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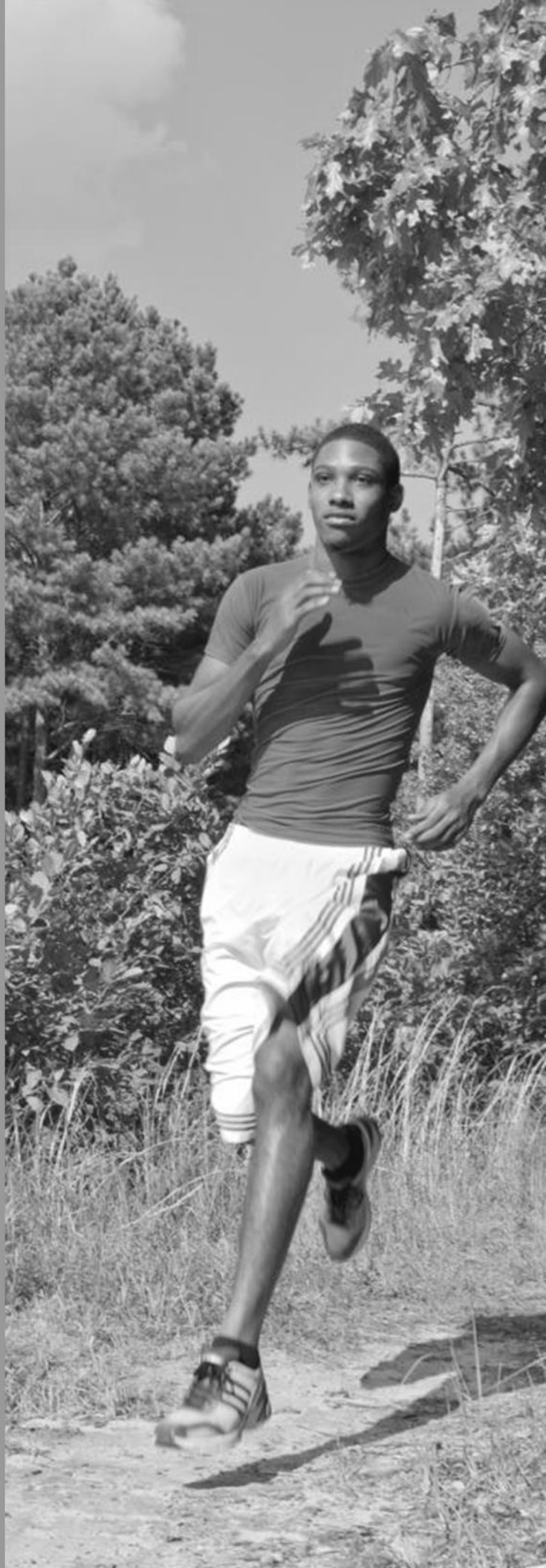
- Required Supplementary Information

Financial Section

The Financial Section includes the Report of the Independent Auditors, the Department's Principal Financial Statements, Notes to the Principal Financial Statements, Required Supplementary Stewardship Information, and Required Supplementary Information.



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* (AFR) represents our accountability report for FY 2014. We will issue the FY 2014 *HHS Summary of Performance and Financial Information*, and the FY 2016 *Annual Performance Report and Congressional Budget Justification* in February 2015.

Through collaboration, our Chief Financial Officer (CFO) community manages financial accountability, transparency, compliance, and risk across the Department by prioritizing resources to drive results. We are committed to using taxpayer resources wisely to carry out the Department's mission. This year, for the first time, the Department received the prestigious *Certificate of Excellence in Accountability Reporting* awarded by the Association of Government Accountants for our FY 2013 AFR.

We are dedicated to upholding these standards of excellence. During 2014, we continued to carry out our role as public stewards and worked together collaboratively to confront the challenges we faced. We have addressed the planned time frames for correcting audit weaknesses and non-compliances in the Other Information section. Other examples of our commitment to these standards of excellence include:

- Continued working together as a CFO community to improve Department-wide financial reporting and systems, with the overall goal to consistently strengthen internal control, maintain data integrity, increase data transparency, and report reliable information on a timely basis.
- Initiated the upgrade of our financial systems to maintain a secure and reliable system environment, with completion expected in FY 2016. We also expanded the use of business intelligence to further enhance the availability and analysis of financial management information to facilitate effective decision making.
- Pursued sharing initiatives using a phased approach, such as the standardization of accounting treatment across systems. Standardization is an important step to substantially comply with federal financial management system requirements, applicable federal accounting standards and the U.S. Government Standard General Ledger at the transaction level as required by the *Federal Financial Management Improvement Act*.
- Strengthened our governance foundation by establishing the Financial Governance Board (FGB) to address, at an enterprise level, financial management areas of common concern across HHS. In addition, the FGB promotes collaboration among stakeholders from the different mission support disciplines such as grants, acquisitions, human resources, information technology, and our shared service provider.

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. For the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, the auditors disclaimed providing an opinion. The disclaimer was primarily due to the uncertainties surrounding provisions of the *Affordable Care Act* and the impact of potential changes in law that would impact underlying assumptions of financial projections. These statements were developed based upon current law using information from the *2014 Medicare Trustees Report*, as required by standards issued by the Federal Accounting Standards Advisory Board. Please refer to the Report of the Independent Auditors, Principal Financial Statements, and Notes to the Principal Financial Statements, in this section 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 further improving the Department's financial management capabilities.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 13, 2014

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 Daniel R. Levinson

DATE: November 13, 2014

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2014 (A-17-14-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2014 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, to audit the HHS (1) consolidated balance sheet as of September 30, 2014 and 2013, 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, 2014, 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 *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 14-02, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2014 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 U.S. generally accepted accounting principles. As presented beginning in note 20 to the

financial statements, with respect to the estimates for the Centers for Medicare & Medicaid Services (CMS) social insurance program as of January 1, 2014 and 2013, CMS management has assumed, in the projections of the program, that the various cost-reduction measures will occur as the Patient Protection and Affordable Care Act (P.L. No. 111-148) (ACA) requires. The Medicare Board of Trustees, in its annual report to Congress, indicated, "While the ACA has been successful in reducing many Medicare expenditures to date, there is a strong possibility that certain of these changes will not be viable in the long range." It further showed the potential impact of this uncertainty in illustrative alternative scenarios and projections intended to provide additional context for the actuarial estimates regarding the long-term sustainability of the social insurance program. The width of the range of the social insurance liability estimates in the various scenarios is significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2014, 2013, 2012, 2011, and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013. Ernst & Young was not able and did not express an opinion on the financial condition of the HHS social insurance program and related changes in the social insurance program for the specified periods.

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*, Ernst & Young identified a material weakness in HHS's financial information management systems and a significant deficiency in its financial reporting systems, analyses, and oversight:

- *Financial Information Management Systems*—Ernst & Young noted HHS had continued to make strides to improve controls that support the information technology infrastructure and financial system applications. HHS operating divisions continued to address and implement the existing governance, financial processes and practices, and system tools needed to enhance controls over application information security and contingency planning. HHS established standard operating procedures and practices to facilitate the improvement of entitywide governance and security assessment and authorization documentation. HHS also continued to establish system-level contingency plans and backup policies and procedures to reduce redundancy and improve availability of infrastructure that supports financial application systems. As in previous fiscal years, Ernst & Young indicated a focused effort is still needed to completely remediate long outstanding deficiencies to a level that supports an auditor's reliance on controls within the financial systems. Deficiencies were noted over controls related to segregation of duties, configuration management, and access to HHS financial systems. The deficiencies identified represent a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2014 audit, Ernst & Young noted further progress as HHS continued to improve current and implement new financial management processes. HHS has started to automate more manual journal entries, upgrade various financial systems, develop new guidance and policies, improve infrastructure, and take other actions to address longstanding financial reporting issues. While progress continued, the audit identified internal control deficiencies in financial systems and processes for producing financial statements,

including a lack of integrated financial management systems and insufficient analysis of certain accounts. Ernst & Young continued to note HHS did not consistently perform controls to ensure differences were properly identified, researched, and resolved in a timely manner and account balances were complete and accurate. Ernst & Young concluded additional improvements in the financial reporting systems and processes are required. These deficiencies collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2014, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of ACA related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. One program, Medicare Fee-for-Service, reported an error rate of over 10 percent, a violation of IPIA. Two other programs, Medicaid and Foster Care, also reported error rates that increased from the error rates reported in FY 2013, another violation of IPIA. We will be communicating further details on agency compliance with improper payment reporting as required by the IPIA later in FY 2015. In addition, HHS's management determined that it may have one potential violation with certain provisions of the Anti-Deficiency Act (P.L. No. 101-508) related to conference spending by the Administration for Children and Families in FY 2014 and FY 2015. On the basis of the material weakness reported over Financial Information Management Systems and the significant deficiency reported over Financial Reporting Systems, Analysis, and Oversight, Ernst & Young concluded HHS also did not comply with the Federal Financial Management Improvement Act of 1996 (P.L No.104-208).

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 14-02, 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 2014 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.

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-17-14-00001.

Attachment

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

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

Ernst & Young LLP
Westpark Corporate Center
8484 Westpark Drive
McLean, VA 22102

Tel: 703-747-1000
www.ey.com

Building a better working world

Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2014 and 2013, 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 related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2014, 2013, 2012, 2011, and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013, and the related notes to these financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2014, 2013, 2012, 2011, and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and 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. 14-02, *Audit Requirements for Federal Financial Statements*. 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.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to HHS' preparation and fair presentation of the financial

statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2014 and 2013, 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 related notes to these financial statements.

Basis for Disclaimer of Opinion on the Statements of Social Insurance and the Related Changes in the Social Insurance Program

As discussed in Note 20 to the financial statements, the statement of social insurance presents the actuarial present value of the HHS' 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. 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, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (Affordable Care Act).

As further described in Note 21 to the financial statements, with respect to the estimates for the HHS social insurance program presented as of January 1, 2014, 2013, 2012, 2011, and 2010, management has assumed in the projections of the program that the various cost-reduction measures will occur as the Affordable Care Act requires. Management 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. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 21, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these

services. If the health sector cannot transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity, actual future costs for Medicare could exceed those shown in the projections. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2014, 2013, 2012, 2011, and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013.

Disclaimer of Opinion on the Statements of Social Insurance and the Related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, 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, 2014, 2013, 2012, 2011, and 2010, and the related changes in the social insurance program for the periods ended January 1, 2014 and 2013.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HHS as of September 30, 2014 and 2013, and its net cost, changes in net position, and budgetary resources for the years then ended, in conformity with U.S. generally accepted accounting principles.

Required Supplementary Information

U.S. 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, which 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.

Other Financial Information and Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS' basic financial statements. The Other Financial Information, as identified on HHS' Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the basic financial statements. The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The Other Information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 13, 2014, 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* in considering HHS' internal control over financial reporting and compliance.

/Ernst & Young LLP/

November 13, 2014

Ernst & Young LLP
Westpark Corporate Center
8484 Westpark Drive
McLean, VA 22102

Tel: 703-747-1000
www.ey.com

Report of Independent Auditors on Internal Control Over Financial Reporting Based on an Audit of 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, in accordance with auditing standards generally accepted in the United States and 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. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2014, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014, and have issued our report thereon dated November 13, 2014. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, 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, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS' internal control. Accordingly, we do not express an opinion on the effectiveness of the HHS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 14-02. 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.

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 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. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit, we did identify certain deficiencies related to Financial Information Management Systems, described below, to be a material weakness. We also identified certain deficiencies related to Financial Reporting Systems, Analyses, and Oversight, described below, to be a significant deficiency.

Material Weakness

Financial Information Management Systems

HHS continued to make strides during fiscal year (FY) 2014 to improve the controls within its supporting information technology (IT) infrastructure and financial application systems. We noted attention among the operating divisions (OPDIVs) to address the existing governance, financial processes and practices, and system tools related to controls over application information security, and contingency planning for financial systems. The following summarizes some of the improvements achieved that resulted from this increased attention.

- Continued to enhance its standard operating procedures and practices to facilitate the improvement of entity-wide governance and security management/security assessment and authorization documentation.

- Continued to enhance its system-level contingency plans, backup policies, and procedures that align to the continuity of operations plan (COOP) and consistent testing practices in order to reduce redundancy and improve availability of the supporting IT infrastructure and financial application systems.

- Updated and implemented service level agreements (SLAs) with key third-party providers and respective backup policies and procedures that align to the COOP and in order to strengthen availability of the supporting IT infrastructure and financial application systems.

- Strengthened the HHS' security program management practices through the implementation of program-wide governance, security authorization activities, and plan of actions and milestones (POA&M) management through the use of the Risk Management Framework Portal (RMFP).

A focused effort is still necessary to remediate the long-outstanding deficiencies in Access Controls, Configuration Management, and Segregation of Duties (SoD) to a level that supports an auditor's reliance on controls within these systems for the financial statement audit. Plans were indicated to be in place by management to decrease the number and severity of the deficiencies

remaining in the other significant systems, including the two primary general ledger applications – Unified Financial Management System (UFMS) and National Institutes of Health (NIH) Business System (NBS). Specifically, management informed us of policy improvements around SoD to include addressing weaknesses around SoD and user recertification weaknesses at the OpDiv level as well as strengthening the configuration management processes. However, the remaining un-remediated deficiencies continue to constitute a material weakness in internal control. These deficiencies fall into the following categories:

- Access Controls – which consist of:
  - Inconsistently maintaining user access reviews, which monitor access, anomalies and findings
  - Ineffective review of super users/end user access, as users are reviewing their own access, and reviews are not performed in a timely manner
- Configuration Management – which consists of:
  - Excessive access for system administrators providing them the ability to develop changes and also migrate those changes into the production environment
  - System Administration access within the production environment as well as development access (SoD issue as well)
  - Lack of automated mechanisms to support change management activities
  - Inability to verify that unauthorized changes were not made to the production environment that did not go through the change approval and management process; additionally, there is a lack of proactive monitoring of changes in support of those reviews
- Segregation of Duties – efforts necessary include:
  - Completely implementing role-based security
  - Establishment of least privileged access considerations for all users
  - Performance of a one-time clean-up activities for roles in conflict, and continued sustainment of SoD principles moving forward

The following is a summary of the deficiencies that we considered most critical. When assessed in aggregate, we continue to conclude they could have a material effect on the financial statements, and as a result, this forms the basis for our conclusion of an IT material weakness:

- Segregation of Duties – Access assignments were excessive for UFMS, GrantSolutions (GS), NBS, Information for Management, Planning, Analysis, and Coordination (IMPACII), Health and Human Services Consolidated Acquisitions Solution (HCAS), Grants Administration Tracking and Evaluation System (GATES), and Enterprise Human Resources & Payroll (EHRP) systems and did not document and implement adequate SoD. Process Owners have not completely identified SoD conflicts that can exist for GATES, GS, NBS, IMPACII, and EHRP and the roles and users with these conflicts. In addition, UFMS, and EHRP applications, developer(s) had full access to both development and production system. Centers for Medicare and Medicaid Services (CMS) continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate SoD. We found several deficiencies that may result in a potential lack of SoD at both the Medicare fee-for-service contractors and across the enterprise.

