit payments. SSA then 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. Medicare Part-D is primarily financed by the General Fund of the Treasury, as well as beneficiary premiums and payments from States.

Entity and Non-Entity Assets

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

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are comprised of delinquent child support payments for the Child Support Enforcement Program, which are withheld from federal tax refunds and interest accrued on over-payments and cost settlements reported by the Medicare contractors.

Fund Balance with Treasury

HHS maintains its available funds with the Treasury. The Fund Balance with Treasury (FBWT) is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by the Treasury and HHS FBWT accounts are reconciled with those of Treasury on a regular basis.

Custodial Activity

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

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. The FDA custodial activity involves collections of Civil Monetary Penalties (CMP) assessed by the Department of Justice (DOJ) on behalf of the FDA. The FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed and distributed animal food and drug products. The CDC custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

Investments, Net

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. Sections 1817 and 1841 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 governmental purposes. Treasury securities are issued by the Bureau of Public Debt to the HI and SMI Trust Funds as evidence of their receipt and are reported as an asset for the Trust Funds and a corresponding 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 raising taxes, raising other receipts, borrowing from the public or repaying less debt, or 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 semi-annually (June and December) by Treasury and at fiscal year-end 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 the Bureau of Public Debt in the form of One Day Certificates and Market-Based Bills, Notes and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Bills issued by the Bureau of Public Debt. Funds are invested for either a 90 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 HHS' intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act (*CHIPRA) established a Child Enrollment Contingency Fund to provide additional funding to States that experience shortfalls in their Children's Health Insurance Programs (CHIP). The ACA extended the availability of the fund through 2015. This fund is invested in Non-Marketable, Market-Based Bills issued by the Bureau of Public Debt. These investments will be redeemed as funds are needed by the States to cover short-term shortfalls in the program.

Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible amounts on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments, Medicare Prescription Drug over-payments, Medicare premiums, State phased-down contributions and Medicaid over-payments and audit disallowances.

Accounts Receivable, Net from the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, HHS calculates the allowance for uncollectible amounts 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 have been recorded at a net realizable amount based on historical analyses of actual recoveries and the rate of disallowances found in favor of the States.

Advances and Accrued Grant Liability

HHS awards grants to various grantees and provides advance payments to meet grantees' cash needs to carry out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability occurs when the accrued grant expenses exceed the outstanding advances to grantees.

HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." "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 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 estimated fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash draw. For the Foster Care Program, included in the Child Welfare Program, the year-end accrual estimate equals the estimated fourth quarter disbursements, plus one-week average of foster care annual expenditures for expenses incurred prior to the cash draw.

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

Inventory and Related Property, Net

Inventory and Related Property, Net 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 Funds (SSFs) for sale to HHS components and other federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC SSF's inventories and using the moving average valuation method for the NIH SSF's 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. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 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 H5N1.

General Property, Plant and Equipment, Net

The General Property, Plant and Equipment, Net 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 Property, Plant and Equipment is full cost, including all costs incurred to bring the Property, Plant and Equipment to a form and location suitable for its intended use and is presented net of accumulated depreciation.

The cost of Property, Plant and Equipment acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception, or the estimated fair market value on the date of acquisition when acquired through a donation. The cost of Property, Plant and Equipment transferred from other federal entities is the

transferring entity's net book value. HHS capitalizes all Property, Plant and Equipment, except internal use software, with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more.

The Property, Plant and Equipment 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) Number 10, *Accounting for Internal Use Software,* requires that the capitalization of internally developed, contractor-developed and commercial off-the-shelf software begin in the software development phase. HHS' capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the threshold for revolving fund accounts is $500 thousand. Costs below the threshold levels are expensed. Software is amortized for a period of time consistent with the estimated useful life used for planning and acquisition purposes. The estimated useful life for internal use software is three to ten years for amortization purposes. HHS begins amortization using the straight-line method when the internal use software is placed in use. Capitalized costs include all direct and indirect costs.

Stewardship Property, Plant & Equipment

Stewardship Property, Plant and Equipment consists of stewardship land whose physical properties resemble those of General Property, Plant and Equipment that are traditionally capitalized in the financial statements. Based on SFFAS Number 29, *Heritage Assets and Stewardship Land,* and due to the immateriality of these assets, HHS does not report a related amount on the balance sheet.

HHS' stewardship assets support the IHS 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 Property, Plant and Equipment), but have always been held by the U.S. Government as separate and distinct because of its long-term trust responsibility. 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 Property, Plant and Equipment, must be returned to the Department of the Interior's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

HHS asset accountability reports differentiate Indian Trust land parcels from General Property, Plant and Equipment situated thereon. The Required Supplementary Information section provides additional information for Stewardship Property, Plant and Equipment.

Liabilities

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

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation and 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 contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for the *Federal Employees' Compensation Act* (FECA) *of 1916* (5 U.S.C. 751) disability payments. The actuarial FECA liability determined by the DOL but not yet billed is also included in this category.

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 Number 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 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. HHS does not have reportable activities as defined by SFFAS Number 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. A 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 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 HHS.

Medicare

The Medicare liability is developed by the CMS Office of the Actuary and includes:

- An estimate of claims incurred that may or may not have been submitted to the Medicare contractors, but not yet approved for payment;
- Actual claims approved for payment by the Medicare contractors for which checks have not yet been issued;
- Checks issued by the Medicare contractors in payment of claims that have not yet been cashed by payees;
- Periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year;

- An estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

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. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS 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, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid

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

Federal Employee and Veterans' Benefits

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory 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. 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 federal employees injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by the DOL which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims paid by the DOL but not yet billed to agencies and (2) 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, HHS contributes the employer's matching share for Social Security and Medicare Insurance. FERS offers a Thrift Savings Plan into which HHS automatically contributes 1 percent of employee pay and matches the first 3 percent of employee contributions dollar for dollar. Each dollar of the employee's next 2 percent of basic pay is matched at 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, 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. 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. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

Contingencies

A loss contingency is an existing condition, situation or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should 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 Number 5, *Accounting for Liabilities of the Federal Government,* as amended by SFFAS Number 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

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

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present values 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 Medicare 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 April 23, 2012. In addition, the estimates depend on many economic, demographic and health care-specific assumptions. These include 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 2012*. 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 Recovery and Reinvestment Act

The *American Recovery and Reinvestment Act of 2009* (*Recovery Act*) became law on February 17, 2009. The *Recovery Act* enhances energy independence, expands educational opportunities, preserves and improves affordable health care, provides tax relief and protects those in greatest need.

The *Recovery Act* provides an estimated $138 billion to HHS from 2009 through 2021, to fund Health Information Technology, Comparative Effectiveness Research, Prevention and Wellness, Scientific Research, Social Services and Medicaid relief to the States.

Affordable Care Act

During FY 2010, President Obama signed health insurance reform legislation giving Americans more control over their health care. The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* collectively referred to as the *Affordable Care Act* ensures that all Americans have access to quality, affordable health care, while significantly reducing long-term health care costs. Further information is available at http://www.healthcare.gov.

Under the ACA, HHS was authorized to execute several new programs, which include Pre-existing Condition Insurance Plan Program, Early Retiree Reinsurance Program, Affordable Insurance Exchanges and the CO-OP Program. A brief description of these programs and their impact on the financial statements is presented below.

Pre-existing Condition Insurance Plan Program

This program offers coverage to uninsured Americans who have been unable to obtain health coverage because of a pre-existing health condition. Plans are administered through two processes: supporting state-run programs or providing insurance coverage directly to individuals in states where states do not run their own programs. Congress appropriated $5 billion for the life of this interim program, which enables coverage until the Exchanges programs become operational.

The ACA provides HHS Secretary significant authorities to ensure the financial sustainability of this program, including, under Section 1101 Paragraph (g) (2), the authority to eliminate deficits under the program if available funds are less than estimated expenses. The Secretary also has the authority under Paragraph (g) (4) to stop taking applications to comply with funding limitations. This program ends on January 1, 2014.

Early Retiree Reinsurance Program

Pursuant to the ACA, HHS established a temporary reinsurance program to reimburse a portion of the employer cost of providing health insurance coverage for early retirees. The ACA imposes limitations on the amounts of such reimbursements per claim have been established. Congress appropriated $5 billion for the life of this program. The ACA authorizes the HHS Secretary to stop taking applications for participation in the program based on the availability of funding. On June 29, 2010 HHS began accepting applications from employers. The program permits approved applicants to submit for reimbursement expenses incurred after June 1, 2010. This program ends on January 1, 2014.

Affordable Insurance Exchanges

Grants have been provided to the States to establish Affordable Insurance Exchanges, better known as Health Benefit Insurance Exchanges. HHS has awarded about $2 billion to date in Exchange grants to states, including Establishment grants to 33 states and D.C.

Consumer Operated and Oriented Plan Program

The CO-OP Program fosters qualified non-profit health insurance issuers created to offer qualified health plans to the individual and small group markets in each state. Under this program, HHS provides assistance to organizations applying to become qualified, non-profit health insurance issuers through loans to assist in meeting start-up costs and repayable grants to assist the applicant meet State solvency requirements. In accordance with regulations to be developed by HHS not later than July 1, 2013, as well as legislative requirements, loans shall be repaid within five years and the repayable grants within 15 years, considering State reserve requirements and solvency regulations. Congress appropriated $6 billion to carry out this assistance program under the ACA. The *FY 2012 Labor/Health and Human Services Appropriations Act* included a $400 million rescission. The *Department of Defense and Full-Year Continuing Appropriations Act* included a $2.2 billion rescission of the CO-OP budget authority. In FY 2012, CMS awarded the first loan agreements for both start up and solvency requirements.

Note 2. Entity and Non-Entity Assets (in Millions)

Non-Entity Intragovernmental Assets	2012	2011
Fund Balance with Treasury	$ 1	$ 11
Accounts Receivable	6	13
Total Non-Entity Intragovernmental Assets	7	24
Accounts Receivable With the Public	22	16
Total Non-Entity Assets	29	40
Total Entity Assets	530,624	532,840
Total Assets	$ 530,653	$ 532,880

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2012	2011
Trust Funds	$ 23,544	$ 6,370
Revolving Funds	1,205	1,175
Appropriated Funds	171,893	158,927
Other Funds	706	383
Total	$ 197,348	$ 166,855
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 75,237	$ 44,434
Unavailable	8,718	7,367
Obligated Balance not yet Disbursed	170,666	178,174
Non-Budgetary Fund Balance with Treasury	(57,273)	(63,120)
Total	$ 197,348	$ 166,855

Other Funds include balances in deposit, suspense and related non-spending accounts. The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $16.3 billion and $19.0 billion as of September 30, 2012 and September 30, 2011, respectively. The restricted amount is primarily for the

ACA programs, Children's Health Insurance Program, CMS Program Management, State Grants and Demonstrations and the *Recovery Act* Health Information Technology Program. In FY 2012, HHS received $25.6 billion in direct appropriations under the ACA, of which $3.7 billion is restricted for future use.

The Non-Budgetary FBWT negative balances reported for September 30, 2012 and 2011 are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net (in Millions)

2012 Intragovernmental Securities	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Non-Marketable: Par Value	$ 297,616	$ -	$ 3,193	$ 300,809	$ 300,809
Non-Marketable: Market-Based	5,692	(156)	36	5,572	5,572
Total, Intragovernmental	$ 303,308	$ (156)	$ 3,229	$ 306,381	$ 306,381

2011 Intragovernmental Securities	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Non-Marketable: Par Value	$ 316,386	$ -	$ 3,586	$ 319,972	$ 319,972
Non-Marketable: Market-Based	5,552	(111)	30	5,471	5,471
Total, Intragovernmental	$ 321,938	$ (111)	$ 3,616	$ 325,443	$ 325,443

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, 2014 through June 30, 2026, with interest rates ranging from 2.5 percent to 6.5 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2013, with an interest rate of 1.25 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in fiscal years 2012 through 2018. The Market-Based Notes paid from 1.875 percent to 4.125 percent during October 1, 2011 to September 30, 2012 and 3.125 percent to 4.75 percent during October 1, 2010 to September 30, 2011. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds during the fiscal year ended September 30, 2012, yielded from 0.02 percent to 0.22 percent depending on the date purchased and the time to maturity.