- Configuration Management (CM) – CM processes for NBS, HCAS, GATES, GS, UFMS, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. For UFMS, we found that system administrators have access to the production environment as well as development access giving them the capability to migrate code. We also found that GATES baseline configuration is not documented for the application and database levels. We also noted CMS did not fully document waivers to change management policies when those waivers involved contractors.

- Access Controls – Access controls exceptions were identified across the UFMS, HCAS, GATES, GS, EHRP, and CFRS systems. Specifically, proactive user access reviews and subsequent actions that were needed to be performed were not done in a timely manner. Additionally, for HCAS and UFMS, certain users were certifying their own access, and evidence of access modifications performed as a part of the certification was not documented. GATES and GS do not have formal documented procedures for conducting the Grants Management Review Board (GMRB) report reviews, explicitly giving guidance for what and how to perform the review, as well as what documents should be retained to support the reviews. Also, approximately 10% of EHRP active users have not been reviewed by HR managers to ensure that only authorized users have access to the application. At CMS, several vulnerabilities in system configurations, program coding, input validation, and incident response procedures were observed for the Medicare fee-for-service network.

- FISMA compliance – The security management program, as required by the Federal Information Security Management Act (FISMA) of 2002, 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, the 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 a part of our FY 2014 FISMA assessment, we performed our procedures at the following OPDIVs: (1) Indian Health Service (IHS), (2) U.S. Food and Drug Administration, (3) NIH, (4) CMS, and (5) the HHS Office of the Secretary. Our procedures identified the following deficiencies identified across the OPDIVs reviewed:

  – Continuous Monitoring – We noted that the implementation and reporting capabilities with respect to continuous monitoring are being refined. However, the Department does not currently have a consistent and effective continuous monitoring program. Such a program should identify and reconcile both user access and identification of physical IT devices on the network. We noted that the implementation and reporting capabilities with respect to continuous monitoring are being refined.

  – Patch Management – The Department does not have an effective process for timely implementation of critical system patches. We noted inconsistencies in processes as well as deficiencies with asset identification and asset management.

  – Identity and Access Management – The Department needs to standardize identification and access management procedures to provision, recertify, and de-provision user accounts.

  – 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 – 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.

Recommendations

HHS should continue the focus achieved in FY 2014 to remediate the remaining deficiencies. The following are some specific considerations:

- Continue to identify, assess, modify, and monitor Access Controls, Configuration Management, and SoD to further enhance the security posture of all applications. Specific recommendations for the non-CMS OPDIV applications include:
  - Develop and implement procedures to monitor, review and investigate user access to include users with known SoD conflicts in a timely manner. Additionally, ensure that all reviews and modifications/removal of access or other actions performed as a result of the review process is documented in an organizationally specified timely manner (industry best practice is within 10 business days.)
  - 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.
  - Develop and implement a process and procedures for physical inventory identification as well as reconciliation of physical IT assets to those devices on the network
  - For GATES/GS, ACF management should consistently implement the GATES and GS SoD matrices and monitor compliance to ensure that access to each system is granted in accordance with the SoD matrix and commensurate with user's job roles and responsibilities.
  - For UFMS, HCAS, EHRP, NBS, and IMPACII management should develop a plan to implement controls for identifying, documenting, and monitoring SoD conflicts within the change management process. SoD conflicts should be considered when granting access to the development, test, and production environments in order to limit the number of users with conflicting access to only those users that require access specifically for their job function, including business justification for any allowable conflicts. Additionally, management should segregate all access to both the development and production environments for any single user.
  - Continue to test, track, and authorize all system changes planned for release into the production environment. Management should periodically review the list of changes made in the production environment and confirm that the changes made have gone through the formal change management process and that only authorized changes were implemented into the production environment.

– For UFMS, management should enforce SoD within the change management process and review the access of all personnel (including administrators) who access development libraries and production libraries for appropriateness based on the principle of least privilege.

– For GATES and GS, management should update policies and procedures to include guidance for how to perform the GMRB report reviews, what to review, and what documents should be retained to support the review.

– For EHRP, the review of all active accounts, including system accounts, should be conducted on a consistent basis so that only authorized users have access to the application.

We have performed a separate financial statement audit of CMS for FY 2014 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

Throughout the course of this year's audit, we were informed that a handful of HHS applications, to include GATES and EHRP, were going to be retired in the near future and replaced by other internal systems or other governmental centers of excellence. However, a focused effort should still be made to remediate weaknesses identified across all systems currently in operation, including systems that will be retired in the coming years, so as to mitigate risk and exposure to exploitation.

Significant Deficiency

Financial Reporting Systems, Analyses, and Oversight

During FY 2014, our audit identified further progress as HHS continued to implement new processes, automate manual entries, upgrade (or plan for the upgrade) of its various systems, relocate certain shared service center processes, develop new guidance and policies, improve communication, improve its infrastructure by planning for the consolidation and relocation of HHS offices, hire new experienced personnel, and provide training to address significant long-standing issues. However, HHS and its OPDIVs' internal reviews 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 discussed above and related processes continued to be developed throughout FY 2014 and will require additional refinements in FY 2015 and beyond. Within the context of the approximately $900 billion in departmental net outlays, the ultimate resolution of our specific 2014 findings were not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that should continue to be resolved.

Lack of Integrated Financial Management System

The Federal Financial Management Improvement Act of 1996 (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. Over the past 18 years, HHS has continued its efforts to overcome certain issues that have affected its ability to become compliant with the FFMIA, including the following long-standing issues, for which HHS and the audit have identified and reported in the past:

- The recording of billions of dollars in manual journal entries to ensure balances within financial systems are correct

- Departures from requirements specified in OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*, and OMB A-130, *Management of Federal Information Resources*, related to access and change management controls within financial systems, as discussed above

- The use of surveys or data calls to the OPDIVs or to the specified program to obtain information for specified requests

- The lack of sufficient integration within the various financial systems which are not complemented with sufficient manual preventative and detective-type controls, including CMS' durable medical equipment (DME) Medicare Administrative Contractors (MACs) who have not fully implemented CMS' HIGLAS and the NIH Business System which 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

- Inconsistencies across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized, including intragovernmental and intergovernmental transactions

Resource limitations and other priorities have consistently been identified as the causes for delays in upgrading certain system and financial internal control processes limiting HHS' ability to comply with requirements under FFMIA.

With the passage of new laws, including the Digital Accountability and Transparency Act (the Data Act), and the continued implementation of Treasury requirements, including the continued implementation of the Government-wide Treasury Account Symbol Adjusted Trial Balance

System (GTAS) and other treasury endeavors, HHS has taken an aggressive approach in addressing its compliance with the FFMIA Act. During FY 2014, the Department has moved forward in its planning and initial implementation to upgrade its financial systems, expected to be completed by FY 2016; initiated the updating and implementation of the Department-wide accounting treatment manual (effective in FY 2016) to enable the collection of consistent financial data and consistency in the processing of financial activity among its accounting centers; prioritized and centralized additional resources in addressing certain issues related to controls within its financial information management systems; and continued to automate the manual journal entry processes required to ensure financial data is accurate.

As it continues its pursuit in resolving these long-standing issues, HHS needs to be vigilant in developing, maintaining, and implementing consistent policies and procedures, monitoring the implementation of its upgrades, providing extensive training throughout the Department to ensure consistent application, and developing a monitoring program to ensure continued compliance.

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, we found that certain controls were not consistently performed to ensure that differences were properly identified, researched, and resolved in a timely manner and that account balances were complete and accurate. We identified 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

As deficiencies exist in financial systems, management compensates by implementing and strengthening other manual controls to ensure that errors and irregularities are prevented or detected in a timely manner. These manual and compensating controls may include monitoring of budgets, reconciliations of accounts, analyses of fluctuations, aging of accounts, and manual and supervisory reviews. During our audit, we found that certain controls still required further improvements. The following represent specific areas that need enhanced periodic reconciliation and analysis:

- *Departmental Review of OPDIV Financial Statements and Other Financial Activity* – Although the Department performs periodic reviews of OPDIV financial activity related to required financial reporting or external inquiry, we noted that limited routine communication from OPDIVs to notify the Department of newly adopted, unique and/or complex financial management activity for purposes that may impact the

Department's required financial reporting was not taking place on a routine basis. Progress was noted during our review of the financial statements whereby differences had been reduced by a significant level through the Department's review. However, for CMS, we noted that full communication of significant or complex activities had not taken place with the Department. Since CMS makes up over 80% of the Department's financial statements, the Department should have an opportunity to review CMS financial statements and discuss treatment of significant transactions prior to external release. Reporting matters should be communicated in advance and on a regular basis because of the uniqueness and complexity of the operations at CMS. Open communication will improve and align the reporting between CMS and the Department to ensure consistent reporting.

- *Intra- and Inter-governmental Transactions* – HHS processes more than $1.5 billion annually in intergovernmental and HHS transactions annually. During FY 2014, certain controls related to intra-HHS transactions within the OPDIVs were not working sufficiently to identify errors in a timely fashion. Intra-HHS transactions are those transactions between HHS OPDIVs that require elimination to ensure the HHS financial statements are fairly stated. For example, we identified one interagency agreement between the NIH and the Program Support Center whereby a charge of $5.9 million was recorded against the incorrect interagency agreement due to the inappropriate reference included on the Intra-Governmental Payment and Collection (IPAC) documentation. Further, due to the incorrect reference on the IPAC and it not being identified in a timely manner, an additional $4.6 million IPAC was charged and could not be recorded, as the obligation was not sufficient to cover the difference. As a result, $1.2 million remained in suspense for approximately a year as the research of the difference had not taken place at the point we selected the sample for our audit. Once identified, the Program Support Center (PSC) and the National Institute of Health (NIH) performed analysis and determined that the incorrect reference and subsequent posting had occurred. Based on discussions with NIH and PSC personnel, we believe there were several causes for the untimely resolution of the posting, including the following: insufficient communications between NIH's Office of Finance, its Institutes and the PSC; NIH's process for researching interagency agreements and related activities; NIH's untimely research of transactions included in its fund balance with Treasury suspense account; and the need for further information/documentation on IPAC charges, specifically appropriate interagency agreement numbers, modifications, and potentially purchase order numbers.

  Additionally, in certain cases, 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 intragovernmental and intra-HHS levels. At the intra-HHS reporting level, the Consolidated Financial Reporting System (CFRS)

has reported unresolved intra-HHS differences from each reciprocal category of nearly $150 million. This activity has been identified as "Federal" within HHS, but the Trading Partners have not resolved the differences.

- *Property, Plant, and Equipment* – We found that sufficient documentation was not readily available to support certain amounts and disclosures related to property, plant, and equipment. Additionally, we noted that certain assets that were purchased in prior years and put into service were not recorded to the accounting records until fiscal year 2014.

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 that sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. For example, HHS management indicated that, while certain policies within its procedural manuals have been drafted awaiting final approval, including sections within its accounting treatment manual, others continue to be on a listing waiting to be updated. Full implementation of the updated accounting treatment manual is not expected until FY 2016. 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 updated guidance. It is our understanding that the Department and its OPDIVs are currently updating all financial management procedures.

Further, 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.

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 its internal controls dated November 10, 2014. 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 business partner risk management, noted elsewhere in this report, to be a significant deficiency for the CMS internal control over financial reporting.

Our observations related to financial management controls included a recommendation that as CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, identifying, evaluating, and reviewing such analysis would assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered. It may be beneficial for CMS to identify a cross-functional working group to perform such analysis.

Business Partner Risk Management at CMS

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. We continued to identify areas where improvements could be made in the control environment related to the oversight of third-party 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 recorded amounts. Through its OMB Circular No. A-123, *Management's Responsibility for Internal Control* (A-123), AT Section 801, *Reporting on Controls at a Service Organization* (AT 801), and regional office processes, CMS 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. During our audit activities, we identified deficiencies where actions are required in the following circumstances: (1) the claims completeness validation process between the claims submitted by the providers and the claims received by the MACs; (2) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (3) the claims outstanding greater than one year – periodic review, track, or monitor those aged claims other than those identified as bankruptcy, fraud, or abuse; and (4) the provider records – reconcile, review, or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely and accurately and completely processed.

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 move forward in its planning and implementation to upgrade its financial systems; prioritize and centralize additional resources in addressing certain issues related to controls within its financial information management systems; and continue to automate the manual journal entry processes required to ensure financial data is accurate.

- Continue to update and implement the Department-wide accounting treatment manual and other guidance to enable the collection of consistent financial data and consistency in the processing of financial activity among its accounting centers and headquarters. As policies and procedures are developed, training should be developed and delivered across all OPDIVs to determine consistent application of the new policies. Additionally, ongoing monitoring processes should be enhanced to ensure appropriateness and consistency over the long-term and continued compliance.

- Develop increased communication protocols with all OPDIVs, especially CMS, to enhance notification and awareness of newly adopted, unique and/or complex financial management activity for purposes that may impact the Department's required financial reporting.

- Strengthen controls surrounding the property, plant, and equipment and related processes to ensure that documentation is maintained and that balances are accurate and supportable.

- Continue to focus on the area of intra- and intergovernmental transactions to ensure partner codes are identifiable with the transaction and that trading partners are accounting for transactions consistently. HHS should also develop policies and procedures to be implemented across HHS regarding the use of interagency agreements – both within HHS and with other agencies. The policies should identify required IPAC information, which may include agreement or modification numbers, transaction account symbols, and, to the extent possible, purchase order numbers. Once developed, HHS should provide Department-wide training to ensure consistency in interpretation of the policies in accounting for interagency and intraagency activity. It should also discuss processes to utilize when differences between trading parties exist. Further, HHS should enhance its communication processes to ensure interagency agreements are recorded correctly with differences being resolved on a timely basis. This may entail sharing of information, periodic meetings, or use of an independent group – such as headquarters or Treasury to mediate differences. Finally,

to the extent that differences may be recorded in a fund balance with Treasury suspense account, HHS should develop and monitor processes to ensure suspense account transactions are cleared properly on a timely basis.

- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine, or significant transactions; enhance the financial reporting process; and address or identify transactions that required cross-functional input. Enhancement of this process may assist to develop, document, and validate the new critical accounting matters that are identified or implemented during the year and improve the timeliness and completeness of the white papers. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

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 2013 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:

Material Weakness		
Issue Area	**Summary Control Issue**	**FY 2013 Status**
Financial Management Information Systems	• Segregation of Duties • Change Management • Access Controls • FISMA Compliance	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; however, certain issues identified require continued focus. Additionally, issues related to intragovernmental and intergovernmental transactions were identified. Modified Repeat Condition

HHS' Response to Findings

HHS' response to the findings identified in our audit and examination are included in its letter dated November 13, 2014, which has been included at the end of this report. HHS' response was not subjected to either the auditing procedures applied in the audit of the financial statements or the attest procedures applied in the examination of internal control and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

/Ernst & Young LLP/

November 13, 2014

Ernst & Young LLP
Westpark Corporate Center
8484 Westpark Drive
McLean, VA 22102

Tel: 703-747-1000
www.ey.com

Report of Independent Auditors 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, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Department of Health and Human Services (HHS), which comprise the consolidated balance sheet as of September 30, 2014, and the related consolidated statements of net cost and changes in net position and the combined statements of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014, and have issued our report thereon dated November 13, 2014. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, 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, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014.

Compliance and Other Matters

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. 14-02, 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 or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 14-02, as described below.

During fiscal (FY) 2014, HHS' management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to FY 2014 and FY 2015 obligation of funds for conference spending at the Administration for Children and Families.

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) and the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2013 (P.L. 112-248) (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. For example, 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). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF 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, which 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. Additionally, the Medicare Fee-for-Service program error rate exceeded 10%. Also, HHS is not in full compliance with Section 6411 of the Affordable Care Act, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. HHS indicated it remains committed to implementing this provision of the Affordable Care Act, and anticipates awarding a Medicare Part C Recovery Audit Contractor contract in 2015.

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:

- During fiscal year 2014, thousands of manual journal vouchers were required to be recorded in Unified Financial Management System (UFMS)/National Institute of Health (NIH) Business System (NBS) to post certain types of transactions not currently configured correctly within UFMS and for the purpose of ensuring that balances within financial systems are correct to enable the development of periodic financial statements.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB A-130, *Management of Federal Information Resources*, and OMB A-123 Appendix D, *Management's Responsibility for Internal Control in Federal Agencies*. 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.

- The lack of sufficient integration within the various financial systems which are not complemented with sufficient manual preventative and detective type controls, including CMS' durable medical equipment (DME) Medicare Administrative Contractors (MACs) who have not fully implemented CMS' HIGLAS and the NBS which 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.

- Inconsistencies across the various accounting centers and financial systems on how accounting transactions are captured and which standard general ledger accounts are utilized, including intragovernmental and intergovernmental transactions.

* * * * *

HHS' Response to Findings

Our Report on Internal Control dated November 13, 2014, 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 13, 2014. We did not audit management's comments, and accordingly, we express no opinion on them. Additionally, HHS is updating its Department-wide corrective action plan to address FFMIA and other financial management issues.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on HHS' compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS' compliance. Accordingly, this communication is not suitable for any other purpose.

/Ernst & Young LLP/

November 13, 2014

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 2014 Financial Statement Audit

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

We appreciate the opportunity to comment on the draft reports you provided. We generally concur with the findings identified in the Report on Internal Control. The final reports will be included in our FY 2014 Agency Financial Report. In response to your reports, we will prepare corrective action plans to address the identified findings with particular focus on the reported material weakness, as described below.

The size and complexity of our information technology environment pose significant challenges to resolving the deficiencies across our multiple financial management systems. While we have addressed deficiencies and risks as they arise, a more strategic overall approach to strengthening controls and security over our financial systems environment is needed. To accomplish this, the Department's Chief Financial Officer and Chief Information Officer communities are working together to develop a corrective action plan with milestones for addressing the identified financial systems material weakness in a sustainable manner. We are also working closely with your office and EY to identify and prioritize key risks, and to track our progress. HHS is dedicating additional resources to significantly lower the risk in our financial systems in 2015.

Our stakeholders are committed to implementing this strategic approach and the Department's Risk Management and Financial Oversight Board will oversee this effort.

We look forward to continued collaboration with the OIG to improve our stewardship of taxpayer funds.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
November 13, 2014

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services

Consolidated Balance Sheet

As of September 30, 2014 and 2013

(in Millions)

	2014	2013
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 176,958	$ 159,192
Investments, Net (Note 4)	278,900	281,723
Accounts Receivable, Net (Note 5)	919	3,649
Other Assets (Note 8)	95	103
Total Intragovernmental Assets	456,872	444,667
Accounts Receivable, Net (Note 5)	10,159	10,933
Inventory and Related Property, Net (Note 6)	8,606	8,602
General Property, Plant and Equipment, Net (Note 7)	5,868	5,364
Other Assets (Note 8)	810	689
Total Assets	$ 482,315	$ 470,255
Stewardship Property Plant and Equipment (Note 1)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 401	$ 565
Other Liabilities (Note 13)	3,022	2,009
Total Intragovernmental Liabilities	3,423	2,574
Accounts Payable	555	662
Entitlement Benefits Due and Payable (Note 10)	91,037	77,277
Accrued Grant Liability (Note 12)	3,314	3,949
Federal Employee and Veterans' Benefits (Note 11)	11,979	11,566
Contingencies and Commitments (Note 14)	11,332	8,900
Other Liabilities (Note 13)	2,501	2,581
Total Liabilities	124,141	107,509
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 19)	16,215	4,469
Unexpended Appropriations - All Other funds	107,427	105,728
Cumulative Results of Operations - Funds from Dedicated Collections (Note 19)	227,551	243,996
Cumulative Results of Operations - All Other funds	6,981	8,553
Total Funds from Dedicated Collections	243,766	248,465
Total All Other Funds	114,408	114,281
Total Net Position	358,174	362,746
Total Liabilities and Net Position	$ 482,315	$ 470,255

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, 2014 and 2013
(in Millions)

	2014	2013
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 910,511	$ 848,967
Exchange Revenue (Note 15)	(73,276)	(69,745)
CMS Net Cost of Operations	837,235	779,222
Other Segments:		
Administration for Children and Families (ACF)	49,283	50,566
Administration for Community Living (ACL)	1,485	1,449
Agency for Healthcare Research and Quality (AHRQ)	386	606
Centers for Disease Control and Prevention (CDC)	10,336	10,771
Food and Drug Administration (FDA)	3,833	3,394
Health Resources and Services Administration (HRSA)	8,817	8,720
Indian Health Service (IHS)	6,339	5,551
National Institutes of Health (NIH)	30,676	30,691
Office of the Secretary (OS)	4,209	3,900
Program Support Center (PSC)	1,784	1,636
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,275	3,432
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	$ 120,423	$ 120,716
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	82	230
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	$ 120,505	$ 120,946
Exchange Revenue (Note 15)	(5,758)	(3,918)
Other Segments Net Cost of Operations	114,747	117,028
Net Cost of Operations (Note 15)	$ 951,982	$ 896,250

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, 2014
(in Millions)

	2014			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 243,996	$ 8,553	$ -	$ 252,549
Budgetary Financing Sources:				
Other Adjustments (Recessions, etc.) (+/-)	-	(573)	-	(573)
Appropriations Used	260,360	432,855	-	693,215
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	227,822	-	-	227,822
Non-exchange Revenue - Investment Revenue	11,360	3	-	11,363
Non-exchange Revenue - Other	3,826	-	-	3,826
Donations and Forfeitures of Cash and Cash Equivalents	63	-	-	63
Transfers-in/out without Reimbursement	(3,389)	2,083	-	(1,306)
Other (+/-)	-	-	-	-
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	53	-	53
Transfers-in/out Without Reimbursement (+/-)	(4)	(1)	-	(5)
Imputed Financing	37	711	(194)	554
Other (+/-)	-	(1,047)	-	(1,047)
Total Financing Sources	500,075	434,084	(194)	933,965
Net Cost of Operations (+/-)	516,520	435,656	(194)	951,982
Net Change	(16,445)	(1,572)	-	(18,017)
Cumulative Results of Operations:	$ 227,551	$ 6,981	$ -	$ 234,532
Unexpended Appropriations:				
Beginning Balances	$ 4,469	$ 105,728	$ -	$ 110,197
Budgetary Financing Sources:				
Appropriations Received	273,772	458,633	-	732,405
Appropriations Transferred in/out	-	(4)	-	(4)
Other Adjustments	(1,666)	(24,075)	-	(25,741)
Appropriations Used	(260,360)	(432,855)	-	(693,215)
Total Budgetary Financing Sources	11,746	1,699	-	13,445
Total Unexpended Appropriations	16,215	107,427	-	123,642
Net Position	$ 243,766	$ 114,408	$ -	$ 358,174

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, 2013
(in Millions)

	2013			
	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Cumulative Results of Operations:				
Beginning Balances	$ 267,009	$ 7,967	$ -	$ 274,976
Budgetary Financing Sources:				
Appropriations Used	247,682	397,158	-	644,840
Non-exchange Revenue				
Non-exchange Revenue - Tax Revenue	213,106	-	-	213,106
Non-exchange Revenue - Investment Revenue	12,051	3	-	12,054
Non-exchange Revenue - Other	4,761	-	-	4,761
Donations and Forfeitures of Cash and Cash Equivalents	50	-	-	50
Transfers-in/out without Reimbursement	(3,363)	2,313	-	(1,050)
Other (+/-)	-	4	-	4
Other Financing Sources (Non-Exchange):				
Donations and Forfeitures of Property	-	7	-	7
Transfers-in/out Without Reimbursement (+/-)	(2)	(5)	-	(7)
Imputed Financing	37	687	(189)	535
Other (+/-)	1	(478)	-	(477)
Total Financing Sources	474,323	399,689	(189)	873,823
Net Cost of Operations (+/-)	497,336	399,103	(189)	896,250
Net Change	(23,013)	586	-	(22,427)
Cumulative Results of Operations:	$ 243,996	$ 8,553	$ -	$ 252,549
Unexpended Appropriations:				
Beginning Balances	$ 20,418	$ 135,768	$ -	$ 156,186
Budgetary Financing Sources:				
Appropriations Received	249,300	401,316	-	650,616
Appropriations Transferred in/out	-	120	-	120
Other Adjustments	(17,567)	(34,318)	-	(51,885)
Appropriations Used	(247,682)	(397,158)	-	(644,840)
Total Budgetary Financing Sources	(15,949)	(30,040)	-	(45,989)
Total Unexpended Appropriations	4,469	105,728	-	110,197
Net Position	$ 248,465	$ 114,281	$ -	$ 362,746

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, 2014 and 2013
(in Millions)

	2014		2013	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated Balance, Brought Forward, Oct 1	$ 41,577	$ 111	$ 80,780	$ 3,175
Recoveries of Prior Year Unpaid Obligations	26,083	-	24,598	-
Other Changes in Unobligated Balance	(719)	(62)	(1,221)	(1)
Unobligated Balance from Prior Year Budget Authority, Net	66,941	49	104,157	3,174
Appropriations (Discretionary and Mandatory)	1,320,180	(4)	1,193,733	-
Borrowing Authority (Discretionary and Mandatory)	-	237	-	(2,064)
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	24,658	198	25,409	(685)
Total Budgetary Resources	$ 1,411,779	$ 480	$ 1,323,299	$ 425
Status of Budgetary Resources:				
Obligations Incurred (Note 18)	$ 1,373,901	$ 477	$ 1,281,722	$ 314
Unobligated Balance, End of Year:				
Apportioned	29,384	-	29,993	40
Exempt from Apportionment	39	-	2,059	-
Unapportioned	8,455	3	9,525	71
Total Unobligated Balance, End of Year	37,878	3	41,577	111
Total Budgetary Resources	$ 1,411,779	$ 480	$ 1,323,299	$ 425
Change in Obligated Balance:				
Unpaid Obligations:				
Unpaid Obligations, Brought Forward, Oct 1	$ 188,654	$ 1,248	$ 180,754	$ 1,602
Obligations Incurred (Note 18)	1,373,901	477	1,281,722	314
Outlays (Gross)	(1,320,306)	(727)	(1,249,330)	(668)
Actual Transfers, unpaid obligations	-	-	106	-
Recoveries of Prior Year Unpaid Obligations	(26,083)	-	(24,598)	-
Unpaid Obligations, End of Year	$ 216,166	$ 998	$ 188,654	$ 1,248
Uncollected Payments:				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (11,018)	$ (536)	$ (10,103)	$ (1,587)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	(820)	106	(915)	1,051
Uncollected Payments from Federal Sources, End of Year	$ (11,838)	$ (430)	$ (11,018)	$ (536)
Memorandum (non-add) Entries:				
Obligated Balance, Start of Year	$ 177,636	$ 712	$ 170,651	$ 15
Obligated Balance, End of Year	$ 204,328	$ 568	$ 177,636	$ 712
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,344,838	$ 431	$ 1,219,142	$ (2,749)
Actual Offsetting Collections (Discretionary and Mandatory)	(23,687)	(315)	(24,812)	(366)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(820)	106	(915)	1,051
Budget Authority, Net (Discretionary and Mandatory)	$ 1,320,331	$ 222	$ 1,193,415	$ (2,064)
Outlays, Gross (Discretionary and Mandatory)	$ 1,320,306	$ 727	$ 1,249,330	$ 668
Actual Offsetting Collections (Discretionary and Mandatory)	(23,687)	(315)	(24,812)	(366)
Outlays, Net (Discretionary and Mandatory)	1,296,619	412	1,224,518	302
Distributed Offsetting Receipts	(359,650)	-	(336,655)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 936,969	$ 412	$ 887,863	$ 302

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 (Unaudited)