The non-earmarked investments held by the CHIP Child Enrollment Contingency Fund in the amount of $2.1 billion as of September 30, 2012, 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)

2012 *Intragovernmental*	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Entity	$ 814	$ -	$ -	$ 814	$ -	$ 814
Non-Entity	6	-	-	6	-	6
Total, Intragovernmental	$ 820	$ -	$ -	$ 820	$ -	$ 820
With the Public						
Entity						
Medicare	$ 9,014	$ -	$ -	$ 9,014	$ (1,408)	$ 7,606
Other	3,882	11	3	3,896	(581)	3,315
Non-Entity	50	5	-	55	(33)	22
Total With the Public	$ 12,946	$ 16	$ 3	$ 12,965	$ (2,022)	$ 10,943

2011 *Intragovernmental*	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Entity	$ 1,007	$ -	$ -	$ 1,007	$ -	$ 1,007
Non-Entity	13	-	-	13	-	13
Total, Intragovernmental	$ 1,020	$ -	$ -	$ 1,020	$ -	$ 1,020
With the Public						
Entity						
Medicare	$ 8,920	$ -	$ -	$ 8,920	$ (1,434)	$ 7,486
Other	3,905	10	3	3,918	(512)	3,406
Non-Entity	34	5	-	39	(23)	16
Total With the Public	$ 12,859	$ 15	$ 3	$ 12,877	$ (1,969)	$ 10,908

Note 6. Inventory and Related Property, Net (in Millions)

	2012	2011
Inventory Held for Current Sale, Net	$ 12	$ 10
Operating Materials and Supplies Held for Use	129	451
Stockpile Materials Held for Emergency or Contingency	7,931	6,085
Inventory and Related Property, Net	$ 8,072	$ 6,546

Note 7. General Property, Plant and Equipment, Net (in Millions)

			2012		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	704	-	704
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,648	(2,282)	3,366
Equipment	Straight Line	3-20 Yrs	1,783	(999)	784
Internal Use Software	Straight Line	5-10 Yrs	1,131	(732)	399
Assets Under Capital Lease (Note 15)	Straight Line	1-30 Yrs	119	(46)	73
Leasehold Improvements	Straight Line	*Life of Lease	49	(26)	23
Totals			$ 9,486	$ (4,085)	$ 5,401

			2011		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	740	-	740
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,592	(2,125)	3,467
Equipment	Straight Line	3-20 Yrs	1,785	(954)	831
Internal Use Software	Straight Line	5-10 Yrs	1,123	(660)	463
Assets Under Capital Lease (Note 15)	Straight Line	1-30 Yrs	133	(56)	77
Leasehold Improvements	Straight Line	*Life of Lease	50	(23)	27
Totals			$ 9,475	$ (3,818)	$ 5,657

*7 to 15 years or the life of the lease, whichever is shorter.

Note 8. Advances (in Millions)

	2012	2011
Intragovernmental		
Advances to Other Federal Entities	$ 48	$ 29
With the Public		
Travel Advances & Emergency Employee Salary Advances	1	2
Medicare Advantage Prescription Drug Plan	-	10,040
Part D Prescription Drug Plan	1,188	5,901
Other Prepayments & Deferred Charges	55	147
Total With the Public	$ 1,244	$ 16,090

In FY 2012, advances with the public consists of advance payments issued for the Medicare Part D Prescription Drug plan, in the amount of $1.2 billion for services that will be provided in FY 2013 ($1.0 billion in FY 2011). The decrease is primarily due to advance payments of $14.9 billion made in September of FY 2011 for Medicare Advantage Prescription Drug plan in the amount of $10.0 billion and Part D Prescription Drug Plan in the amount of $4.9 billion for services provided in October of FY 2012. This advance payment was not necessary in FY 2012.

Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)

	2012	2011
Intragovernmental		
Accrued Payroll and Benefits	$ 62	$ 58
Other	170	974
Total Intragovernmental	$ 232	$ 1,032
Federal Employee and Veterans' Benefits (Note 11)	11,008	10,219
Accrued Payroll and Benefits	638	576
Contingencies and Commitments (Note 14)	6,766	3,623
Other	110	1,352
Total Liabilities Not Covered by Budgetary Resources	$ 18,754	$ 16,802
Total Liabilities Covered by Budgetary Resources	80,737	88,115
Total Liabilities	$ 99,491	$ 104,917

Note 10. Entitlement Benefits Due and Payable (in Millions)

	2012	2011
Medicare	$ 46,436	$ 54,292
Medicaid	24,955	26,069
Other	1,102	521
Totals	$ 72,493	$ 80,882

Medicare benefits payable consists of a $38.8 billion estimate ($47.7 billion in FY 2011) of Medicare services incurred, but not paid as of September 30, 2012, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable consists of $2.8 billion in FY 2012 ($1.9 billion in FY 2011) for amounts owed to plans relating to risk and other payment-related adjustments and $2.5 billion in FY 2012 ($2.1 billion in FY 2011) owed to plans after the completion of the Prescription Drug payment reconciliation.

The Medicare Retiree Drug Subsidy consists of a $2.4 billion estimate ($2.6 billion in FY 2011) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2012. As part of the *Medicare Modernization Act*, the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen employer- and union-based retiree prescription drug plans.

Medicaid benefits payable of $25.0 billion as of September 30, 2012 ($26.1 billion in FY 2011) is an estimate of the net federal share of expenses that have been incurred by the states but not yet reported to HHS. This estimate incorporates claim activity tracked under *Recovery Act* of $0.2 billion ($1.1 billion in FY 2011). An estimated CHIP benefits payable of $0.7 billion has been recorded as of September 30, 2012, ($0.5 billion in FY 2011) for the net federal share of expenses that have been incurred by the states but not yet reported to HHS as of September 30, 2012.

Note 11. Federal Employee and Veterans' Benefits (in Millions)

	2012	2011
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 10,131	$ 9,365
PHS Commissioned Corp Post-retirement Health Benefits	603	585
Workers' Compensation Benefits (Actuarial FECA Liability)	274	269
Total, Federal Employee and Veterans' Benefits	$ 11,008	$ 10,219

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,613 active duty officers and 6,165 retiree annuitants and survivors. As of September 30, 2012, the actuarial accrued liability for the retirement benefit plan was $10.1 billion and $0.6 billion for non-Medicare coverage of the Post Retirement Medical Plan.

The Commission Corp Retirement System and Post-Retirement Benefits are not funded. Therefore, in accordance with SFFAS Number 33, 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 cashflow. A single discount rate may be used for all the projected cashflows, if the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2012 and September 30, 2011, were:

	2012	2011
Interest on federal securities	4.88 percent	5.03 percent
Annual basic pay scale increase	2.92 percent	3.22 percent
Annual inflation	2.42 percent	2.47 percent

The following shows key valuation results as of September 30, 2012 and 2011, in conformance with the actuarial reporting standards set forth in the SFFAS Number 5, *Accounting for Liabilities of the Federal Government* and SFFAS Number 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2012 and actuarial assumptions. The September 30, 2012 valuation includes an increase in liabilities of $784 million resulting from an increase in costs and an actuarial loss from changes in assumptions and experience. Volatility of the discount rate significantly affects the liabilities for these benefits. Therefore, to mitigate the impact of this volatility, SFFAS Number 33 also provides for the use of historical average rates to prevent the undue influence of current or near term rates.

	2012	2011
Beginning Liability Balance	$ 9,950	$ 9,726
Expense		
Normal Cost	240	233
Interest on the liability balance	475	479
Actuarial (Gain)/Loss		
From experience	182	(154)
From assumption changes		
Change in discount rate assumption	294	155
Change in inflation/salary increase assumption	(87)	(46)
Change in Others	108	(37)
Net Actuarial (Gain)/Loss	497	(82)
Total expense	$ 1,212	$ 630
Less amounts paid	(428)	(406)
Ending Liability Balance	$ 10,734	$ 9,950

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the OMB's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting as of September 30, 2012 and September 30, 2011 appear below.

2012	2011
2.293% in Year 1	3.535% in Year 1
3.138% in Year 2 and thereafter	4.025% 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 (COLA) and medical inflation factors such as consumer price index-medical (CPIM) 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 COLA and CPIM used in projections are:

FY	COLA	CPIM
2012	N/A	N/A
2013	2.83%	3.65%
2014	2.03%	3.66%
2015	1.93%	3.72%
2016	2.00%	3.73%
2017	2.03%	3.80%

Note 12. Accrued Grant Liability (in Millions)

	2012	2011
Estimated Accrual for Amounts Due to Grantees	$ 21,994	$ 23,735
Offsetting Grant Advances	(18,246)	(19,250)
Net Accrued Grant Liability	$ 3,748	$ 4,485

Note 13. Other Liabilities (in Millions)

	2012		2011	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 115	$ 1,103	$ 107	$ 924
Advances from Others	315	125	292	84
Deferred Revenue	-	455	-	456
Capital Lease Liability (Note 15)	63	20	66	21
Custodial Liabilities	736	15	822	30
Other	201	1,244	(187)	1,897
Total Other Liabilities	$ 1,430	$ 2,962	$ 1,100	$ 3,412

Note 14. Contingencies and Commitments

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. 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. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances

For FY 2012, $3.9 billion ($3.0 billion in FY 2011) is accrued representing Medicaid audit and program disallowances of $1.9 billion ($1.0 billion in FY 2011) and of $2.0 billion ($2.0 billion in FY 2011) for reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HHS. 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.

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 IBNR liability, resulting in a projected liability for the 5,041 cases (6,683 in FY 2011) remaining on appeal as of September 30, 2012. In FY 2012, a total of 652 new cases were filed (821 in FY 2011). The PRRB rendered decisions on 98 cases in FY 2012 (122 in FY 2011); and 2,215 additional cases (1,863 in FY 2011) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v. Ramah Navajo Chapter*, dated June 18, 2012, is likely to result in increased claims against the Indian Health Service. Tribes are expected to file claims for prior years and seek to consolidate their claims in a class action lawsuit. It is not clear if these will be filed as administrative cases or filed in Federal District Court. An estimated loss relating to this matter is accrued in the financial statements.

The Vaccine Injury Compensation Program is administered by HRSA and provides compensation for vaccine-related injury or death. A contingent liability has been accrued in the financial statements for the estimated future payment value of injury claims outstanding as of September 30, 2012.

Obligations Related to Canceled 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 canceled pursuant to the *National Defense Authorization Act*. The total payments related to canceled appropriations are estimated at $1.1 billion and $1.1 billion as of September 30, 2012 and 2011, respectively.

Note 15. Leases (in Millions)

Capital Leases

HHS has entered into various capital leases with private entities and with the General Services Administration (GSA) for offices and laboratory space. Lease terms vary from one to 30 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 (Note 7)

	2012	2011
Assets under Capital Lease	$ 119	$ 133
Accumulated Amortization	(46)	(56)
Assets under Capital Lease, Net	$ 73	$ 77

Future Minimum Payments

	2012	2011
Year 1	$ 10	$ 10
Year 2	10	10
Year 3	10	10
Year 4	11	10
Year 5	11	11
After 5 Years	67	80
Total Minimum Lease Payments	119	131
Imputed Interest	(36)	(44)
Total Capital Lease Liability (Note 13)	$ 83	$ 87

Operating Leases

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-cancelable lease terms from 1 to 50 years. The GSA leases, in general, are cancelable with 120 days notice and not included in the table below. Under an operating lease, the cost of the lease is expensed as incurred.