75-Year Projection as of January 1, 2014 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2014	2013	2012	2011	2010
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 20 and 21)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 8,398	$ 8,147	$ 7,929	$ 7,581	$ 7,216
SMI Part B	17,127	15,227	14,431	13,595	12,688
SMI Part D	5,928	5,871	5,866	6,438	6,355
Have attained eligibility age (age 65 or over)					
HI	332	301	302	262	248
SMI Part B	2,873	2,620	2,395	2,122	1,972
SMI Part D	775	722	694	695	646
Those expected to become participants					
HI	7,812	7,744	7,367	7,260	6,944
SMI Part B	4,311	3,530	3,333	3,223	3,077
SMI Part D	2,609	2,617	2,568	2,817	2,714
All current and future participants					
HI	16,542	16,192	15,598	15,104	14,408
SMI Part B	24,311	21,377	20,159	18,940	17,737
SMI Part D	9,312	9,211	9,128	9,950	9,715
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 20 and 21)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,117	$ 14,629	$ 14,919	$ 12,887	$ 12,032
SMI Part B	17,003	15,075	14,303	13,489	12,587
SMI Part D	5,928	5,871	5,866	6,438	6,355
Have attained eligibility age (age 65 and over)					
HI	3,484	3,422	3,369	2,923	2,648
SMI Part B	3,171	2,887	2,646	2,343	2,166
SMI Part D	775	722	694	695	646
Those expected to become participants					
HI	2,764	2,913	2,891	2,546	2,411
SMI Part B	4,137	3,415	3,211	3,108	2,984
SMI Part D	2,609	2,617	2,568	2,817	2,714
All current and future participants:					
HI	20,365	20,963	21,179	18,356	17,090
SMI Part B	24,311	21,377	20,159	18,940	17,737
SMI Part D	9,312	9,211	9,128	9,950	9,715
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 20 and 21)					
HI	$ (3,823)	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)
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 20 and 21)					
HI	$ (3,823)	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	205	220	244	272	304
SMI Part B	74	66	80	71	76
SMI Part D	1	1	1	1	1
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 20 and 21)					
HI	$ (3,618)	$ (4,551)	$ (5,337)	$ (2,980)	$ (2,378)
SMI Part B	74	66	80	71	76
SMI Part D	1	1	1	1	1

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) (Unaudited)

75-Year Projection as of January 1, 2014 and Prior Base Years

(in Billions)

	Estimates from Prior Years				
	2014	2013	2012	2011	2010
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)	$ 3,980	$ 3,643	$ 3,391	$ 3,079	$ 2,866
Expenditures	7,430	7,031	6,709	5,961	5,459
Income less expenditures	(3,450)	(3,388)	(3,319)	(2,882)	(2,593)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	31,453	29,244	28,227	27,615	26,259
Expenditures	37,048	35,574	35,088	32,814	30,974
Income less expenditures	(5,595)	(6,330)	(6,861)	(5,199)	(4,715)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(9,045)	(9,718)	(10,180)	(8,081)	(7,308)
Combined Medicare Trust Fund assets at start of period	280	288	325	344	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(8,764)	(9,430)	(9,855)	(7,737)	(6,927)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	14,732	13,891	13,268	13,300	12,735
Expenditures	9,510	8,945	8,669	8,471	8,109
Income less expenditures	5,222	4,946	4,599	4,829	4,626
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,823)	(4,772)	(5,581)	(3,252)	(2,683)
Combined Medicare Trust Fund assets at start of period	280	288	325	344	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (3,542)	$ (4,484)	$ (5,256)	$ (2,908)	$ (2,302)

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)

For the Two Year Period Ending January 1, 2014

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 22)					
As of January 1, 2013	$ 46,779	$ 51,550	$ (4,772)	$ 288	$ (4,484)
Reasons for change					
Change in the valuation period	1,962	2,201	(239)	(19)	(258)
Change in projection base	(98)	(545)	447	12	458
Changes in the demographic assumptions	180	318	(139)	-	(139)
Changes in economic and health care assumptions	1,293	521	772	-	772
Changes in law	50	(57)	108	-	108
Net changes	3,387	2,438	949	(7)	942
As of January 1, 2014	$ 50,166	$ 53,988	$ (3,823)	$ 280	$ (3,542)
HI - Part A (Note 22)					
As of January 1, 2013	$ 16,192	$ 20,963	$ (4,772)	$ 220	$ (4,551)
Reasons for change					
Change in the valuation period	619	858	(239)	(22)	(261)
Change in projection base	123	(323)	447	7	454
Changes in the demographic assumptions	(45)	93	(139)	-	(139)
Changes in economic and health care assumptions	(346)	(1,118)	772	-	772
Changes in law	-	(108)	108	-	108
Net changes	350	(598)	949	(15)	934
As of January 1, 2014	$ 16,542	$ 20,365	$ (3,823)	$ 205	$ (3,618)
SMI - Part B (Note 22)					
As of January 1, 2013	$ 21,377	$ 21,377	$ -	$ 66	$ 66
Reasons for change					
Change in the valuation period	894	894	-	3	3
Change in projection base	(391)	(391)	-	4	4
Changes in the demographic assumptions	(203)	(203)	-	-	-
Changes in economic and health care assumptions	2,638	2,638	-	-	-
Changes in law	(2)	(2)	-	-	-
Net changes	2,935	2,935	-	8	8
As of January 1, 2014	$ 24,311	$ 24,311	$ -	$ 74	$ 74
SMI - Part D (Note 22)					
As of January 1, 2013	$ 9,211	$ 9,211	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	450	450	-	-	-
Change in projection base	170	170	-	-	-
Changes in the demographic assumptions	428	428	-	-	-
Changes in economic and health care assumptions	(999)	(999)	-	-	-
Changes in law	53	53	-	-	-
Net changes	102	102	-	-	-
As of January 1, 2014	$ 9,312	$ 9,312	$ -	$ 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 (Continued) (Unaudited)

For the Two Year Period Ending January 1, 2014

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 22)					
As of January 1, 2012	$ 44,885	$ 50,467	$ (5,581)	$ 325	$ (5,256)
Reasons for change					
Change in the valuation period	1,972	2,257	(285)	(46)	(331)
Change in projection base	(944)	(1,252)	308	9	317
Changes in the demographic assumptions	1,219	495	724	-	724
Changes in economic and health care assumptions	(342)	(374)	31	-	31
Changes in law	(11)	(42)	31	-	31
Net changes	1,893	1,084	809	(37)	772
As of January 1, 2013	$ 46,779	$ 51,550	$ (4,772)	$ 288	$ (4,484)
HI - Part A (Note 22)					
As of January 1, 2012	$ 15,598	$ 21,179	$ (5,581)	$ 244	$ (5,337)
Reasons for change					
Change in the valuation period	631	916	(285)	(29)	(314)
Change in projection base	(258)	(566)	308	5	313
Changes in the demographic assumptions	764	40	724	-	724
Changes in economic and health care assumptions	(544)	(576)	31	-	31
Changes in law	-	(31)	31	-	31
Net changes	593	(216)	809	(24)	786
As of January 1, 2013	$ 16,192	$ 20,963	$ (4,772)	$ 220	$ (4,551)
SMI - Part B (Note 22)					
As of January 1, 2012	$ 20,159	$ 20,159	$ -	$ 80	$ 80
Reasons for change					
Change in the valuation period	874	874	-	(17)	(17)
Change in projection base	(504)	(504)	-	3	3
Changes in the demographic assumptions	212	212	-	-	-
Changes in economic and health care assumptions	647	647	-	-	-
Changes in law	(12)	(12)	-	-	-
Net changes	1,217	1,217	-	(13)	(13)
As of January 1, 2013	$ 21,377	$ 21,377	$ -	$ 66	$ 66
SMI - Part D (Note 22)					
As of January 1, 2012	$ 9,128	$ 9,128	$ -	$ 1	$ 1
Reasons for change					
Change in the valuation period	467	467	-	-	-
Change in projection base	(182)	(182)	-	-	-
Changes in the demographic assumptions	242	242	-	-	-
Changes in economic and health care assumptions	(446)	(446)	-	-	-
Changes in law	1	1	-	-	-
Net changes	83	83	-	-	-
As of January 1, 2013	$ 9,211	$ 9,211	$ -	$ 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

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

The accompanying financial statements include activities and operations of the United States Department of Health and Human Services (HHS or the Department).

HHS is a Cabinet-level agency of the executive branch of the Federal Government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* 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 composed of the Office of the Secretary (OS) and 11 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 and/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. 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:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS) – excluding the Program Support Center
- Program Support Center (PSC)
- 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.

B. 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 Officer 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's financial records 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.

C. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with accounting principles generally accepted in the U.S. 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.

D. 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 entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers 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.

Under the *Affordable Care Act*, HHS has established a child relationship with the Internal Revenue Service of the Department of Treasury for the payment of the advance premium tax credits and cost-sharing reductions to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Department of Agriculture, Justice and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of Interior and Department of Treasury.

E. Reclassifications and Adjustments

Certain FY 2013 balances have been reclassified to conform to FY 2014 financial statement presentations. The effects are immaterial.

F. Funds from Dedicated Collections

Generally, funds from dedicated collections are financed by specifically identified revenues, provided to the government by non-federal sources, often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. A statute committing the Federal Government to use specifically identified revenues and/or other financing sources that are originally provided to the Federal Government from a non-federal source only for designated activities, benefits or purposes;
2. Explicit authority for the fund to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits or purposes; and
3. A requirement to account for and report on the receipt, use and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the Federal Government's general revenues.

HHS's major funds from dedicated collections 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 by employers via the quarterly IRS, 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 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. 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 Prescription Drug Benefit – Part D. The program makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. Beneficiaries eligible for Medicaid are automatically enrolled unless they have other credible drug coverage. HHS reports the Prescription Drug Benefit within the financial statements as part of the SMI Trust Fund, in the Medicare column. Drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans, which add coverage to Fee-for-Service (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. The Low Income Subsidy helps those with limited income and resources.

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 includes 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.

G. 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 the 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 two programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program and the Health Center Loan Program.

1. **Direct Loans.** Under the *Patient Protection and Affordable Care Act*, 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. Disbursements have been made for both types of loans.
2. **Loan Guarantees.** HHS administers guaranteed loans under the Health Center Loan Program. Loans receivable represent defaulted guaranteed loans which have been paid to lenders and also include interest due to HHS on the defaulted loans. The liability for loan guarantees is valued at the present value of the cash outflows from HHS less the present value of related inflows.

HHS reports loans in accordance with the *Federal Credit Reform Act*. Budgetary related activity is reported separately within the Combined Statement of Budgetary Resources.

As of June 30, 2014, the assets and liabilities of the Health Education Assistance Loan (HEAL) program were transferred to the Department of Education under section 525 of Division H of the *Consolidated Appropriations Act*, 2014 (Public Law 113-76).

Exchange Revenue

Exchange revenue results when HHS provides goods or services to another entity for a price 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's operating costs are paid out of funds appropriated to other federal entities. 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's 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.

H. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different 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 including the SSA and the Treasury. The SSA determines eligibility for Medicare programs and also deducts Medicare Part - B premiums from Social Security benefit payments for Social Security beneficiaries who elect to enroll in the Medicare Part - B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part-B Trust Fund. 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 United States, as well as beneficiary premiums and payments from states.

I. 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 composed 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.

J. Fund Balance with Treasury (FBwT)

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

K. Custodial Activity

In accordance with guidance set forth in OMB Circular A-136, HHS reports custodial activities on its Consolidated 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 IRS 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 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.

L. 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 as dedicated collections, 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, a dedicated collections 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 Securities 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's 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 *Affordable Care Act* 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.

M. 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, CMPs & Other Restitutions, state phased-down contributions, audit disallowances, and the recognition of Medicare Secondary Payer (MSP) accounts receivable.

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.

N. 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 on the cash-basis of accounting, as the grantees draw funds. These grants are funded based on allocations 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, 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.

O. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists 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 (SSF) 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 are 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, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC and H5N1.

P. 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. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of Property, Plant and Equipment transferred from other federal entities is the transferring entity's net book value. Except for internal use software, HHS capitalizes all Property, Plant and Equipment with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more.

HHS has commitments under various operating leases with private entities and General Services Administration (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.

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.

In accordance with SFFAS Number 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's 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 using the straight line method over a period of seven to ten years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

Q. Stewardship Property, Plant and 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. In accordance with SFFAS Number 8, *Supplementary Stewardship Reporting*, HHS does not report a related amount on the Balance Sheet.

HHS's 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.

R. 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's 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.

S. 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.

T. 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.

U. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare, Medicaid and CHIP 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 and CHIP

The Medicaid and Children's Health Insurance Program (CHIP) 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.

V. 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 billed by the DOL to agencies but not yet paid; 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 one percent of employee pay and matches the first three percent of employee contributions dollar for dollar. Each dollar of the employee's next two 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.

W. 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.

HHS has no material obligations related to cancelled appropriations for which we have a contractual commitment for payment or for contractual arrangements which many require future financial obligations.

X. Statement of Social Insurance

The Statement of Social Insurance 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 May 31, 2013. 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 Statement of Social Insurance actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2014*. 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.

Y. *Affordable Care Act*

In FY 2010, President Barack 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 helping to reduce health care costs. Further information is available at http://www.healthcare.gov.

The *Affordable Care Act* contains the most significant changes to health care coverage since the passing of the *Social Security Act*. The *Affordable Care Act* provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO

include: Affordable Insurance Marketplaces (the "Marketplace") and the CO-OP program. A brief description of these programs and their impact on the financial statement is presented below.

Health Insurance Marketplaces

Grants have been provided to the states to establish Affordable Insurance Exchanges, better known as Health Insurance Marketplaces. As of September 30, 2014, HHS awarded about $5.1 billion in cumulative Marketplace grants to states, including Establishment grants to 37 states and the District of Columbia. All Marketplaces launched open enrollment on October 1, 2013.

To help make health insurance more affordable to consumers, HHS makes payments of advance premium tax credits (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. APTC and CSR payments (which are included in the Internal Revenue Service financial statements; see Note 1) are a critical component of the Marketplace, and $30 billion has been allocated for these payments. In addition to these payments on behalf of consumers, HHS collects Marketplace user fees from issuers participating in the Federally-facilitated Marketplace (FFM).

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. 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 to assist the applicant meet state solvency requirements. In accordance with regulations as well as legislative requirements, start-up loans shall be repaid within five years and the solvency loans within 15 years after disbursement, considering state reserve requirements and solvency regulations. CO-OP Program loans have been awarded in 24 states.