Future Minimum Payments

	2012	2011
Year 1	$ 103	$ 108
Year 2	99	103
Year 3	122	100
Year 4	124	121
Year 5	125	124
After 5 Years	675	799
Total Operating Lease Liability	$ 1,248	$ 1,355

Note 16. Revenue (in Millions)

2012 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 108	$ 5,809	$ 1,013	$ 35	$ 6,965	$ (2,660)	$ 4,305
Exchange Revenue	(42)	(3,080)	(19)	(9)	(3,150)	2,502	(648)
Net Cost, *Intragovernmental*	$ 66	$ 2,729	$ 994	$ 26	$ 3,815	$ (158)	$ 3,657
With the Public							
Gross Cost	$ 13,240	$ 327,474	$ 541,532	$ 37,298	$ 919,544	$ -	$ 919,544
Exchange Revenue	(2)	(2,808)	(64,839)	(5)	(67,654)	-	(67,654)
Net Cost, *With the Public*	$ 13,238	$ 324,666	$ 476,693	$ 37,293	$ 851,890	$ -	$ 851,890
Total Gross Cost	$ 13,348	$ 333,283	$ 542,545	$ 37,333	$ 926,509	$ (2,660)	$ 923,849
Total Exchange Revenue	(44)	(5,888)	(64,858)	(14)	(70,804)	2,502	(68,302)
Total Net Cost of Operations	$ 13,304	$ 327,395	$ 477,687	$ 37,319	$ 855,705	$ (158)	$ 855,547

2011 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

	Education Training & Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Intragovernmental							
Gross Cost	$ 122	$ 5,571	$ 868	$ 34	$ 6,595	$ (2,463)	$ 4,132
Exchange Revenue	(34)	(3,408)	(18)	(28)	(3,488)	2,336	(1,152)
Net Cost, *Intragovernmental*	$ 88	$ 2,163	$ 850	$ 6	$ 3,107	$ (127)	$ 2,980
With the Public							
Gross Cost	$ 14,450	$ 349,347	$ 536,630	$ 41,040	$ 941,467	$ -	$ 941,467
Exchange Revenue	3	(2,837)	(63,475)	(5)	(66,314)	-	(66,314)
Net Cost, *With the Public*	$ 14,453	$ 346,510	$ 473,155	$ 41,035	$ 875,153	$ -	$ 875,153
Total Gross Cost	$ 14,572	$ 354,918	$ 537,498	$ 41,074	$ 948,062	$ (2,463)	$ 945,599
Total Exchange Revenue	(31)	(6,245)	(63,493)	(33)	(69,802)	2,336	(67,466)
Total Net Cost of Operations	$ 14,541	$ 348,673	$ 474,005	$ 41,041	$ 878,260	$ (127)	$ 878,133

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $68.3 billion and $67.5 billion through September 30, 2012 and 2011, respectively. HHS' exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

Note 17. Terms of Borrowing Authority Used and Available Borrowing Authority

HHS has indefinite borrowing authority for direct and guaranteed loan programs discussed in Note 1.

Requirements for Repayments of Borrowings

Borrowings are repaid on nonexpenditures transfers as maturity dates become due. For financing accounts, maturity dates are based on the period of time used in the subsidy calculation, not the contractual term of the loans. There has been no repayment of debt in FY 2012. As of September 30, 2012, HHS had borrowing authority available of $3.1 billion.

Financing Sources for Repayments of Borrowings

HHS will use interest received as well as principal repayments on direct loans to repay debt in the non-budgetary direct loan program financing accounts. HHS will also use residual unobligated balances, where applicable, as another source for repayment.

Other Terms of Borrowing Authority Used

In general, borrowings are for periods of between one year and approximately 50 years depending upon the loan program/cohort. Interest rates on borrowings in the financing accounts are assigned on the basis of the Treasury rate in effect during the period of loan disbursements. Some individual loans are disbursed over several quarters or years. Consequently, several interest rates can be applicable to an individual loan. Thus, a single weighted average interest rate is maintained for each cohort and is adjusted each year until the disbursements for the cohort have been made. Each year, the current average annual interest rate is weighted by current year disbursements and merged with the prior years' weighted average to calculate a new weighted average.

Note 18. Apportionment Categories of Obligations Incurred and Undelivered Orders (in Millions)

	2012		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 94,380	$ 7,310	$ 101,690
Category B (Restricted and Distributed by Activity)	590,300	936	591,236
Exempt from Apportionment	512,954	-	512,954
Total Obligations Incurred	$ 1,197,634	$ 8,246	$ 1,205,880

	2011		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 94,512	$ 6,960	$ 101,472
Category B (Restricted and Distributed by Activity)	634,981	422	635,403
Exempt from Apportionment	526,657	-	526,657
Total Obligations Incurred	$ 1,256,150	$ 7,382	$ 1,263,532

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular Number 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*.

Undelivered Orders include obligations that have been issued but are not yet drawn down and goods and services ordered that have not been received. HHS reported $96.8 billion of budgetary resources obligated for undelivered orders as of September 30, 2012 and $95.1 billion as of September 30, 2011.

Note 19. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances consist of appropriated funds, revolving funds, management funds, Gift Funds, Trust Funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. Annual appropriations are available for sponsoring and conducting medical research, for other new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years.

All Trust Fund receipts collected by HHS during 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 not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the Trust Funds and become available for obligation as needed. The entire Trust Fund balances in the amount of $245.4 billion as of September 30, 2012 and $260.7 billion as of September 30, 2011, are included as Investments in the Consolidated Balance Sheet.

The NIH Funds consist of the following:

- The revolving and management funds available for centralized research support services and administrative activities.
    - Revolving funds are no-year funds available until expended.
    - The management fund is available for two fiscal years.
- The Gift Funds consist of the Conditional, Unconditional and Patient Emergency Funds and are also available until expended.
    - 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 Patient Emergency Fund is intended solely for the benefit of patients.
- The CRADA funds received are available for the performance of the contractual agreement and are available for the term of the agreement.
- Royalty funds are available for obligation for two fiscal years after the fiscal year in which the funds are received. These funds 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.

NIH is not authorized to spend the Gift Funds to support functions not encompassed within the terms of the gift. 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.

Note 20. Explanation of Differences between the Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

The *Budget of the United States Government* (also known as the *President's Budget)*, with the actual amounts for FY 2012, has not been published, therefore, no comparisons can be made between FY 2012 amounts presented in the Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2014 President's Budget* is expected to be released in February 2013 and may be obtained from OMB's website, http://www.whitehouse.gov/omb/budget or from the Government Printing Office.

HHS reconciled the amounts of the FY 2011 column on the Statement of Budgetary Resources to the actual amounts for FY 2011 from the Appendix in the *FY 2013 President's Budget* for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2011	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 1,315,333	$ 1,263,532	$ 322,724	$ 1,214,256
Expired Accounts	(6,235)	-	-	-
Other	(251)	275	354	103
Budget of the U.S. Government	$ 1,308,847	$ 1,263,807	$ 323,078	$ 1,214,359

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 Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries and other amounts included in the Statement of Budgetary Resources that are not included in the *President's Budget*. The Other differences include expired authorities which are appropriately reported on the Statement of Budgetary Resources but not included in the *President's Budget.*

The Other amounts in the obligations incurred include adjustments for reimbursable activity primarily in the NIH Management Fund reported on the Statement of Budgetary Resources but not included in the *President's Budget*. Additionally, the *President's Budget* includes $133 million of reclassification of reimbursable activity in the obligations incurred for the Miscellaneous Trust Funds, which is not on the Statement of Budgetary Resources. The Other differences in the offsetting receipts consist of General Fund Proprietary Receipts and Collections of Receivables from Special accounts as well as some of the IHS trust fund activities being transferred to a non-trust/special fund appropriation. Lastly, other differences in the net outlays include outlays reported on the HHS' Statement of Budgetary Resources and included in the Department of Homeland Security's *President's Budget* for Project Bioshield and adjustments for reimbursable activity in the NIH Management Fund reported on the Statement of Budgetary Resources but not included in the *President's Budget.*

Note 21. Earmarked Funds (in Millions)

Medicare is the largest earmarked fund group managed by HHS and is presented in a separate column in the schedule below. The Medicare programs include the HI Trust Fund, the Medicare SMI Trust Fund, the Medicare SMI Prescription Drug Benefit – Part D and the Medicare Integrity Program. See Note 1 for a description of each fund's purpose and how 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 generally 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 standard monthly SMI premium per beneficiary was $99.90 for January 1, 2012, through September 30, 2012 and $115.40 from October 1, 2011, through December 31, 2011. The earmarked financial statement balances are shown below.

Balance Sheet as of September 30, 2012	2012		
	Medicare	Other	Total
Fund Balance with Treasury	$ 23,254	$ 1,935	$ 25,189
Investments	300,809	3,477	304,286
Other Assets	8,651	255	8,906
Total Assets	$ 332,714	$ 5,667	$ 338,381
Entitlement Benefits Due and Payable	$ 46,436	$ -	$ 46,436
Other Liabilities	3,959	559	4,518
Total Liabilities	$ 50,395	$ 559	$ 50,954
Unexpended Appropriations	20,519	(101)	20,418
Cumulative Results of Operations	261,800	5,209	267,009
Total Liabilities and Net Position	$ 332,714	$ 5,667	$ 338,381
Statement of Net Cost			
For the Period Ended September 30, 2012			
Gross Program Costs	$ 542,545	$ 308	$ 542,853
Less: Exchange Revenues	64,858	1,497	66,355
Net Cost of Operations	$ 477,687	$ (1,189)	$ 476,498
Statement of Changes in Net Position			
For the Period Ended September 30, 2012			
Net Position Beginning of Period	$ 293,197	$ 4,401	$ 297,598
Non-Exchange Revenue	221,987	326	222,313
Other Financing Sources	244,822	(808)	244,014
Net Cost of Operations	(477,687)	1,189	(476,498)
Change in Net Position	(10,878)	707	(10,171)
Net Position End of Period	$ 282,319	$ 5,108	$ 287,427

Balance Sheet as of September 30, 2011	2011		
	Medicare	Other	Total
Fund Balance with Treasury	$ 6,130	$ 1,513	$ 7,643
Investments	319,972	3,377	323,349
Other Assets	23,604	1,060	24,664
Total Assets	$ 349,706	$ 5,950	$ 355,656
Entitlement Benefits Due and Payable	$ 54,292	$ -	$ 54,292
Other Liabilities	2,217	1,549	3,766
Total Liabilities	56,509	1,549	58,058
Unexpended Appropriations	4,335	(99)	4,236
Cumulative Results of Operations	288,862	4,500	293,362
Total Liabilities and Net Position	$ 349,706	$ 5,950	$ 355,656

Statement of Net Cost For the Period Ended September 30, 2011			
Gross Program Costs	$ 537,498	$ 302	$ 537,800
Less: Exchange Revenues	63,493	1,349	64,842
Net Cost of Operations	$ 474,005	$ (1,047)	$ 472,958

Statement of Changes in Net Position For the Period Ended September 30, 2011			
Net Position Beginning of Period	$ 315,223	$ 3,786	$ 319,009
Non-Exchange Revenue	210,169	377	210,546
Other Financing Sources	241,810	(809)	241,001
Net Cost of Operations	(474,005)	1,047	(472,958)
Change in Net Position	(22,026)	615	(21,411)
Net Position, End of Period	$ 293,197	$ 4,401	$ 297,598

Note 22. Statement of Social Insurance (unaudited)

The SOSI presents the projected 75-year actuarial present values 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 Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel. Please see Note 23 below for further information on this panel (the Panel).