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

	2014	2013
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	$ 8	$ -
Accounts Receivable	-	11
Total Non-Entity Intragovernmental Assets	8	11
Accounts Receivable With the Public	20	30
Total Non-Entity Assets	28	41
Total Entity Assets	482,287	470,214
Total Assets	$ 482,315	$ 470,255

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2014	2013
Trust Funds	$ 19,551	$ 9,916
Revolving Funds	1,275	1,263
Appropriated Funds	155,736	147,547
Other Funds	396	466
Total	$ 176,958	$ 159,192

Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 29,423	$ 32,092
Unavailable	8,458	9,596
Obligated Balance not yet Disbursed	204,896	178,348
Non-Budgetary Fund Balance with Treasury	(65,819)	(60,844)
Total	$ 176,958	$ 159,192

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 $12.4 billion and $13.0 billion as of September 30, 2014 and 2013, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, CHIP, CMS Program Management, State Grants and Demonstrations and the Recovery Act Health Information Technology Program. In FY 2014, HHS received $21.6 billion in apportioned under the *Affordable Care Act*, of which $8.3 billion is restricted for future use.

The Non-Budgetary FBwT negative balances reported for September 30, 2014 and 2013 are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net (in Millions)

2014	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 270,598	$ -	$ 2,688	$ 273,286	$ 273,286
Non-Marketable: Market-Based	5,779	(193)	28	5,614	5,614
Total, Intragovernmental	$ 276,377	$ (193)	$ 2,716	$ 278,900	$ 278,900

2013	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 273,395	$ -	$ 2,778	$ 276,173	$ 276,173
Non-Marketable: Market-Based	5,711	(191)	30	5,550	5,550
Total, Intragovernmental	$ 279,106	$ (191)	$ 2,808	$ 281,723	$ 281,723

HHS investments consist primarily of Medicare Trust Fund (funds from dedicated collections) investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2016 through June 30, 2029, with interest rates ranging from 2.25 percent to 5.625 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2015, with an interest rate of 2.125 percent to 2.375 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (funds from dedicated collections) will mature through fiscal year 2020. The Market-Based Notes paid from 1.0 percent to 4.125 percent during October 1, 2013 to September 30, 2014 and 1.0 percent to 4.125 percent during October 1, 2012 to September 30, 2013. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market-Based Securities held in the NIH gift funds during the fiscal year ended September 30, 2014, yielded from 0.015 percent to 0.095 percent depending on the date purchased and the time to maturity.

The investments held by the CHIP Child Enrollment Contingency Fund in the amount of $2.1 billion as of September 30, 2014, 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)

2014	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 919	$ -	$ 919	$ -	$ 919
Non-Entity	-	-	-	-	-
Total, Intragovernmental	$ 919	$ -	$ 919	$ -	$ 919
With the Public					
Entity					
Medicare	$ 7,881	$ -	$ 7,881	$ (1,649)	$ 6,232
Other	5,558	7	5,565	(1,658)	3,907
Non-Entity	-	40	40	(20)	20
Total With the Public	$ 13,439	$ 47	$ 13,486	$ (3,327)	$ 10,159

2013	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net HHS Receivables
Intragovernmental					
Entity	$ 3,638	$ -	$ 3,638	$ -	$ 3,638
Non-Entity	11	-	11	-	11
Total, Intragovernmental	$ 3,649	$ -	$ 3,649	$ -	$ 3,649
With the Public					
Entity					
Medicare	$ 8,811	$ -	$ 8,811	$ (1,595)	$ 7,216
Other	4,582	13	4,595	(908)	3,687
Non-Entity	52	2	54	(24)	30
Total With the Public	$ 13,445	$ 15	$ 13,460	$ (2,527)	$ 10,933

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

	2014	2013
Inventory Held for Current Sale, Net	$ 8	$ 8
Operating Materials and Supplies Held for Use	120	113
Stockpile Materials Held for Emergency or Contingency	8,478	8,481
Inventory and Related Property, Net	$ 8,606	$ 8,602

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

			2014		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 53	$ -	$ 53
Construction in Progress	-	-	549	-	549
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	6,122	(2,615)	3,507
Equipment	Straight Line	3-20 Yrs	1,858	(1,149)	709
Internal Use Software	Straight Line	7-10 Yrs	1,827	(860)	967
Assets Under Capital Lease	Straight Line	1-30 Yrs	119	(55)	64
Leasehold Improvements	Straight Line	*Life of Lease	51	(32)	19
Totals			$ 10,579	$ (4,711)	$ 5,868

			2013		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	756	-	756
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,747	(2,448)	3,299
Equipment	Straight Line	3-20 Yrs	1,861	(1,087)	774
Internal Use Software	Straight Line	7-10 Yrs	1,167	(774)	393
Assets Under Capital Lease	Straight Line	1-30 Yrs	119	(50)	69
Leasehold Improvements	Straight Line	*Life of Lease	50	(29)	21
Totals			$ 9,752	$ (4,388)	$ 5,364

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

Note 8. Other Assets (in Millions)

	2014	2013
Intragovernmental		
Advances to Other Federal Entities	$ 95	$ 103
With the Public		
Other Prepayments & Deferred Charges	21	33
Direct Loan	769	644
Other	20	12
Total With the Public	$ 810	$ 689

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

	2014	2013
Intragovernmental		
Accrued Payroll and Benefits	$ 60	$ 63
Other	748	174
Total Intragovernmental	$ 808	$ 237
Federal Employee and Veterans' Benefits (Note 11)	11,979	11,566
Accrued Payroll and Benefits	620	603
Contingencies and Commitments (Note 14)	11,332	8,900
Other	152	165
Total Liabilities Not Covered by Budgetary Resources	$ 24,891	$ 21,471
Total Liabilities Covered by Budgetary Resources	99,250	86,038
Total Liabilities	$ 124,141	$ 107,509

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

	2014	2013
Medicare FFS	$ 41,311	$ 38,729
Medicare Advantage/Prescription Drug Program	16,280	9,885
Medicaid	32,275	27,588
CHIP	923	693
Other	248	382
Totals	$ 91,037	$ 77,277

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare FFS benefits payable liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and

that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year, and (e) an estimate of retroactive settlements of cost reports. The September 30, 2014 and 2013 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2014. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2014.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS.

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

	2014	2013
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 11,154	$ 10,712
PHS Commissioned Corp Post-retirement Health Benefits	537	561
Workers' Compensation Benefits (Actuarial FECA Liability)	288	293
Total, Federal Employee and Veterans' Benefits	$ 11,979	$ 11,566

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,760 active duty officers and 6,466 retiree annuitants and survivors. As of September 30, 2014, the actuarial accrued liability for the retirement benefit plan was $11.2 billion and $0.5 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, 2014 and 2013, were:

	2014	2013
Interest on federal securities	4.65 percent	4.68 percent
Annual basic pay scale increase	2.93 percent	2.90 percent
Annual inflation	2.43 percent	2.40 percent

The following shows key valuation results as of September 30, 2014 and 2013, 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, 2014 and actuarial assumptions. The September 30, 2014 valuation includes an increase in liabilities of $418 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.

	2014	2013
Beginning Liability Balance	$ 11,273	$ 10,734
Expense		
Normal Cost	274	263
Interest on the liability balance	517	491
Actuarial (Gain)/Loss		
From experience	(63)	(18)
From assumption changes		
Change in discount rate assumption	2	282
Change in inflation/salary increase assumption	44	(29)
Change in Others	99	(5)
Net Actuarial (Gain)/Loss	82	230
Total expense	$ 873	$ 984
Less amounts paid	(455)	(445)
Ending Liability Balance	$ 11,691	$ 11,273

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. In FY 2014, the fund effected a change in accounting estimate to refine the methodology used for selecting the interest rate assumptions and enhance matching between the timing of cash flows and interest rates. For FY 2014, projected annual payments were discounted to present value based on OMB's interest rate assumptions which were interpolated to reflect the average duration in year for income payments and medical payments. In FY 2013 and prior years, these projected annual benefit payments were discounted to present value using OMB's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting as of September 30, 2014 and 2013 appear below.

	2014	2013
Wage Benefits	3.455% in Year 1 3.455% in Year 2 and thereafter	2.727% in Year 1 3.127% in Year 2 and thereafter
Medical Benefits	2.855% in Year 1 2.855% in Year 2 and thereafter	2.334% in Year 1 2.860% 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
2014	N/A	N/A
2015	1.73%	2.93%
2016	2.17%	3.76%
2017	2.13%	3.86%
2018	2.23%	3.90%
2019	2.30%	3.90%

Note 12. Accrued Grant Liability (in Millions)

	2014	2013
Estimated Accrual for Amounts Due to Grantees	$ 21,641	$ 22,410
Offsetting Grant Advances	(18,327)	(18,461)
Net Accrued Grant Liability	$ 3,314	$ 3,949

Note 13. Other Liabilities (in Millions)

	2014		2013	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 109	$ 918	$ 101	$ 983
Advances from Others	339	106	360	98
Deferred Revenue	-	483	-	445
Custodial Liabilities	934	15	930	18
Legal Liabilities (Note 14)	707	-	106	-
Other	933	979	512	1,037
Total Other Liabilities	$ 3,022	$ 2,501	$ 2,009	$ 2,581

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 and State Plan Amendments

The Medicaid amount of $8.5 billion ($6.1 billion in FY 2013) consists of Medicaid audit and program disallowances of $2.9 billion ($3.0 billion in FY 2013) and of $5.6 billion ($3.1 billion in FY 2013) 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 9,311 cases (7,124 in FY 2013) remaining on appeal as of September 30, 2014. In FY 2014, a total of 4,400 new cases were filed (3,907 in FY 2013) and 12 cases were reopened (9 in FY 2013). The PRRB rendered decisions on 73 cases in FY 2014 (210 in FY 2013); and 2,152 additional cases (1,623 in FY 2013) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB receives no information on the value of 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 of injury claims.

Note 15. Revenue (in Millions)

2014 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	$ 158	$ 7,059	$ 1,052	$ 87	$ 8,356	$ (2,935)	$ 5,421
Exchange Revenue	(53)	(3,555)	(16)	(12)	(3,636)	2,741	(895)
Net Cost, *Intragovernmental*	105	3,504	1,036	75	4,720	(194)	4,526
With the Public							
Gross Cost	13,025	385,456	589,581	37,583	1,025,645	-	1,025,645
Exchange Revenue	-	(5,607)	(72,551)	(31)	(78,189)	-	(78,189)
Net Cost, *With the Public*	13,025	379,849	517,030	37,552	947,456	-	947,456
Total Gross Cost	13,183	392,515	590,633	37,670	1,034,001	(2,935)	1,031,066
Total Exchange Revenue	(53)	(9,162)	(72,567)	(43)	(81,825)	2,741	(79,084)
Total Net Cost of Operations	$ 13,130	$ 383,353	$ 518,066	$ 37,627	$ 952,176	$ (194)	$ 951,982

2013 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	$ 141	$ 5,736	$ 1,022	$ 56	$ 6,955	$ (2,684)	$ 4,271
Exchange Revenue	(38)	(3,179)	(43)	(10)	(3,270)	2,495	(775)
Net Cost, *Intragovernmental*	103	2,557	979	46	3,685	(189)	3,496
With the Public							
Gross Cost	13,556	347,006	566,826	38,318	965,706	-	965,706
Exchange Revenue	-	(3,704)	(69,229)	(19)	(72,952)	-	(72,952)
Net Cost, *With the Public*	13,556	343,302	497,597	38,299	892,754	-	892,754
Total Gross Cost	13,697	352,742	567,848	38,374	972,661	(2,684)	969,977
Total Exchange Revenue	(38)	(6,883)	(69,272)	(29)	(76,222)	2,495	(73,727)
Total Net Cost of Operations	$ 13,659	$ 345,859	$ 498,576	$ 38,345	$ 896,439	$ (189)	$ 896,250

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $79.1 billion and $73.7 billion through September 30, 2014 and 2013, respectively. HHS's 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 16. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances at year end on the Statement of Budgetary Resources consist of Trust Funds, appropriated funds, revolving funds, management funds, gift funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All Trust Fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the Trust Funds and become available for obligation as needed. The entire Trust Fund balances in the amount of $225.0 billion as of September 30, 2014, ($245.0 billion in FY 2013) are included in Investments on the Balance Sheets.

Note 17. Explanation of Differences between the Combined 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 2014, has not been published, therefore, no comparisons can be made between FY 2014 amounts presented in the Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The FY 2016 *President's Budget* is expected to be released in February 2015 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 2013 column on the Statement of Budgetary Resources to the actual amounts for FY 2013 from the Appendix in the FY 2015 *President's Budget* for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2013	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Statement of Budgetary Resources	$ 1,323,724	$ 1,282,036	$ 336,655	$ 1,224,820
Expired Accounts	(8,985)	39	-	-
Other	(561)	29	372	(131)
Budget of the U.S. Government	$ 1,314,178	$ 1,282,104	$ 337,027	$ 1,224,689

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 Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

The Other differences in the budgetary resources includes an adjustments made to reclassify recoveries. In addition, sequestration was not reported in the HHS Statement of Budgetary Resources for the Federal Hospital Insurance Trust Fund but was included in the *President's Budget*.

The Other differences in the offsetting receipts consist primarily of adjustments made by NIH to prior year entry recorded in the Combined Statement of Budgetary Resources but not included in the *President's Budget* and other differences related to General Fund Proprietary Receipts and Intra-Departmental Delegation of Authority (IDDA) in the Combined Statement of Budgetary Resources.

Lastly, the Other differences in the net outlays include outlays reported on the HHS's Combined Statement of Budgetary Resources and included in the Department of Homeland Security's *President's Budget* for Project Bioshield, and a back dated warrant processed for the Payments to Health Care Trust Funds during the revision window.

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

	2014		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 94,625	$ 8,084	$ 102,709
Category B (Restricted and Distributed by Activity)	628,534	3,004	631,538
Exempt from Apportionment	640,113	18	640,131
Total Obligations Incurred	$ 1,363,272	$ 11,106	$ 1,374,378

	2013		
	Direct	Reimbursable	Total
Category A (Distributed by Quarter)	$ 90,955	$ 7,287	$ 98,242
Category B (Restricted and Distributed by Activity)	637,450	1,973	639,423
Exempt from Apportionment	544,371	-	544,371
Total Obligations Incurred	$ 1,272,776	$ 9,260	$ 1,282,036

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 $117.0 billion of budgetary resources obligated for undelivered orders as of September 30, 2014 and $93.3 billion as of September 30, 2013.

Note 19. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections fund group managed by HHS and is presented in a separate column in the schedule on the next page. 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 funds from dedicated collections financial statement balances are shown below.