The SOSI projections are based on current law and reflect the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*, which is referred to collectively as the *Affordable Care Act*. The *Affordable Care Act* improves the financial outlook for Medicare substantially; however, the full effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the long-range future. It is important to note that the substantially improved results for HI and SMI Part B depend in part on the long-range feasibility of lower increases in Medicare payment rates to most categories of providers, as mandated by the *Affordable Care Act*. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. Please see Note 23 below for further information on the impact of the *Affordable Care Act*.

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 current Medicare laws, regulations and policies in effect on April 23, 2012 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 transfers from the general fund of the Treasury made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI and transfers from State governments are 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. 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.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cashflows, which are calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The HI Trust Fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic and health care cost trends for the future, HI income is expected to fall 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, the SOSI also sets forth the same 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. 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 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. Please see Note 23 below for important information on the further uncertainty, resulting from the provisions in the *Affordable Care Act*, associated with the current-law projections presented in the SOSI. 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 April 23, 2012. In addition, the estimates depend on many economic, demographic and health care-specific assumptions, including changes in per beneficiary health care cost, wages and the 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, based on current law, used in the projections of Medicare spending displayed in this section, are included in the following table on the next page. The assumptions underlying the 2012 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2012. 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 on the next page reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within the table on the next page, for the prior years is publicly available on the CMS website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2012

					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]
2012	2.04	960,000	759.3	1.74	3.75	2.01	2.6	-0.1	3.9	2.1	0.4
2020	2.04	1,205,000	708.6	1.26	4.07	2.81	2.2	3.8	5.3	6.2	2.7
2030	2.02	1,125,000	650.4	1.13	3.93	2.80	2.0	4.9	4.8	5.5	2.9
2040	2.00	1,075,000	598.8	1.17	3.97	2.80	2.2	5.4	4.5	5.3	2.9
2050	2.00	1,050,000	553.3	1.11	3.91	2.80	2.1	4.1	4.1	5.0	2.9
2060	2.00	1,040,000	513.2	1.10	3.90	2.80	2.1	4.0	4.1	4.8	2.9
2070	2.00	1,035,000	477.7	1.09	3.89	2.80	2.1	4.1	3.9	4.6	2.9
2080	2.00	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	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 projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. These ultimate values assumed for the current year and the prior four years are summarized in the table in the next page. 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 2012-2008

					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]
FY 2012	2.0	1,030,000	446.0	1.1	3.9	2.8	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9
FY 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9
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

[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 2008–2011, 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 2008–2011, the assumption presented is the value assumed in the year 2080. For 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. Except for minor fluctuations, 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 2012 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2011 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 23. Affordable Care Act and SMI Part B Physician Payment Update Factor (unaudited)

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the ACA. It is important to note, however, that these improved results for HI and SMI Part B since 2010 depend in part on the long-range feasibility of the various cost-saving measures in ACA—in particular, the lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. It is possible that health care providers could improve their productivity, reduce wasteful expenditures and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

A transformation of health care in the U.S., affecting both the means of delivery and the method of paying for care, is also a possibility. The ACA takes important steps in this direction by initiating programs of research into innovative payment and service delivery models, such as accountable care organizations, patient-centered "medical homes," improvement in care coordination for individuals with multiple chronic health conditions, improvement in coordination of post-acute care, payment bundling, "pay for performance," and assistance for individuals in making informed health choices. If researchers and policy makers can demonstrate that the new approaches developed through these initiatives will improve the quality of health care and/or reduce costs, then the Secretary of HHS can adopt them for Medicare without further legislation. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower Medicare cost growth rates to levels compatible with the lower price updates payable under current law.

The ability of new delivery and payment methods to significantly lower cost growth rates is uncertain at this time, since specific changes have not yet been designed, tested or evaluated. Hopes for success are high, but at this time there is insufficient evidence to support an assumption that improvements in efficiency can occur of the magnitude needed to align with the statutory Medicare price updates.

The reduction in provider payment updates, if implemented for all future years as required under current law, could have secondary impacts on provider participation, beneficiary access to care; quality of services; and other factors. These possible impacts are very speculative and at present there is no consensus among experts as to their potential scope. Further research and analysis will help to better inform this issue and may enable the development of specific projections of secondary effects under current law in the future.

In addition, the Medicare Part B projections reflect a reduction of almost 31 percent in payment rates for physician services in 2013, as required under current law. If lawmakers act to prevent this decrease, as they have for 2003 through 2012, then actual Part B and total SMI costs will significantly exceed the projections shown in this report.

Because knowledge of the potential long-range effects of the productivity adjustments, delivery and payment innovations and certain other aspects of the *Affordable Care Act* is so limited, in August 2010, HHS Secretary, working on behalf of the Board of Trustees, established an independent group of expert actuaries and economists to review the assumptions and methods used by the Trustees to make projections of the financial status of the Trust Funds. The members of the Panel began their deliberations in November 2010 and were asked to focus their immediate attention on the long-range Medicare cost growth assumptions.

In December 2011, the Panel members unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements. Both the Office of the

Actuary at CMS and the Board of Trustees support these recommendations and they form the basis for the long-range cost growth assumptions used in this annual report. The new methodology is explained in more detail in section IV.D of the *2012 Medicare Trustees Report*.

The Panel also recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 and 2011 Trustees Reports, for the purpose of illustrating the higher Medicare costs that would result if the reduction in physician payment rates and the productivity adjustments to most other provider payment updates are not fully implemented as required under current law.[7]

The SOSI projections must be based on current law. Therefore, the productivity adjustments are assumed to occur in all future years, as required by the ACA. In addition, an approximate 31 percent reduction in Medicare payment rates for physician services in January 2013, as estimated in the 2012 Trustees Report, is assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override this reduction. Therefore, it is important to note that the actual future costs for Medicare are likely to exceed those shown by these current-law projections.

Illustrative Scenario

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. This alternative scenario assumes that the productivity adjustments are gradually phased down during 2020 to 2034 and that the physician fee reductions are overridden. These examples were developed for illustrative purposes only; the calculations have not been audited; no endorsement of the illustrative alternative to current law by the Trustees, CMS or the CMS Office of the Actuary, should be inferred; 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 affecting the productivity adjustments and physician payments under Medicare and of the broad range of uncertainty associated with such impacts. The table on the next page contains a comparison of the Medicare 75-year present values of income and expenditures under current law with those under the alternative scenario illustration.

[7]The *Interim Report of the Technical Review Panel on the Medicare Trustees Report* is available at http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml. Once it is completed, the final report will be available at http://aspe.hhs.gov/health/medpanel/2010/.

Medicare Present Values
(in Billions)

Income	Current law (unaudited)	Alternative scenario[1, 2] (unaudited)
Part A	$15,598	$15,600
Part B	20,159	28,007
Part D	9,128	9,129
Expenditures		
Part A	21,179	25,494
Part B	20,159	28,007
Part D	9,128	9,129
Income less expenditures		
Part A	$(5,581)	$(9,895)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2012 Trustees' Report.
[2]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections that differ from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS or the Office of the Actuary should be inferred.

As expected, the differences between the current-law projections and the illustrative alternative are substantial, although both represent a sizable improvement in the financial outlook for Medicare compared to the laws in effect prior to the *Affordable Care Act*. This difference in outlook serves as a compelling reminder of the importance of developing and implementing further means of reducing health care cost growth in the coming years. All Part A fee-for-service providers are affected by the productivity adjustments, so the current law projections reflect an estimated 1.1 percent reduction in annual Part A cost growth each year. If the productivity adjustments were gradually phased down, as illustrated under the alternative scenario, the present value of Part A expenditures is estimated to be roughly 20 percent higher than the current-law projection. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario.

The Part B expenditure projections are significantly higher under the alternative scenario than under current law, both because of the assumed gradual phase-out of the productivity adjustments and the assumption that the scheduled physician fee reductions would be overridden and based on 1 percent annual increases through 2021, based on a recommendation by the 2010-2011 Medicare Technical Review Panel. The productivity adjustments are assumed to affect more than half of Part B expenditures at the time their phase-out is assumed to begin. Similarly, physician fee schedule services are assumed to be roughly 30 percent higher under the alternative scenario than under current law at that time. The combined effect of these two factors results in a present value of Part B expenditures under the alternative scenario that is approximately 39 percent higher than the current-law projection.

The Part D projections are basically unaffected under the alternative projection because the services are not impacted by the productivity adjustments or the physician fee schedule reductions. The very minor impact is the result of a slight change in the discount rates that are used to calculate the present values.

The extent to which actual future Part A and Part B costs exceed the projected current-law amounts due to changes to the productivity adjustments and physician payments depends on both the specific changes that might

be legislated and on whether Congress would pass further provisions to help offset such costs. As noted, these examples only reflect hypothetical changes to provider payment rates.

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 24. Statement of Changes in Social Insurance Amounts (unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of future income (excluding interest) for current and future participants; (2) present value of future expenditures for current and future participants; (3) present value of future non-interest income less future expenditures for current and future participants (the open group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of future non-interest income less future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes shows the reconciliation changing from the period beginning on January 1, 2011 to the period beginning on January 1, 2012 and the reconciliation changing from the period beginning on January 1, 2010 to the period beginning on January 1, 2011. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated expenditures has the same effect on estimated total income and vice versa. Therefore, any change has no impact on the future net cashflow. In order to enhance the presentation, the changes in the present values of income and expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

1. Change in the valuation period
2. Change in the projection base
3. Changes in demographic assumptions
4. Changes in economic and health care assumption
5. Changes in law

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered.

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 22 summarizes these assumptions for the current year.

Period beginning on January 1, 2011 and ending January 1, 2012

Present values as of January 1, 2011 are calculated using interest rates from the intermediate assumptions of the *2011 Trustees Report*. All other present values in this part of the Statement are calculated as a present value as of January 1, 2012. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions and law are determined using the interest rates under the intermediate assumptions of the *2011 Trustees Report*. Since interest rates are economic assumptions, the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the *2012 Trustees Report*.

Period beginning on January 1, 2010 and ending January 1, 2011

Present values as of January 1, 2010 are calculated using interest rates from the intermediate assumptions of the 2010 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2011. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions and law are determined using the interest rates under the intermediate assumptions of the *2010 Trustees Report*. Since interest rates are economic assumptions, the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the *2011 Trustees Report.*

Change in the Valuation Period

Period beginning on January 1, 2011 and ending January 1, 2012

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2011-85) to the current valuation period (2012-86) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2011 and replaces it with a much larger negative net cashflow for 2086. The present value of future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2011-85 to 2012-86. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2011 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Period beginning on January 1, 2010 and ending January 1, 2011

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2010-84) to the current valuation period (2011-85) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2010 and replaces it with a much larger negative net cashflow for 2085. The present value of future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2010-84 to 2011-85. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2010 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in the Projection Base

Period beginning on January 1, 2011 and ending January 1, 2012

Actual income and expenditures in 2011 were different than what was anticipated when the *2011 Trustees Report* projections were prepared. Part A income was slightly higher than estimated and Part A expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B and D projection-base changes is an increase in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2011 and January 1, 2012 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Period beginning on January 1, 2010 and ending January 1, 2011

Actual income and expenditures in 2010 were different than what was anticipated when the 2010 Trustees Report projections were prepared. Part A income was lower than estimated and Part A expenditures were higher than anticipated, due to the impacts of the economic recession. Part B total income and expenditures were lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B and D projection base changes is a slight decrease in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2010 and January 1, 2011 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in Demographic Assumptions

Period beginning on January 1, 2011 and ending January 1, 2012

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting demographic values were changed.

- Preliminary birth rate data for 2009 and 2010 are lower than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.
- The current valuation incorporates final data on legal immigration levels for 2010. The levels are slightly lower than the estimates used in the prior valuation.
- Updated starting population levels and the interaction of these levels with the changes in the fertility and immigration assumptions result in higher ratios of retirement age population to working age population than in the prior valuation.

These changes have little impact on the Part A present values of future expenditures and income. However, since overall population projections are lower compared to the prior valuation, these changes lower the Part B and Part D present values of expenditures and also income because of the financing mechanism in place for both.

Period beginning on January 1, 2010 and ending January 1, 2011

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting demographic values were changed.

- The inclusion of final mortality data for 2007 results in lower starting death rates and faster near-term declines in death rates at older ages for the current valuation period.
- Revised historical estimates of net other immigration and final data on legal immigration for 2009 are also used in the current valuation. Based on estimates from the Department of Homeland Security for 2007 and 2008 and due to the weak U.S. economy since 2008, net other immigration levels for 2007-10 are assumed negative for the current valuation period. These levels are significantly lower than the positive estimates used in the prior valuation period.
- Birth rates projected through 2026 are slightly lower in the current valuation; preliminary birth data for 2008 and 2009 was lower than was expected for the prior valuation.

These changes have little impact on the present values of future expenditures and income.

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2011 and ending January 1, 2012

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate economic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting economic values and near-term economic growth rate assumptions were changed. The economic recovery has been slower than was assumed for the prior valuation period.

- For the current valuation period, HI taxable earnings are considerably lower for the starting year, 2011, than were projected for the prior valuation period. The projected level of taxable earnings grows more slowly through 2017 for the current valuation period.
- Price inflation in 2011 was higher than expected, with the cost-of-living adjustment in December 2011 being 2.9 percentage points higher than was assumed in the prior valuation.
- The real interest rate is projected to be lower over the first ten years of the current valuation period.

Inclusion of each of these economic revisions decreases the present value of future net cashflow.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Case mix growth assumptions for inpatient hospitals were lowered.
- Utilization rate and case mix increase assumptions for skilled nursing facilities and home health agencies were increased.
- Growth in hospice services was increased.
- Increase in average pre-ACA “baseline” growth rate from GDP+1 percent to GDP+1.4 percent to better account for the level of payment rate updates for Medicare (prior to the ACA) compared to private health insurance and other payers of health insurance in the U.S.

- Use of the "factors contributing to growth" model, developed by the Office of the Actuary at CMS, for year-by-year growth rate assumptions in long range.

- The impact of this change, in association with the baseline growth rate assumption described just above, has the biggest effect on the change in the net present value of income less expenditures. It resulted in an increase in the present value of Part A and Part B expenditures of roughly $1 trillion and $570 billion, respectively. Since the present value of Part A income is unaffected by these changes and the present value of Part B income is also higher by $570 billion, the net present value of income less expenditures is lower by about $1 trillion. Therefore, approximately $1 trillion of the $2.3 trillion is due to these changes.

- Lower assumed growth rate for prescription drug expenditures in the U.S. overall.

- Explicit projection of Part B services indexed by the CPI (e.g., Ambulatory Surgical Center, lab and DME services).

- The impact of this change lowers the present value of Part B expenditures and income by roughly $570 billion and has no effect on the net present value of income over expenditures.

The net impact of these changes resulted in a decrease in the future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of expenditures and a very slight decrease on the present value of income, with an overall decrease on the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Period beginning on January 1, 2010 and ending January 1, 2011

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate economic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting economic values and near-term economic growth rate assumptions were changed. The economic recovery has been slower than was assumed for the prior valuation period.

- For the current valuation period, HI taxable earnings are considerably lower for the starting year, 2010, than were projected for the prior valuation period. The projected level of taxable earnings grows more slowly through 2017 for the current valuation period.
- Unemployment rates are slightly higher over first few years of the projection for the current valuation period.
- The interest rates assumed in the short-range period are lower for the current valuation period.

Inclusion of each of these economic revisions decreases the present value of future net cashflow.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rates for certain hospitals were lowered.
- Components of price updates for hospitals were increased.
- Components of price updates for home health agency services were lowered.
- Slightly lower residual assumptions for certain Part B services in the short-range period.
- Slight refinement in the Part B application of the ACA multifactor productivity adjustments in the long range period, which lowers expenditures.

- The utilization assumed for beneficiaries assumed to switch from Medicare Advantage to fee-for-service was lowered.
- The utilization assumed for beneficiaries assumed to switch from fee-for-service to Medicare Advantage was increased.
- Assumed utilization of skilled nursing facility and home health agency services was increased.
- Reduction in the projected growth in prescription drug spending in the U.S.

These changes had a net positive impact on the future net cashflow for total Medicare. For Part A, these changes resulted in a net increase to the present value of both income and expenditures, with an overall increase on the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Changes in Law

Period beginning on January 1, 2011 and ending January 1, 2012

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year income, expenditures and net cashflow. However, there were three specific provisions enacted that had a fairly substantial impact on the Medicare program. These include the 2 percent sequestration of expenditures in February 2013 through January 2022 required by the *Budget Control Act of 2011,* which reduces the present value of expenditures for Medicare; the extension of the 0 percent physician payment update through 2012 required by the *Temporary Payroll Tax Cut Continuation Act of 2011* and the *Middle Class Tax Relief and Job Creation Act of 2012*, which slightly increases the present value of Part B expenditures; and the reduction in bad debt payments required by the *Middle Class Tax Relief and Job Creation Act of 2012*, which reduces the present value of Part A and Part B expenditures.

Period beginning on January 1, 2010 and ending January 1, 2011

Although Medicare legislation was enacted since the prior valuation date, most of the provisions have a negligible impact on the present value of the 75-year income, expenditures and net cashflow. However, the enacted changes to the physician payment update very slightly increased the present value of both income and expenditures, but had no effect on the 75-year present value of future net cashflow.

Note 25. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)

	2012	2011
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,205,880	$ 1,263,532
Spending Authority from Offsetting Collections and Recoveries	(47,415)	(46,369)
Obligations Net of Offsetting Collections and Recoveries	1,158,465	1,217,163
Distributed Offsetting Receipts	(317,777)	(322,724)
Net Obligations	840,688	894,439
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	21	458
Total Resources Used to Finance Activities	$ 840,709	$ 894,897
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	(13,909)	10,504
Resources That Fund Expenses Recognized in Prior Periods	138	158
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(1,255)	(921)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,652	861
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	1,995	2,260
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	(11,379)	12,862
Total Resources Used to Finance the Net Cost of Operations	$ 852,088	$ 882,035
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	2,870	(3,493)
Components Not Requiring or Generating Resources	589	(409)
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	3,459	(3,902)
Net Cost of Operations	$ 855,547	$ 878,133

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2012

Responsibility Segment Program	2012	2011	2010	2009	2008
Administration for Children and Families					
Administration on Developmental Disabilities	$ 6	$ 11	$ 9	$ 10	$ 8
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	705	761	691	447	400
National Institutes of Health					
Research Training and Career Development	1,858	1,920	1,915	1,862	1,792
Totals	$ 2,569	$ 2,692	$ 2,615	$ 2,319	$ 2,200

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. Three HHS operating divisions conduct education and training programs under this category: ACF, NIH and HRSA.

Administration for Children and Families

ACF is able to estimate Investment in Human Capital for the Administration for Intellectual and Developmental Disabilities (AIDD) using existing data collection activities. Under AIDD, as of September 30, 2012, 17 Projects of National Significance (PNS) grants have been awarded for FY 2012. 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 $6 million as of September 30, 2012.

Health Resources and Services Administration

Under Clinician Recruitment and Service, the National Health Service Corps (NHSC) is a network of 10,000 primary care providers and 17,000 sites working in communities with limited access to health care across the country. To support their service, the NHSC provides clinicians with financial support in the form of loan repayment and scholarships. In addition, the Nursing Education Loan Repayment and Scholarship programs help alleviate the critical shortage of nurses by providing financial incentives in exchange for their service at Critical Shortage Facilities.

The Health Professions Training programs make grants to health professions schools and training programs, which use the funds to develop, expand and enhance their efforts to train the health workforce America needs. They include programs focused on increasing diversity, encouraging clinicians to practice in underserved areas and preparing health care providers equipped to meet the needs of the aging U.S. population. Primary care medicine and dentistry, nursing, public health, psychology, allied health and chiropractic training programs benefit from specific grant programs. The Bureau of Health Professions (BHPr) also administers a scholarship for disadvantaged students and student loan programs for health professions schools.

National Institutes of Health

The NIH Research Training Program 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. NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research depends upon the continued development of new, highly trained investigators.

Investment in Research and Development (in Millions)

As of September 30, 2012

Responsibility Segments	Basic	Applied	Develop-mental	2012 Total	2011	2010	2009	2008	Grand Total
ACF	$ -	$ 2	$ -	$ 2	$ 7	$ 9	$ 16	$ 25	$ 59
AHRQ	-	401	-	401	333	263	203	184	1,384
CDC	-	408	-	408	457	465	755	440	2,525
FDA	73	-	7	80	58	48	36	67	289
NIH	18,409	12,272	-	30,681	32,902	31,342	27,889	27,302	150,116
Totals	$ 18,482	$ 13,083	$ 7	$ 31,572	$ 33,757	$ 32,127	$ 28,899	$ 28,018	$ 154,373

The research and development programs in HHS include the following.

Administration for Children and Families

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 may lead healthier and more productive lives.

Agency for Healthcare Research and Quality

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.

Centers for Disease Control and Prevention

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.

Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While the 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* 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 U.S.).

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.

National Institutes of Health

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 (in Millions)

For the Year Ended September 30, 2012

	CMS					
Budgetary Resources:	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[8]	Agency Combined Totals	Non-Budgetary Credit Reform Financing Account
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 512	$ 51,218	$ 51,730	$ 71
Recoveries of Prior Year Unpaid Obligations	436	117	20,560	4,633	25,746	-
Other Changes in Unobligated Balance	(84)	(77)	-	(4,363)	(4,524)	-
Unobligated Balance from Prior Year Budget Authority, Net	352	40	21,072	51,488	72,952	71
Appropriations (Discretionary and Mandatory)	255,815	236,355	266,620	433,070	1,191,860	-
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	3,194
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	138	17	687	19,280	20,122	1,636
Total Budgetary Resources	$ 256,305	$ 236,412	$ 288,379	$ 503,838	$ 1,284,934	$ 4,901
Status of Budgetary Resources:						
Obligations Incurred	$ 256,305	$ 236,412	$ 267,289	$ 444,148	$ 1,204,154	$ 1,726
Unobligated Balances, End of Year:						
Apportioned	-	-	21,032	50,887	71,919	3,134
Exempt from Apportionment	-	-	-	184	184	-
Unapportioned	-	-	58	8,619	8,677	41
Total Unobligated Balance, End of Year	-	-	21,090	59,690	80,780	3,175
Total Status of Budgetary Resources	$ 256,305	$ 236,412	$ 288,379	$ 503,838	$ 1,284,934	$ 4,901
Change in Obligated Balance:						
Unpaid Obligations, Brought Forward, Oct 1	$ 32,194	$ 24,063	$ 27,726	$ 104,551	$ 188,534	$ -
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	(1)	-	-	(10,359)	(10,360)	-
Obligated Balance, Start of Year (Net)	32,193	24,063	27,726	94,192	178,174	-
Obligation Incurred	256,305	236,412	267,289	444,148	1,204,154	1,726
Outlays (Gross)	(263,854)	(235,954)	(247,618)	(438,762)	(1,186,188)	(124)
Change in Uncollected Customer Payments from Federal Sources	-	-	-	257	257	(1,587)
Recoveries of Prior Year Unpaid Obligations	(436)	(117)	(20,560)	(4,633)	(25,746)	-
Obligated Balance, End of Year Unpaid Obligations, End of Year (Gross)	24,209	24,404	26,837	105,304	180,754	1,602
Uncollected Customer Payments from Federal Sources, End of Year	(1)	-	-	(10,102)	(10,103)	(1,587)
Obligated Balance, End of Year (Net)	$ 24,208	$ 24,404	$ 26,837	$ 95,202	$ 170,651	$ 15