	2014		
Consolidated Balance Sheet as of September 30	Medicare	Other	Total
Fund Balance with Treasury	$ 19,189	$ 3,581	$ 22,770
Investments	273,286	3,513	276,799
Other Assets	7,225	221	7,446
Total Assets	$ 299,700	$ 7,315	$ 307,015
Entitlement Benefits Due and Payable	$ 57,591	$ -	$ 57,591
Other Liabilities	4,999	659	5,658
Total Liabilities	$ 62,590	$ 659	$ 63,249
Unexpended Appropriations	16,315	(100)	16,215
Cumulative Results of Operations	220,795	6,756	227,551
Total Liabilities and Net Position	$ 299,700	$ 7,315	$ 307,015
Consolidated Statement of Net Cost for the Period Ended September 30			
Gross Program Costs	$ 590,633	$ 1,109	$ 591,742
Less: Exchange Revenues	72,567	2,655	75,222
Net Cost of Operations	$ 518,066	$ (1,546)	$ 516,520
Consolidated Statement of Changes in Net Position for the Period Ended September 30			
Net Position Beginning of Period	$ 242,714	$ 5,751	$ 248,465
Non-Exchange Revenue	242,701	307	243,008
Other Financing Sources	269,761	(948)	268,813
Net Cost of Operations	(518,066)	1,546	(516,520)
Change in Net Position	$ (5,604)	$ 905	$ (4,699)
Net Position End of Period	$ 237,110	$ 6,656	$ 243,766

Consolidated Balance Sheet as of September 30	2013 Medicare	Other	Total
Fund Balance with Treasury	$ 9,448	$ 2,711	$ 12,159
Investments	276,173	3,452	279,625
Other Assets	11,025	215	11,240
Total Assets	$ 296,646	$ 6,378	$ 303,024
Entitlement Benefits Due and Payable	$ 48,614	$ -	$ 48,614
Other Liabilities	5,318	627	5,945
Total Liabilities	$ 53,932	$ 627	$ 54,559
Unexpended Appropriations	$ 4,569	$ (100)	$ 4,469
Cumulative Results of Operations	238,145	5,851	243,996
Total Liabilities and Net Position	$ 296,646	$ 6,378	$ 303,024
Consolidated Statement of Net Cost for the Period Ended September 30			
Gross Program Costs	$ 567,848	$ 738	$ 568,586
Less: Exchange Revenues	69,272	1,978	71,250
Net Cost of Operations	$ 498,576	$ (1,240)	$ 497,336
Consolidated Statement of Changes in Net Position for the Period Ended September 30			
Net Position Beginning of Period	$ 282,319	$ 5,108	$ 287,427
Non-Exchange Revenue	229,649	269	229,918
Other Financing Sources	229,322	(866)	228,456
Net Cost of Operations	(498,576)	1,240	(497,336)
Change in Net Position	$ (39,605)	$ 643	$ (38,962)
Net Position End of Period	$ 242,714	$ 5,751	$ 248,465

Note 20. Statement of Social Insurance (Unaudited)

The Statement of Social Insurance presents, for the 75-year projection period, the present values of the income and expenditures of the HI and SMI trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' reasonable 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.

As noted in the Trustees Report, the basis for the Part B projections has changed since last year. The scheduled reductions under the sustainable growth rate (SGR) formula for updating the physician fee schedule have been

overridden by lawmakers each year beginning with 2003. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of an estimated 20.8 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have for every year starting with 2003. For this reason, the income, expenditures, and assets for Part B reflect the Trustees' *projected baseline* scenario, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015.

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 July 28, 2014 but also reflect the nearly certain override of the physician fee reductions scheduled under current law. 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 Statement of Social Insurance 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 Statement of Social Insurance 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 Statement of Social Insurance also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated 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 Statement of Social Insurance also sets forth the same calculation for the closed group of participants. The closed group 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 estimated future income over estimated 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 estimated 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 inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the Statement of Social Insurance. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop 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 Trustees' projected baseline scenario. 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 following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2014 Statement of Social Insurance actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2014. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within Table 1, for the prior years is publicly available on the CMS website at http://www.cms.hhs.gov/CFOReport.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2014

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
2014	1.91	1,345,000	779.8	2.18	3.78	1.61	3.1	−2.9	3.4	0.2	0.3
2020	2.06	1,350,000	730.2	1.42	4.12	2.70	2.6	4.0	5.6	6.3	2.7
2030	2.03	1,160,000	667.6	1.24	3.94	2.70	2.1	4.5	5.1	5.3	2.9
2040	2.00	1,105,000	614.6	1.15	3.85	2.70	2.2	5.2	4.9	5.2	2.9
2050	2.00	1,085,000	568.1	1.11	3.81	2.70	2.1	4.1	4.5	5.0	2.9
2060	2.00	1,070,000	527.1	1.10	3.80	2.70	2.1	3.8	4.3	4.7	2.9
2070	2.00	1,065,000	490.8	1.09	3.79	2.70	2.1	4.0	4.2	4.6	2.9
2080	2.00	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage 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 Statement of Social Insurance 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 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports, are summarized in Table 2 below.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2014-2010

					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 2014	2.0	1,060,000	458.4	1.13	3.83	2.7	2.1	3.8	4.1	4.4	2.9
FY 2013	2.0	1,055,000	419.8	1.13	3.93	2.8	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.12	3.92	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

[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. The ultimate level of net legal immigration is 790,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[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. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[5]Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[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 soon after the 10th year of each projection period.

Note 21. Alternative SOSI Projections (Unaudited)

As mentioned previously, the Statement of Social Insurance projections reflect a projected baseline scenario, which includes an override of the SGR formula for updating physician payment rates. This scenario also assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity—will occur as the *Affordable Care Act* requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. The ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions. Before such an outcome would occur, lawmakers would likely intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments, as lawmakers have done

repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent.[4] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the 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 under Medicare and of the broad range of uncertainty associated with such impacts.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under the projected baseline with those under current law—including the almost 21-percent scheduled reduction in physician payment rates under the SGR formula—and the illustrative alternative scenario.

Medicare Present Values

(in Billions)

	Projected baseline (Unaudited)	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income			
Part A	$16,542	$16,542	$16,550
Part B	24,311	21,847	27,286
Part D	9,312	9,327	9,440
Expenditures			
Part A	20,365	20,396	24,848
Part B	24,311	21,847	27,286
Part D	9,312	9,327	9,440
Income less expenditures			
Part A	(3,823)	(3,854)	(8,297)
Part B	0	0	0
Part D	0	0	0

[1]These amounts are not presented in the 2014 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 differs both from the projected baseline emphasized throughout the 2014 Trustees Report and from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

As expected, the projected baseline and current-law projections differ most markedly for Part B, since the physician fee reductions do not affect Part A and Part D directly.[5] The present values of estimated future income and expenditures under current law are roughly 10 percent lower than under the projected baseline projections.

[4]The Trustees have used this approach since 2007 to address concerns with the SGR provision. Starting with the 2010 annual report, following enactment of the *Affordable Care Act*, the illustrative alternative projections have included changes to the productivity adjustments.
[5]The differences between the projected baseline and current law for Parts A and D are the result of (1) changes in the operations of the Independent Payment Advisory Board (IPAB) due to modifications in the Part B projections; and (2) slight changes to the discount rates.

The difference between the projected baseline and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the projected baseline and current-law projections reflect an estimated 1.1-percent reduction in annual cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the estimated present value of Part A and Part B expenditures would be higher than the projected baseline projections by roughly 22 percent and 12 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario; and the present value of Part B income is also 12 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected 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 amounts due to changes to the productivity adjustments depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

Note 22. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated 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 estimated future noninterest income less estimated 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 in Social Insurance Amounts shows the reconciliation from the period beginning on January 1, 2013 to the period beginning on January 1, 2014, and the reconciliation from the period beginning on January 1, 2012 to the period beginning on January 1, 2013. 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 future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cashflow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

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

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- 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 20 summarizes these assumptions for the current year.

Period beginning on January 1, 2013 and ending January 1, 2014

Present values as of January 1, 2013 are calculated using interest rates from the intermediate assumptions of the 2013 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2014. 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 2013 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report.

Period beginning on January 1, 2012 and ending January 1, 2013

Present values as of January 1, 2012 are calculated using interest rates from the intermediate assumptions of the 2012 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2013. 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 2012 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2013 Trustees Report.

Change in the Valuation Period

Period beginning on January 1, 2013 and ending January 1, 2014

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2013-87) to the current valuation period (2014-88) 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 2013 and replaces it with a much larger negative net cashflow for 2088. The present value of estimated 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 2013-87 to 2014-88. 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 2013 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Period beginning on January 1, 2012 and ending January 1, 2013

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2012-86) to the current valuation period (2013-87) 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 2012 and replaces it with a much larger negative net cashflow for 2087. The present value of estimated 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 2012-86 to 2013-87. 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 2012 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in Projection Base

Period beginning on January 1, 2013 and ending January 1, 2014

Actual income and expenditures in 2013 were different than what was anticipated when the 2013 Trustees Report projections were prepared. Part A income was slightly higher and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly higher on an incurred basis than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2013 and January 1, 2014 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Period beginning on January 1, 2012 and ending January 1, 2013

Actual income and expenditures in 2012 were different than what was anticipated when the 2012 Trustees Report projections were prepared. Part A income and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also 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 an increase in the estimated future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2012 and January 1, 2013 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in the Demographic Assumptions

Period beginning on January 1, 2013 and ending January 1, 2014

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 (beginning on January 1, 2014) are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Preliminary birth rate data for 2012 indicated lower birth rates 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.

There was one change in demographic methodology:

The modeling of the other immigrant population was divided into three distinct groups for the current valuation: (1) those with temporary legal status; (2) those never authorized to be in the country; and (3) those who had temporary legal status previously but are no longer authorized to be in the country.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cashflow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

A further assumption change was made that resulted in higher Part D enrollment for the current valuation period. The participation rate represents the percentage of beneficiaries assumed to enroll in a Part D plan out of all eligible and, in prior years, was assumed to stay relatively constant at the same rate as the recent historical period. However, since actual participation has consistently been higher than expected, it was decided to increase the participation rate by 1 percent per year for the first 3 years of the projection period, before leveling out. This results in an assumed 62.4 percent participation rate, prior to adjustments for beneficiaries who have retiree drug subsidy coverage and those who are assumed to drop out because they are required to pay an income-related premium, for 2017 and later, which is higher than the 57.2 percent that was assumed for all years in the prior valuation period. This assumption change resulted in an increase in the present value of estimated future income and estimated future expenditures for Part D, and had no impact on the Part A and Part B present values.

Period beginning on January 1, 2012 and ending January 1, 2013

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at SSA.

For the current valuation (beginning on January 1, 2013), changes in ultimate assumptions and recent data for immigration have significant effects.

- The assumed ultimate annual immigration of "other immigrants", that is, those entering the country without legal permanent resident (LPR) status, is 1.4 million in the current valuation, compared with 1.5 million assumed for the prior valuation.
- The assumed ultimate annual number of persons attaining LPR status is 1.05 million for the current valuation, compared with 1.0 million assumed for the prior valuation. The distribution of the ultimate number between those entering the country with LPR status and those adjusting status after having already entered the country was also revised.

Otherwise, the ultimate demographic assumptions for the current valuation are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

Final mortality data for 2008 and 2009 show substantially larger reductions in death rates for the current valuation than were expected in the prior valuation. The new data show a lower starting level of death rates and a faster rate of decline in death rates over the next 25 years.

Final fertility (birth) data for 2009 and 2010, and preliminary data for 2011, indicate lower birth rates for these years than were assumed in the prior valuation.

New historical data for marital status, for the number of new marriages, for "other immigration", and for the size of the population (based on the 2010 Census) were used in the current valuation.

These changes increased the Part A present values of estimated future expenditures and income. Since overall population projections are higher compared to the prior valuation, these changes increase the Part B and Part D present values of estimated future expenditures, and also estimated future income because of the financing mechanism in place for both.

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2013 and ending January 1, 2014

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2014), there was one change to the ultimate economic assumptions:

The ultimate annual rate of change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is assumed to be 2.7 percent per year in the current valuation period, compared to 2.8 percent per year in the previous valuation period. Lowering the ultimate average annual increase in the CPI-W makes it more comparable to recent historical annual increases.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values, and the way these values transition to the ultimate assumptions, were changed.

The ratio of average taxable earnings to the average wage index is lower by 1.9 percent in 2012 and 1.5 percent in 2013, compared to the previous valuation period.

There were two main changes in the economic methodology:

- Projected labor force participation rates for the older population are slightly lower for the current valuation in order to better reflect the difference in participation rates between never-married and married populations and the projected improvement in life expectancy.
- Different earnings levels are assigned to the three distinct groups of the other immigrant population supplied by demography. (This change decreased the present value of future cashflows by about the same amount as the related change in the demography methodology increased the present value of future cashflows.)

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

- The projections emphasized in the 2014 Medicare Trustees Report were changed to reflect the projected baseline scenario. This scenario assumes that the physician payment updates required under the current-law sustainable growth rate formula will be permanently overridden by lawmakers. The use of these projections increases the present value of estimated future expenditures, compared to the current law projections, for Part B by roughly 11 percent, and for total Medicare by about 5 percent.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Case mix increase assumptions for skilled nursing facilities and home health agencies were decreased.
- Market basket differential for skilled nursing facilities was lowered.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Higher increases in productivity rates, resulting in lower payment updates.
- The methodology used to transition from the short-range projections to the long-range projections was refined, resulting in smaller increases during this transition period.
- Lower projected prescription drug trend rates.
- Higher assumed rebates from drug manufacturers.

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

Period beginning on January 1, 2012 and ending January 1, 2013
The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate economic assumptions for the current valuation (beginning on January 1, 2013) are the same as those for the prior valuation. Other changes include:

The real interest rate is projected to be lower over the first ten years of the current valuation.

The starting economic values and near-term economic growth rate assumptions were updated.

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

- Utilization rate and case mix increase assumptions for skilled nursing facilities were decreased.
- Lower projected Medicare Advantage program costs that reflect recent data suggesting that certain provisions of the *Affordable Care Act* will reduce growth in these costs by more than was previously projected.
- Administrative action that increased Medicare Advantage payment rates beginning in 2014 to reflect assumed future legislative overrides of the physician payment reductions.
- Larger than previously projected impact from patent expiration of several major prescription drugs in 2012.
- Lower projected prescription drug trend for 2013.