[8] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $4 billion and net outlays of $3.6 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2012

	CMS					
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[9]	Agency Combined Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:						
Budget Authority, Gross (Discretionary and Mandatory)	$ 255,953	$ 236,372	$ 267,307	$ 452,350	$ 1,211,982	$ 4,830
Actual Offsetting Collections (Discretionary and Mandatory)	(138)	(17)	(687)	(19,449)	(20,291)	(48)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	-	-	257	257	(1,587)
Budget Authority, Net (Discretionary and Mandatory)	$ 255,815	$ 236,355	$ 266,620	$ 433,158	$ 1,191,948	$ 3,195
Outlays, Gross (Discretionary and Mandatory)	$ 263,854	$ 235,954	$ 247,618	$ 438,762	$ 1,186,188	$ 124
Actual Offsetting Collections (Discretionary and Mandatory)	(138)	(17)	(687)	(19,449)	(20,291)	(48)
Outlays, Net (Discretionary and Mandatory)	263,716	235,937	246,931	419,313	1,165,897	76
Distributed Offsetting Receipts	(31,709)	(284,875)	-	(1,193)	(317,777)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 232,007	$ (48,938)	$ 246,931	$ 418,120	$ 848,120	$ 76

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 51,741	$ 51,741	$ 48,575
ACL	1,522	1,522	1,465
AHRQ	400	400	184
CDC	11,872	11,872	10,418
CMS	369,957	369,957	302,201
FDA	4,473	4,473	2,021
HRSA	9,683	9,683	8,869
IHS	6,574	6,574	4,488
NIH	35,845	35,845	32,624
OS	6,323	6,323	3,949
PSC	1,678	1,678	313
SAMHSA	3,770	3,770	3,013
Totals	$ 503,838	$ 503,838	$ 418,120

[9] "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS responsibility segments other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of $4 billion and net outlays of $3.6 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Deferred Maintenance

For the Years Ended September 30, 2012 and 2011

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 a fixed asset 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 service 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. CDC, NIH and FDA all use the condition assessment survey for all classes of property. IHS uses two types of surveys to assess installations – annual general inspections and deep look surveys.

Category of Asset (in Millions)	Condition	Estimated Cost to Return to Acceptable Condition 2012	2011
General PP&E			
Buildings	1 - 4	$ 2,038	$ 1,976
Equipment	3 - 4	14	13
Other Structures	1 - 4	30	30
Total		$ 2,082	$ 2,019

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

As of September 30, 2012

HHS has Indian Trust Lands that are considered a type of property, plant and equipment 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 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 Statements of Federal Financial Accounting Standards Number 29, *Heritage Assets and Stewardship Land*, heritage assets are any real property assets that are individually listed on the National Register of Historic Places. As of September 30, 2012, IHS has no individually listed properties.

The IHS accountability reports differentiates Indian Trust Land parcels from general PP&E situated thereon. The IHS Trust Land balances are removed from HHS FY 2012 Balance Sheet and reported as Stewardship Assets - Indian Trust Lands.

The table below provides a summary of the Distribution of Stewardship Assets by Type and Area, as of September 30, 2012.

Distribution of Stewardship Assets by Type and Area

	Indian Trust Lands	
	Number of Sites	Total Hectares
Aberdeen	9	75
Albuquerque	4	3
Bemidji	2	9
Billings	7	48
Navajo	35	255
Oklahoma City	1	2
Phoenix	12	14
Portland	3	1
Tucson	5	12
Total	78	419

Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the Nation's aged and disabled for almost five decades. A brief description of the provisions of Medicare's HI (Part A) Trust Fund and SMI (Parts B and D) Trust Fund is included in this financial report.

The Required Supplementary Information contained in this section is based on current law and is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

Required Supplementary Information material is generally drawn from the *2012 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 projections in this report incorporate a provision of the *Budget Control Act of 2011* that affects Medicare expenditures. Under this provision, a Joint Select Committee on Deficit Reduction was established, tasked with developing recommendations to reduce the deficit over 10 years and required to report to Congress. This provision also required a sequestration process to be put into effect government-wide, to reduce Federal outlays should the Joint Committee fail to refer legislation or not meet the required savings threshold. Since the Joint Committee did not report recommendations for deficit reduction, the sequestration process will automatically start, effective February 2013, unless Congress acts to address the budget deficit before then. Medicare benefit payments are subject to a maximum 2-percent reduction through the sequestration process, as provided for in the *Budget Control Act*. The sequestration of Federal outlays would end on January 31, 2022.

As was the case with the prior two reports, the projections shown here also incorporate the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the "*Affordable Care Act*" (ACA), contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems and other changes intended to improve the quality of health care and reduce its costs to Medicare.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act*. These improved results for HI and SMI Part B depend in part on the long-range feasibility of the various cost-saving measures in the ACA—in particular, the lower increases in Medicare payment rates to most categories of health care providers. It is possible that providers can improve their productivity, reduce wasteful expenditures and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Whether these provisions of current law can be sustained is debatable due to substantial uncertainty about the adequacy of future Medicare payment rates. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. For these reasons, the estimates shown under current law should be used cautiously in evaluating the overall financial obligation created by Medicare and in assessing the financial status of the individual trust fund accounts. However, the effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees report, which must be based on current law. In addition, the FASAB rules governing the SOSI also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the ACA. In addition, a reduction in Medicare payment rates for physician services of more than 30 percent is assumed to be implemented beginning in 2013 as required under current law, despite the virtual certainty that Congress will override the reduction, as they have every year since 2003.

As will be discussed in more detail later, the long-range Medicare cost growth assumptions under current law take into consideration the recommendations by the 2010-2011 Technical Review Panel on the *Medicare Trustees Report*. These recommendations were designed to build upon the long-range assumptions used in the 2011 and prior Trustees Reports, but they incorporated a more refined analysis of the factors behind those assumptions, most notably for the increases in the price, volume and intensity of health care services overall.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, the Medicare Board of Trustees, in their annual report to Congress, reference two alternative scenarios to illustrate where possible the potential understatement of Medicare costs and projection results. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under hypothetical modifications to current law. No endorsement of the illustrative alternatives by the Trustees, CMS or the Office of the Actuary should be inferred. Additional information on the hypothetical alternatives to current law is provided in Note 22 in these financial statements, in Appendix C of this year's annual *Medicare Trustees Report* and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/.

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is one of the most critical determinants of the projected cost of Medicare-covered health care services in the more distant future. Starting with the 2001 *Medicare Trustees Report*, the assumed average increase in expenditures per beneficiary for the 25th through 75th years of the projection has been based in whole or in part on the growth in per capita GDP plus 1 percentage point.[10] This assumption was recommended by the 2000 Medicare Technical Review Panel and confirmed as reasonable by the 2004 panel. Beginning with the 2006 report, the Trustees adopted a slight refinement of the long-range growth assumption that provided a more gradual transition from current health cost

[10]This assumed increase in the expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which are estimated and applied separately.

growth rates, which had been roughly 2 to 3 percentage points above the level of GDP growth, to the ultimate assumed level of GDP plus 0 percent just after the 75th year and for the indefinite future.[11]

Following enactment of the ACA, the long-range Medicare cost growth assumptions for the 2010 and 2011 *Medicare Trustees Reports* continued to use this same methodology to establish a pre-ACA "baseline" set of annual growth rates. The Trustees then reduced these growth rates for most categories of Medicare expenditures by the 10-year moving average increase in private, non-farm business multifactor productivity, as required under the ACA.[12]

For the *2012 Medicare Trustees Report*, based on the recommendations of the 2010-2011 Medicare Technical Review Panel,[13] the Board of Trustees adopted a long-range pre-ACA baseline cost growth assumption of "GDP plus 1.4 percent" and a "factors contributing to growth" model, which creates specific, year-by-year declining growth rates during the last 50 years of the projection period. As noted previously, the ACA permanently reduces the annual increases in Medicare payment rates for most categories of health service providers by the increase in economy-wide productivity. Thus, the long-range cost growth rate for affected providers is set equal to the pre-ACA baseline growth assumptions, minus the increase in economy-wide multifactor productivity (1.1 percent). In addition, the Medicare Technical Panel concluded that the slower payment updates would have a small, net downward effect on growth in the volume and intensity of services. Based on this conclusion, the growth rates are further adjusted by (0.1) percent annually.

The different provisions for updating payment rates require separate long-range cost growth assumptions for the different categories of providers:

1. All HI and some SMI Part B (primarily outpatient hospital, home health and dialysis), services that are updated annually by provider input price increases, less the increase in economy-wide productivity, have an ultimate growth rate of "GDP plus 0.2 percent" or 4.3 percent on average. Based on the factors model, the year-by-year increases start at "GDP plus 0.4 percent" in 2036 and gradually decline to "GDP minus 0.5 percent" in 2086.

2. Certain SMI Part B services—such as durable medical equipment, laboratory tests, care at ambulatory surgical centers, ambulance services and medical supplies that are updated annually by the Consumer Price Index (CPI) increase, less the increase in productivity—have a long-range growth assumption of "GDP minus 0.6 percent" or 3.5 percent on average. The corresponding year-by-year growth rates are "GDP minus 0.5 percent" in 2036, declining to "GDP minus 1.3 percent" in 2086.

3. Expenditures for services payable under the physician fee schedule are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law.

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[11]The year-by-year growth assumptions were based on a simplified economic model and were determined in a way such that the 75-year actuarial balance for the HI trust fund was consistent with that generated by the constant "GDP plus 1 percent" assumption.

[12]"Multifactor productivity" is a measure of real output per combined unit of labor and capital, reflecting the contributions of all factors of production.

[13]The Panel's interim report is available at http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml. Once it is completed, the final report will be available at http://aspe.hhs.gov/health/medpanel/2010/.

4. All other Part B outlays, which constitute an estimated 12.0 percent of total Part B expenditures in 2021, have an assumed average growth rate of per capita GDP plus 1.0 percent or 5.1 percent on average. The corresponding year-by-year growth rates from the factors model are "GDP plus 1.2 percent" in 2036, declining to "GDP plus 0.3 percent" by 2086.

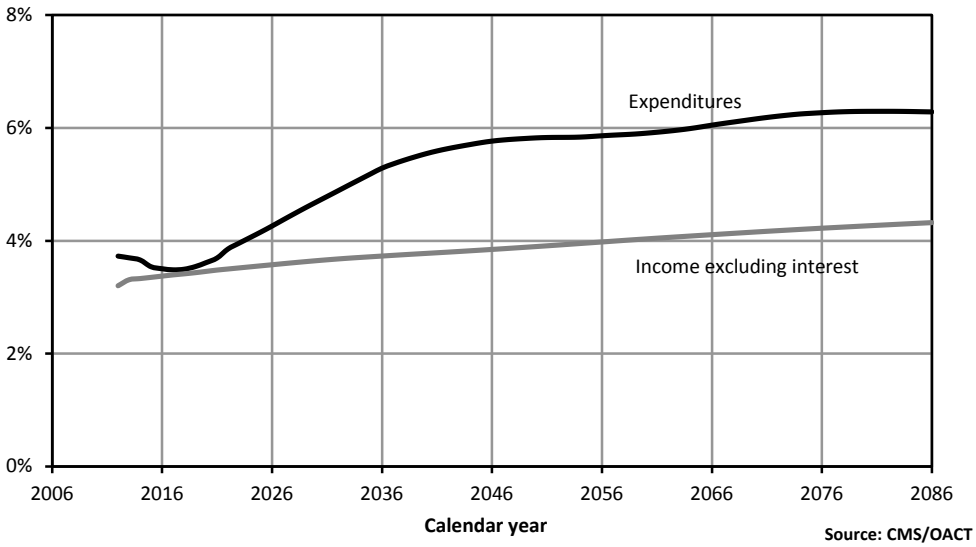
After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 4.1 percent per year for the last 50 years of the projection period, or "GDP plus 0 percent," on average. When Parts A, B and D are combined, the weighted average growth rate for Medicare is 4.3 percent over this same period.