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

Changes in Law

Period beginning on January 1, 2013 and ending January 1, 2014
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 estimated future income, expenditures, and net cashflow. The Continuing Appropriations Resolution of 2014 included several provisions that had an impact on the Medicare program, including a 0.5 percent physician payment update for January through March of 2014, extension of the Medicare sequester to FY 2022 and 2023, and payment reform for long-term care hospitals. Further, sections 1 and 3 of Public Law 113-82 included a further extension of the Medicare sequester to FY 2024. Lastly, the Protecting Access to Medicare Act of 2014 extended the 0.5 percent physician update through December 2014, enacted a 0 percent update for January through March of 2015, improved payment policy for clinical diagnostic lab tests, made revisions to the end-stage renal disease (ESRD) prospective payment system and physician fee schedule, and realigned the Medicare sequester in FY 2024. Overall these provisions resulted in an increase in the

estimated future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures, with an overall increase in the estimated future net cashflow. For Part B, these changes lowered the present value of estimated future expenditures (and also income) only very slightly. For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) also very slightly.

Period beginning on January 1, 2012 and ending January 1, 2013

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. The American Taxpayer Relief Act of 2012 included several provisions that had an impact on the Medicare program. These include the extension of the 0 percent physician payment update through 2013, which slightly increases the present value of Part B expenditures; payments for inpatient hospital services in 2014-2017 are reduced in order to recoup $11 billion in overpayments associated with documentation and coding adjustments during 2008-2010 that were not previously recovered, which lowers the present value of Part A expenditures; reductions to the ESRD bundled payment rate to reflect changes in the utilization of certain drugs and biological and a delay in the inclusion of oral-only ESRD drugs in the rate, which reduces the present value of Part B estimated future expenditures and increases the present value of Part D estimated future expenditures; and the coding intensity adjustment used in determining payments to Medicare Advantage plans was revised, which lowers the present value of Part A and Part B estimated future expenditures.

Note 23. Reconciliation of Net Cost of Operations (Proprietary) to Budget (in Millions)

	2014	2013
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,374,378	$ 1,282,036
Spending Authority from Offsetting Collections and Recoveries	(50,799)	(49,640)
Obligations Net of Offsetting Collections and Recoveries	1,323,579	1,232,396
Distributed Offsetting Receipts	(359,650)	(336,655)
Net Obligations	$ 963,929	$ 895,741
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	(445)	58
Total Resources Used to Finance Activities	$ 963,484	$ 895,799
Resources Used to Finance Items Not Part of the Net Cost of Operations:		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	$ 21,765	$ (3,623)
Resources That Fund Expenses Recognized in Prior Periods	33	54
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(6,715)	(1,202)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,389	1,314
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	3,114	7,089
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	19,586	3,632
Total Resources Used to Finance the Net Cost of Operations	$ 943,898	$ 892,167
Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period		
Components Requiring or Generating Resources in Future Periods	$ 3,399	$ 2,495
Components Not Requiring or Generating Resources	4,685	1,588
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	8,084	4,083
Net Cost of Operations	$ 951,982	$ 896,250

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2014

Responsibility Segment Program	2014	2013	2012	2011	2010
Administration for Children and Families					
Administration for Intellectual and Developmental Disabilities	$ -	$ 6	$ 6	$ 11	$ 9
Administration for Community Living					
Administration for Intellectual and Developmental Disabilities	8	-	-	-	-
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	660	766	705	761	691
National Institutes of Health					
Research Training and Career Development	1,541	1,621	1,858	1,920	1,915
Totals	$ 2,209	$ 2,393	$ 2,569	$ 2,692	$ 2,615

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. The following operating divisions conduct education and training programs under this category:

Administration for Children and Families

While previously administered by the ACF, the Administration for Intellectual and Developmental Disabilities (AIDD) program was transferred to ACL as part of a 2012 reorganization. Funding for this and other AIDD programs is no longer reported by ACF and is administered solely by ACL as of FY 2014.

Administration for Community Living

Projects of National Significance (PNS) grants are awarded to public and 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. Under AIDD, as of September 30, 2014, 27 grants have been awarded for FY 2014. Grants awarded total $7.5 million as of September 30, 2014.

Health Resources and Services Administration

Under Clinician Recruitment and Service, the National Health Service Corps (NHSC) is a network of 9,200 primary care providers and 14,000 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 address the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for 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, 2014

Responsibility Segments	Basic	Applied	Develop-mental	2014 Total	2013	2012	2011	2010	Grand Total
ACF	$ -	$ 3	$ -	$ 3	$ 1	$ 2	$ 7	$ 9	$ 22
AHRQ	-	250	-	250	372	401	333	263	1,619
CDC	60	306	28	394	457	408	457	465	2,181
FDA	96	-	7	103	94	80	58	48	383
NIH	16,631	11,088	-	27,719	29,328	30,681	32,902	31,342	151,972
Totals	$ 16,787	$ 11,647	$ 35	$ 28,469	$ 30,252	$ 31,572	$ 33,757	$ 32,127	$ 156,177

The research and development programs in HHS include the following:

Administration for Children and Families (ACF)

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

Agency for Healthcare Research and Quality (AHRQ)

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

Centers for Disease Control and Prevention (CDC)

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)

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 (NIH)

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

REQUIRED SUPPLEMENTARY INFORMATION

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2014

	CMS					
Budgetary Resources:	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 2,282	$ 39,295	$ 41,577	$ 111
Recoveries of Prior Year Unpaid Obligations	777	2	21,569	3,735	26,083	-
Other Changes in Unobligated Balance	-	-	12	(731)	(719)	(62)
Unobligated Balance from Prior Year Budget Authority, Net	777	2	23,863	42,299	66,941	49
Appropriations (Discretionary and Mandatory)	278,190	264,039	302,282	475,669	1,320,180	(4)
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	237
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	5	18	693	23,942	24,658	198
Total Budgetary Resources	$ 278,972	$ 264,059	$ 326,838	$ 541,910	$ 1,411,779	$ 480
Status of Budgetary Resources:						
Obligations Incurred	$ 278,972	$ 264,059	$ 325,463	$ 505,407	$ 1,373,901	$ 477
Unobligated Balances, End of Year:						
Apportioned	-	-	1,309	28,075	29,384	-
Exempt from Apportionment	-	-	-	39	39	-
Unapportioned	-	-	66	8,389	8,455	3
Total Unobligated Balance, End of Year	-	-	1,375	36,503	37,878	3
Total Status of Budgetary Resources	$ 278,972	$ 264,059	$ 326,838	$ 541,910	$ 1,411,779	$ 480
Change in Obligated Balance:						
Unpaid Obligation:						
Unpaid Obligations, Brought Forward, Oct 1	$ 25,103	$ 24,691	$ 29,877	$ 108,983	$ 188,654	$ 1,248
Obligation Incurred	278,972	264,059	325,463	505,407	1,373,901	477
Outlays (Gross)	(273,796)	(265,932)	(298,365)	(482,213)	(1,320,306)	(727)
Actual Transfers, unpaid obligations (net)	-	-	-	-	-	-
Recoveries of Prior Year Unpaid Obligations	(777)	(2)	(21,569)	(3,735)	(26,083)	-
Unpaid Obligations, End of Year	$ 29,502	$ 22,816	$ 35,406	$ 128,442	$ 216,166	$ 998
Uncollected Payments:						
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ -	$ -	$ -	$ (11,018)	$ (11,018)	$ (536)
Adjustment to Uncollected Payments, Federal Sources	-	-	-	-	-	-
Change in Uncollected Customer Payments from Federal Sources	-	-	-	(820)	(820)	106
Uncollected Payments from Federal Sources, End of Year	$ -	$ -	$ -	$ (11,838)	$ (11,838)	$ (430)
Memorandum (non-add) Entries:						
Obligated Balance, Start of Year	$ 25,103	$ 24,691	$ 29,877	$ 97,965	$ 177,636	$ 712
Obligated Balance, End of Year	$ 29,502	$ 22,816	$ 35,406	$ 116,604	$ 204,328	$ 568

[1] "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 $3.6 billion and gross outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Combining Statement of Budgetary Resources (Continued) (in Millions)

	CMS					
	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[1]	Agency Combined Budgetary Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:						
Budget Authority, Gross (Discretionary and Mandatory)	$ 278,195	$ 264,057	$ 302,975	$ 499,611	$ 1,344,838	$ 431
Actual Offsetting Collections (Discretionary and Mandatory)	(5)	(18)	(693)	(22,971)	(23,687)	(315)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	-	-	-	(820)	(820)	106
Budget Authority, Net (Discretionary and Mandatory)	$ 278,190	$ 264,039	$ 302,282	$ 475,820	$ 1,320,331	$ 222
Outlays, Gross (Discretionary and Mandatory)	$ 273,796	$ 265,932	$ 298,365	$ 482,213	$ 1,320,306	$ 727
Actual Offsetting Collections (Discretionary and Mandatory)	(5)	(18)	(693)	(22,971)	(23,687)	(315)
Outlays, Net (Discretionary and Mandatory)	273,791	265,914	297,672	459,242	1,296,619	412
Distributed Offsetting Receipts	(31,770)	(326,854)	-	(1,026)	(359,650)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 242,021	$ (60,940)	$ 297,672	$ 458,216	$ 936,969	$ 412

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 53,746	$ 53,746	$ 48,672
ACL	1,730	1,730	1,463
AHRQ	423	423	42
CDC	12,058	12,058	10,110
CMS	405,532	405,532	345,628
FDA	5,391	5,391	2,052
HRSA	9,764	9,764	8,960
IHS	6,837	6,837	4,512
NIH	35,092	35,092	29,231
OS	5,827	5,827	3,775
PSC	1,759	1,759	578
SAMHSA	3,751	3,751	3,193
Totals	$ 541,910	$ 541,910	$ 458,216

[1] "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 $3.6 billion and gross outlays of $3.8 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

Deferred Maintenance and Repairs

For the Years Ended September 30, 2014 and 2013

The Federal Accounting Standards Advisory Board (FASAB) issued SFFAS Number 40, *Definitional Changes to Deferred Maintenance and Repairs; Amending Statement of Federal Financial Accounting Standards 6, Accounting for Property, Plant, and Equipment*, effective for periods after September 30, 2011. This standard clarifies that repair activities should be included to better reflect asset management practices, and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repairs activities not performed when they should have been or were scheduled to be, and then were put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components and other activities needed to preserve the asset so that it continues to provide acceptable service and achieves its expected life. Maintenance and repairs do 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 and repair expenses are 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.

		Estimated Cost to Return to Acceptable Condition (in Millions)	
Category of Asset	Condition	2014	2013
General PP&E			
Buildings	1-5	$ 1,876	$ 2,249
Equipment	3-4	12	12
Other Structures	1-5	13	13
Total		$ 1,901	$ 2,274

In a condition assessment survey, 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, 2014

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] property, plant, and equipment), but have always been held by IHS as separate and distinct, because of the government's long-term trust responsibility. All Trust Lands, when no longer needed by the 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.

For the purpose of SFFAS 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, 2014, IHS has no individually listed properties.

The IHS accountability reports differentiate Indian Trust Land parcels from general property, plant, and equipment situated thereon. The IHS Trust Land balances are removed from HHS FY 2014 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, 2014.

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 Hospital Insurance (HI, or Part A) Trust Fund and Supplementary Medical Insurance (SMI, or Parts B and D) Trust Fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the FASAB. Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2014 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 reflect an exception to current law with regard to the sustainable growth rate (SGR) formula for physician fee schedule payment under Part B. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of almost 21 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have every year beginning with 2003. For this reason, the income, expenditures, and assets for Part B shown throughout the report reflect a *projected baseline*, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015. The projections do not represent either a policy recommendation or a prediction of legislative outcomes.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012*; the Continuing Appropriations Resolution, 2014 (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; and the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

These projections 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*, contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving 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 costs.

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 *Affordable Care Act*—in particular, the lower increases in Medicare payment rates to most categories of health care providers. Without fundamental changes in current health care delivery systems, these adjustments would probably not be viable indefinitely. 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. 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.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law cost projections reflect the scheduled SGR reductions to physicians' payment rates and the *Affordable Care Act*-mandated reductions in other Medicare payment rates. Because the physician payment reduction required by current law has been overridden for 12 consecutive years, the Medicare Board of Trustees decided for the 2014 Medicare Trustees Report to emphasize projections under a projected baseline, as mentioned previously. In addition, the Trustees reference in their report an illustrative alternative scenario, which incorporates the override of SGR physician payment rates included in the projected baseline and a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates, as well as an assumed legislative override of the cost-saving actions of the Independent Payment Advisory Board. The difference between the illustrative alternative and the projected baseline projections demonstrates that the long-range costs could be substantially higher than those shown throughout much of the 2014 report if the *Affordable Care Act*'s cost reduction measures prove ineffectual or are scaled back.

Additional information on the projected baseline, current-law, and illustrative alternative projections is provided in Note 21 in these financial statements, in appendix V.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.hhs.gov/ReportsTrustFunds/.

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates (except for physician fee schedule services) and assumptions for volume and intensity growth derived from a "factors contributing to growth" model, which, developed by the Office of the Actuary at CMS, decomposes the major drivers of historical and projected health spending growth into distinct factors. Additionally, the Trustees assume that the Medicare payment rate updates that reflect an economy-wide productivity adjustment will reduce volume and intensity growth slightly below the assumption from the factors model for affected Medicare services. The Trustees' methodology is consistent with the recommendations by the 2010-2011 Technical Review Panel on the Medicare Trustees Report,[6] which incorporated a more refined analysis of the factors behind those assumptions. The Trustees plan to continue to direct research into the factors approach and will consider additional refinements and improvements in forthcoming reports.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements.[7] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

[6]The Panel's final report is available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

[7]For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-*Affordable Care Act*
- Baseline cost growth assumption for Medicare to GDP plus 1.4 percent. (The corresponding assumed average growth rate for all national health expenditures continues to be GDP plus 1 percent.)
- The second approach recommended by the Technical Panel is the factors model developed by the Office of the Actuary at CMS as a possible replacement for the existing process. This model builds upon the key considerations used in establishing the earlier GDP plus 1 percent assumption, together with subsequent refinements in the analysis of growth factors, additional years of data on national health expenditures available since the 2000 Medicare Technical Review Panel's deliberations, and use of projected trends in the model's key factors. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[8]

The Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average "GDP plus" approach.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Medicare Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions under current law.

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.[9] The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in private, nonfarm business multifactor productivity, which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for three categories of health care providers:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

[8]Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs,* 28, no. 5 (2009): 1276-1284.

[9]Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the *Affordable Care Act*, the law did not specify any such adjustments after 2009.