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. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as "taxable payroll").

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected long-range HI cost rates shown in this report are significantly higher than those from the 2011 report. The primary reason for the difference is the faster assumed long-range growth in the volume and intensity of HI services, as recommended by the 2010-2011 Medicare Technical Review Panel.

Chart 1: HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll 2012 - 2086



Source: CMS/OACT

Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.9 percent. Under the ACA, however, high-income workers will pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. As these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

As indicated in Chart 1, the cost rate will initially decline due to the expected economic recovery, the savings provisions of the ACA and the 2 percent reduction in all Medicare expenditures for 2013-2021, as required by the *Budget Control Act of 2011*. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. Under the illustrative alternative, if the slower price updates were not feasible in the long range and were phased down during 2020-2035, then the HI cost rate would be 5.5 percent in 2035 and 9.9 percent in 2085. These levels are about 10 percent and 60 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

HI and SMI Cashflow as a Percentage of GDP

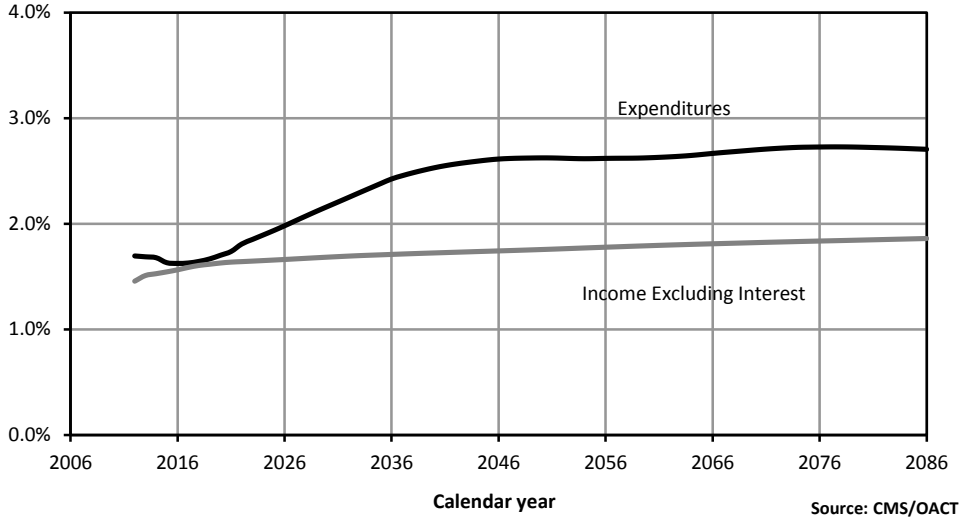
Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial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

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2011, the expenditures were $256.7 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections,[14] HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.3 percent in 2086.

[14]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under hypothetical alternatives to current law, which assumes that (i) the SGR-mandated physician fee schedule payment reductions are replaced with a 1-percent annual increase during 2013-2021 and then gradually transition to the per capita increase in health spending in the US overall; (ii) the productivity adjustments are gradually phased down over 2020-2035; and (iii) the Independent Payment Advisory Board requirements are not implemented. A summary of the illustrative alternative projections is contained in appendix V.C. of the 2012 Trustees Report. No endorsement of the illustrative alternatives to current law by the Trustees, CMS or the Office of the Actuary should be inferred.

Chart 2: HI Expenditures and Income Excluding Interest as a Percentage of GDP 2012 – 2086



Source: CMS/OACT

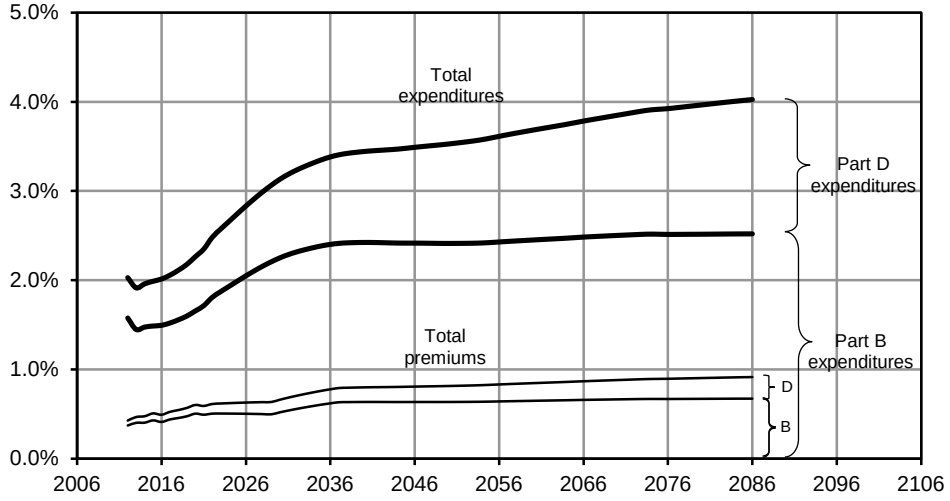
SMI

Due to 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 3 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 incorporates the effects of the ACA. 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 described previously.

Under the intermediate assumptions, annual SMI expenditures were $292.5 billion, or about 1.9 percent of GDP, in 2011. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to more than 4.0 percent by the end of the projection period. Total SMI expenditures in 2086 would be 5.2 percent of GDP if physician payment rates were set as assumed under the illustrative alternative projections. Such costs would represent more than 6.0 percent of GDP under the full illustration, including larger payment updates for most other categories of Part B providers.

Chart 3: SMI Expenditures and Premiums as a Percentage of GDP
2012 - 2086



Source: CMS/OACT

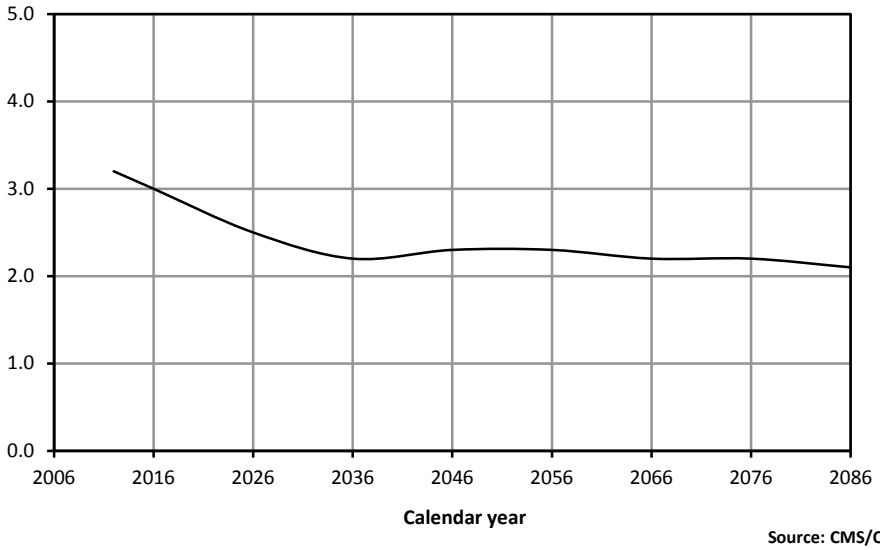
To match the faster growth rates for SMI expenditures under current law, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2012 by about 4.4 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 4 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 2011, every beneficiary had 3.3 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2086.

Chart 4: Number of Covered Workers per HI Beneficiary
2012 - 2086



Source: CMS/OACT

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. Due to 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.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[15] The assumptions varied are the health care cost factors, real-wage differential, CPI, real interest rate, fertility rate and net immigration.[16]

For this analysis, the intermediate economic and demographic assumptions in the *2012 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, 2012 and are based on estimates of income and expenditures during the 75-year projection period.

[15]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 a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

[16]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.

Charts 5 through 10 show the present value of the estimated net cashflow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the ACA result in trust fund surpluses and then decrease until about 2045 when they start to increase (or become less negative) once again. This pattern occurs in part because 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. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

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.

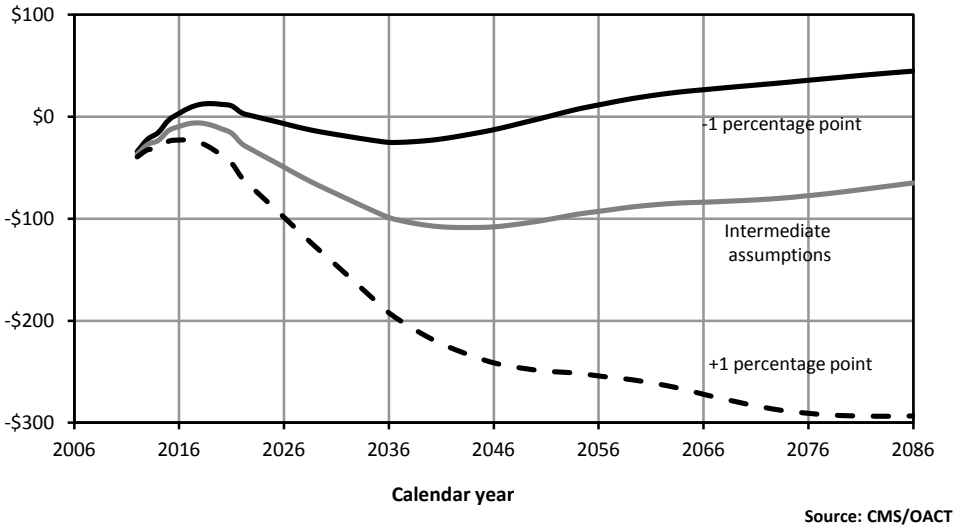
Table 1: Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$533	$(5,581)	$(15,332)

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $6,114 billion. However, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $9,751 billion.

Chart 5 shows projections of the present value of the estimated net cashflow under the three alternative annual growth rate assumptions presented in table 1.

Chart 5: Present Value of HI Net Cashflow with Various Health Care Cost Factors 2012 - 2086
(in Billions)



Source: CMS/OACT

This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI trust fund as a result of the ACA. 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 Chart 5 indicates, 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.[17] In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, yielding ultimate percentage increases in nominal 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

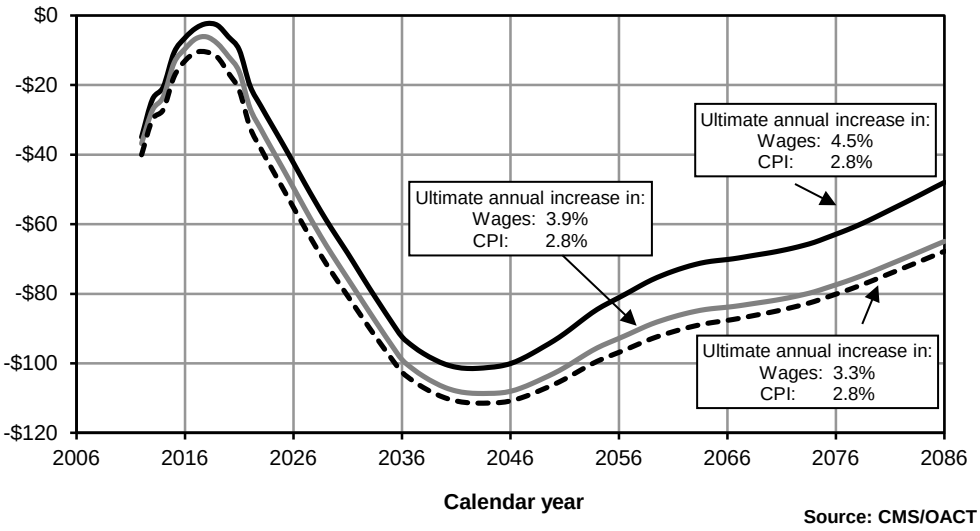
Ultimate percentage increase in wages – CPI	3.3 – 2.8	3.9 – 2.8	4.5 – 2.8
Ultimate percentage increase in real-wage differential	0.5	1.1	1.7
Income minus expenditures (in billions)	$(5,860)	$(5,581)	$(4,839)

[17]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 indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $620 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $230 billion.

Chart 6 shows projections of the present value of the estimated net cashflow under the three alternative real-wage differential assumptions presented in Table 2.

Chart 6: Present Value of HI Net Cashflow with Various Real-Wage Assumptions 2012 - 2086
(in Billions)



Source: CMS/OACT

As illustrated in Chart 6, faster real-wage growth results in smaller HI cashflow deficits, when expressed in present-value dollars. 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 practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the ACA depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong likelihood that certain of these changes will not be viable in the long range.

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 assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 3.0, 4.0 and 5.0 percent, respectively.

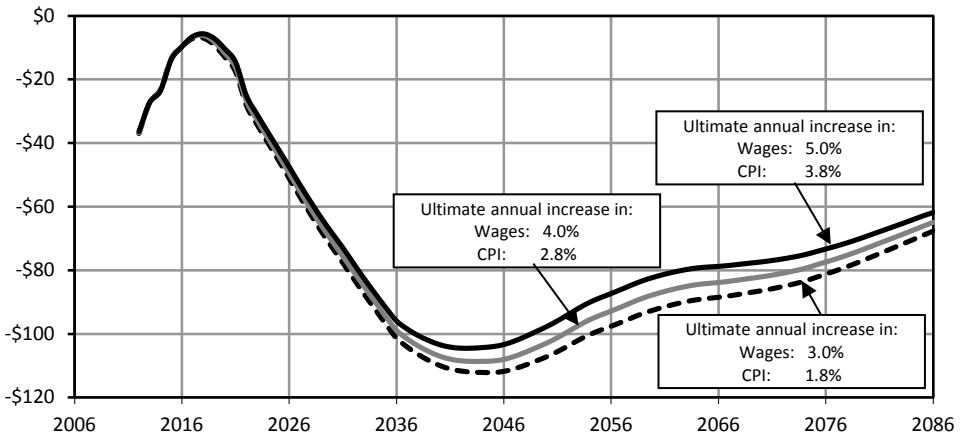
Table 3: Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages − CPI	3.0 − 1.8	4.0 − 2.8	5.0 − 3.8
Income minus expenditures (in billions)	$(5,812)	$(5,581)	$(5,316)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $231 billion. However, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $265 billion.

Chart 7 shows projections of the present value of net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 3.

Chart 7: Present Value of HI Net Cashflow with Various CPI-Increase Assumptions 2012 - 2086
(in Billions)



Source: CMS/OACT

As Chart 7 indicates, this assumption has a small 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 present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the ACA for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation and vice versa.

Real-Interest Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9 and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, which results in ultimate annual yields of 5.2, 5.7 and 6.2 percent, respectively.

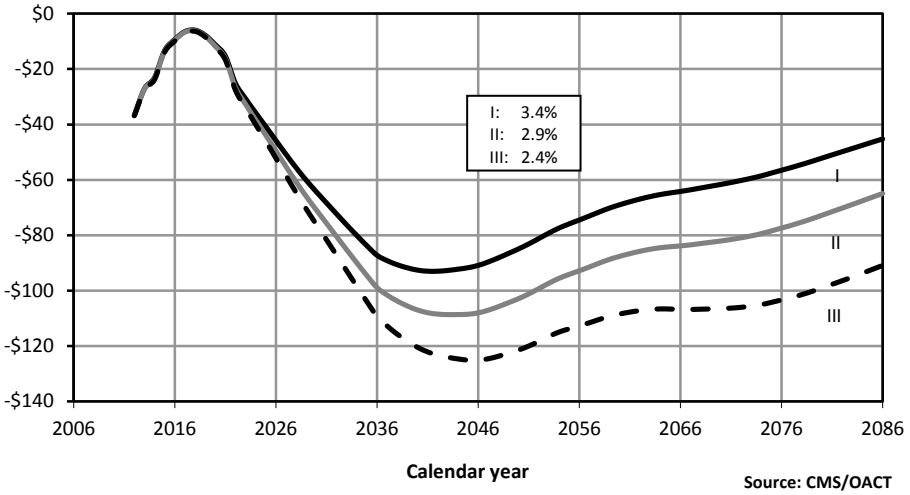
Table 4: Present Value of Estimated HI Income
Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures (in billions)	$(6,713)	$(5,581)	$(4,558)

As illustrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $215 billion.

Chart 8 shows projections of the present value of the estimated net cashflow under the three alternative real-interest assumptions presented in table 4.

Chart 8: Present Value of HI Net Cashflow
with Various Real-Interest Rate Assumptions
2012 - 2086
(in Billions)



Source: CMS/OACT

As shown in Chart 8, the projected HI cashflow when expressed in present values is fairly sensitive to the interest assumption. 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 2024. 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

As 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

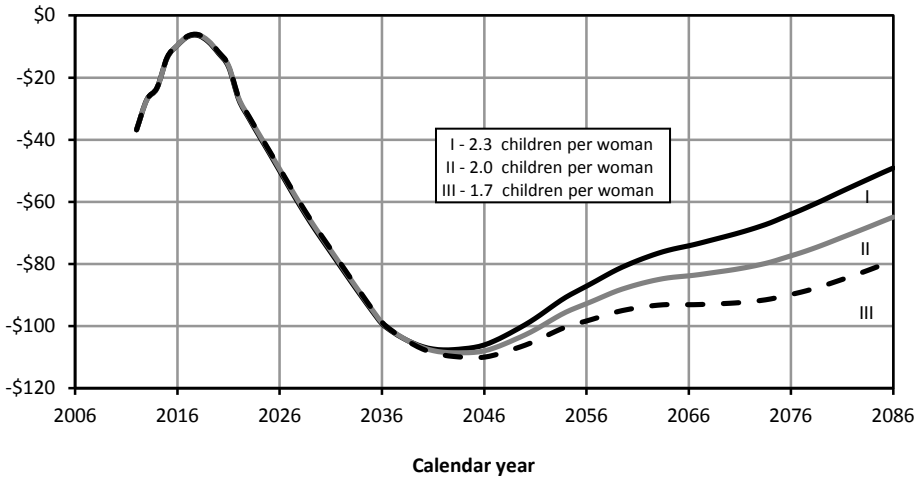
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	$(5,947)	$(5,581)	$(5,199)

[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 $370 billion.

Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in Table 5.

Chart 9: Present Value of HI Net Cashflow with Various Ultimate Fertility Rate Assumptions 2012 - 2086
(in Billions)



Source: CMS/OACT

As Chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cashflows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

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: 790,000 persons, 1,080,000 persons and 1,375,000 persons per year.

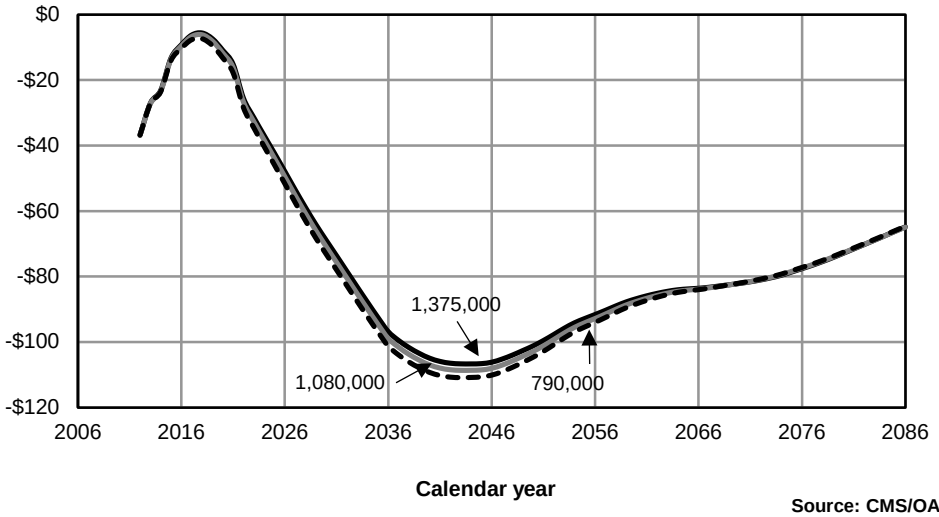
Table 6: Present Value of Estimated HI Income
Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	790,000	1,080,000	1,375,000
Income minus expenditures (in billions)	$(5,663)	$(5,581)	$(5,509)

As indicated in Table 6, if the average annual net immigration assumption is 790,000 persons, the deficit—expressed in present-value dollars—increases by $82 billion. Conversely, if the assumption is 1,375,000 persons, the deficit decreases by $72 billion.

Chart 10 shows projections of the present value of net cashflow under the three alternative average annual net immigration assumptions presented in table 6.

Chart 10: Present Value of HI Net Cashflow
with Various Net Immigration Assumptions
2012 - 2086
(in Billions)



Source: CMS/OACT

Higher net immigration results in smaller HI cashflow deficits, as illustrated in Chart 10. 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.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2024, the same as in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI taxable earnings in 2011 were about equal to last year's estimate. However, the projected rate of growth in these earnings is lower in 2012 through 2014 but then exceeds last year's growth assumptions after 2014. HI expenditures in 2011 were lower than the previous estimate, but the projected level grows more rapidly than shown in last year's report because of changes in HI provider assumptions and the projected faster growth in earnings after 2014. Most of this faster growth is offset by the expected 2-percent reduction in HI outlays under the *Budget Control Act of 2011* for fiscal years 2013 through 2021. HI expenditures have exceeded income annually since 2008 and are projected to continue to do so through the short-range period until the fund becomes exhausted in 2024. The shortfalls can be met with increasing reliance on the redemption of trust fund 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 would 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.

It is important to note that the improved outlook for the HI trust fund, relative to pre-ACA, depends in part on the feasibility of the provider payment update reductions. There is a significant likelihood, however, that these providers would not be able to reduce their cost growth rates sufficiently during this period to match the slower increases in Medicare payments per service, and, in this case, they would eventually become unable to continue providing health care services to Medicare beneficiaries. If such a situation occurred and Congress overrode the payment update reductions, then actual costs would be higher and the HI trust fund would be depleted somewhat sooner.

The HI trust fund remains 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 significant increases in revenues and/or reductions in benefits. These changes are needed partially as a result of the impending retirement of the baby boom generation. If the reductions to HI provider price updates could not be continued in the long run, then the actuarial deficit would be much greater.

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

The financing established for the Part B account for calendar year 2012 is adequate to cover 2012 expected expenditures and to maintain the financial status of the account in 2012 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not viable. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

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

previously estimated, mostly due to the lower assumed growth rates for prescription drug expenditures for 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. Such financing, however, would have to increase faster than the economy to match expected expenditure growth under current law. A critical issue for the SMI trust fund continues to be the impact of the past and expected rapid growth of SMI costs, which place gradually 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 seven fiscal years (2012-2018).[18] This difference is expected to exceed 45 percent of total expenditures in fiscal year 2012, which is the first year of the seven year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. Similar determinations were made in their 2006-2011 annual reports to Congress. With this seventh 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. 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. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown in this section continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected exhaustion of the HI trust fund, this fund's long-range financial imbalance and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare could not be sustained, then these further policy reforms would have to address much larger financial challenges than implied by the current-law projections. In their 2012 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the Nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of…further reforms should occur in the near future."

[18]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; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.