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year increases for these provider services start at 4.4 percent in 2038, or GDP plus 0.4 percent, declining gradually to 3.5 percent in 2088, or GDP minus 0.5 percent. On average, the ultimate cost growth rate for these provider services is 4.2 percent, or GDP plus 0.2 percent.

(ii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in productivity.*

Such services include durable medical equipment, care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.6 percent in 2038, or GDP minus 0.4 percent, declining to 2.7 percent in 2088, or GDP minus 1.3 percent. On average, the total assumed rate of growth for these services is 3.4 percent, which equates to GDP minus 0.6 percent.

(iii) *All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services, including physician payments.*[10]

These Part B outlays constitute an estimated 50 percent of total Part B expenditures in 2023 and consist mostly of payments for physician services, laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[11] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year growth rates for these services are 5.2 percent in 2038, or GDP plus 1.2 percent, declining to 4.3 percent by 2088, or GDP plus 0.3 percent. On average, the rate of growth for these services is 5.0 percent, or GDP plus 1 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 4.6 percent per year for the last 50 years of the projection period, or GDP plus 0.6 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.5 percent over this same time period or GDP plus 0.5 percent, while the growth rate in 2088 is 3.8 percent or GDP minus 0.2 percent.

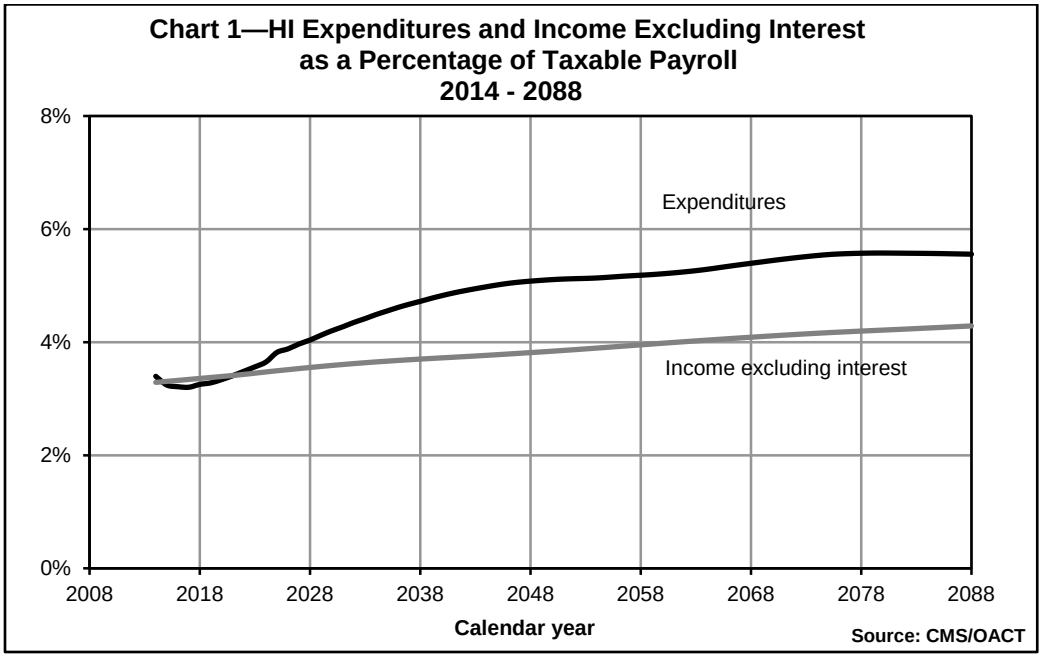
[10] In the long range under the projected baseline, physician services are assumed to increase at the rate equal to the per capita increase in health spending in the U.S. overall.

[11] For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

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 the 2014 report are lower than those from the 2013 report. The primary reasons for the difference are lower-than-expected recent spending and revised utilization assumptions.



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 2.90 percent. Under the *Affordable Care Act*, however, high-income workers 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. Because 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 continuation of the economic recovery, the savings provisions of the *Affordable Care Act*, and the sequestration of Medicare expenditures for 2013-2024. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and partly due to health services cost growth. The effect of these factors will be somewhat offset 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 scenario, if the slower price updates were not

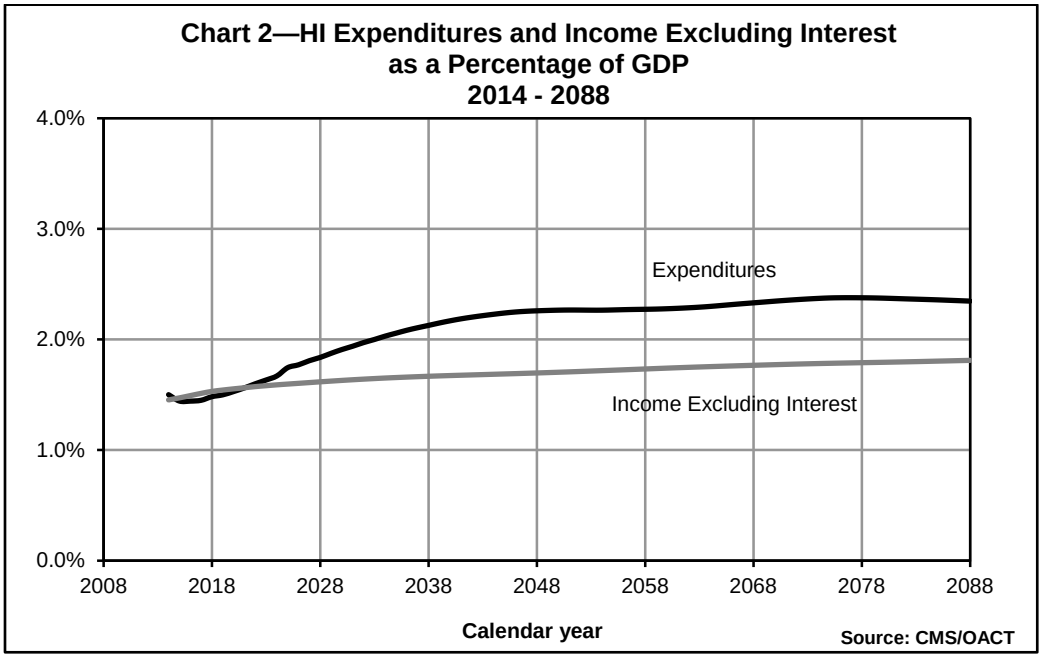
feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.9 percent in 2035 and 8.8 percent in 2085. These levels are about 8 percent and 57 percent higher, respectively, than the projected baseline estimates under the intermediate assumptions.

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 2013, the expenditures were $266.2 billion, which was 1.6 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 scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.8 percent in 2088.

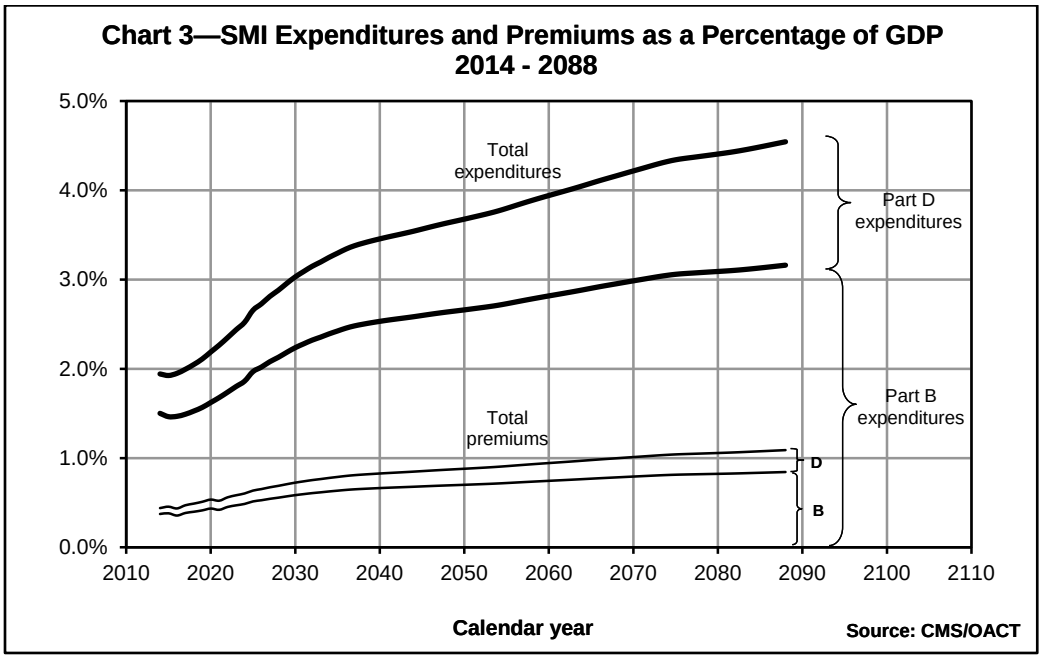


SMI

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

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. 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.

In 2013, SMI expenditures were $316.7 billion, or about 1.9 percent of GDP. Under the projected baseline, they would grow to roughly 3.4 percent of GDP in about 25 years and to more than 4.5 percent by the end of the projection period. (Total SMI expenditures in 2088 would be 4.0 percent of GDP if physician payment rates were set as assumed under the current-law projections. Such costs would represent more than 4.6 percent of GDP under the illustrative alternative, which includes larger payment updates for most non-physician categories of Part B providers.)

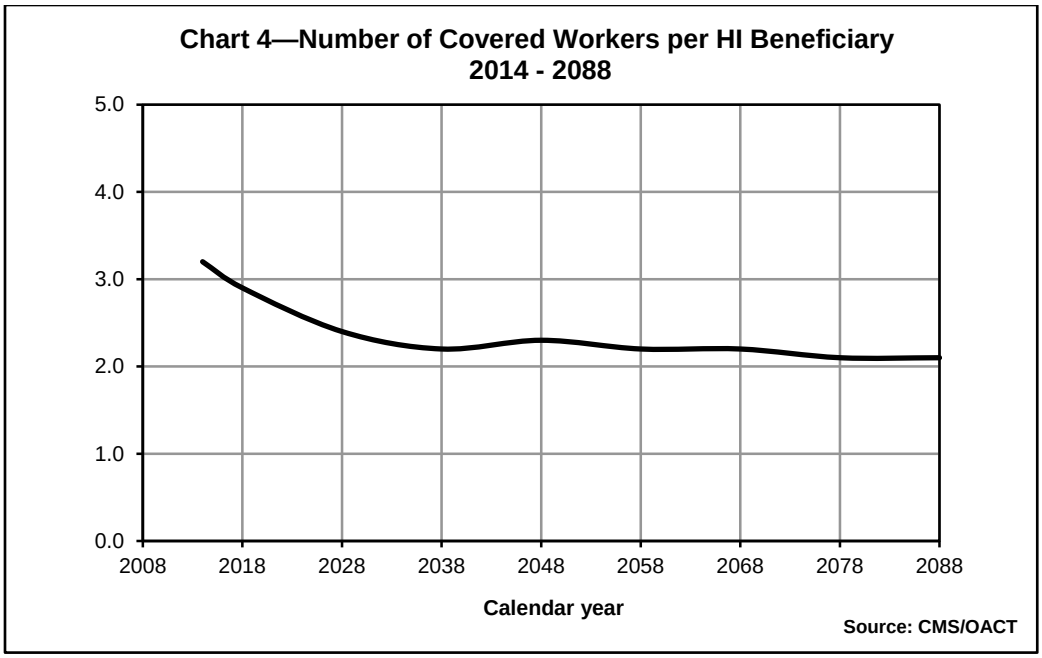


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per beneficiary costs for Part B and Part D benefits are projected to increase after 2014 by about 4.6 percent annually. 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 workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2013, every beneficiary had 3.2 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 2088.



Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or 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.[12] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[13]

For this analysis, the intermediate economic and demographic assumptions in the *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s 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, 2014 and are based on estimates of income and expenditures during the 75-year projection period.

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 *Affordable Care Act* result in trust fund surpluses, and then decrease until about 2047 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

[12] 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.

[13] 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.

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

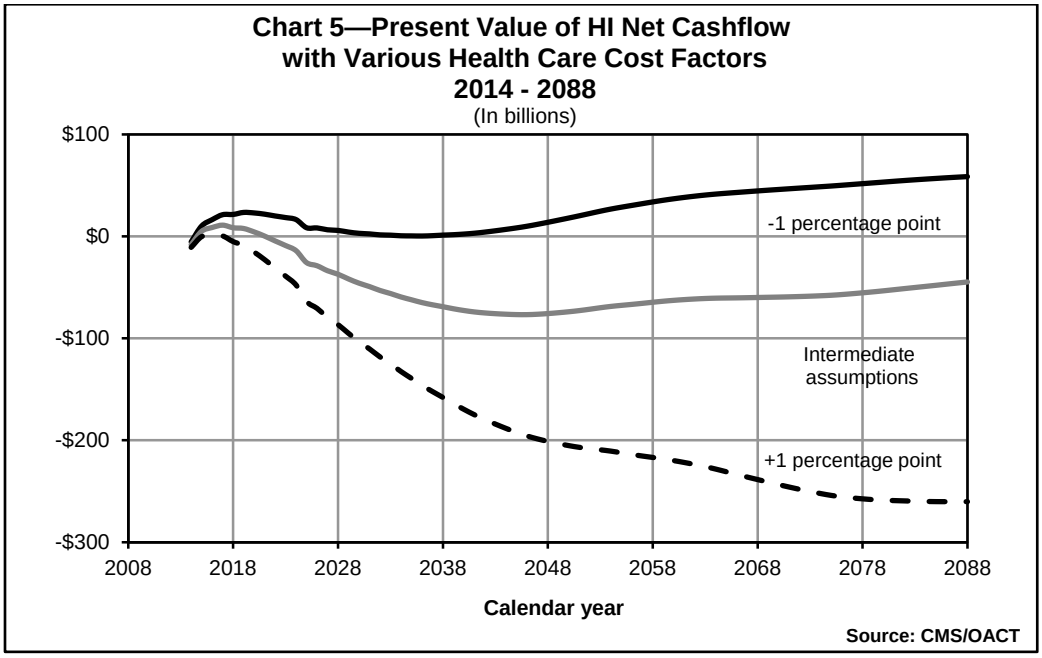
Table 1 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, 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)	$1,996	$(3,823)	$(13,090)

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $5,819 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $9,267 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.



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 *Affordable Care Act*. 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 1.8 percentage points.[14] In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.5 percent, respectively.

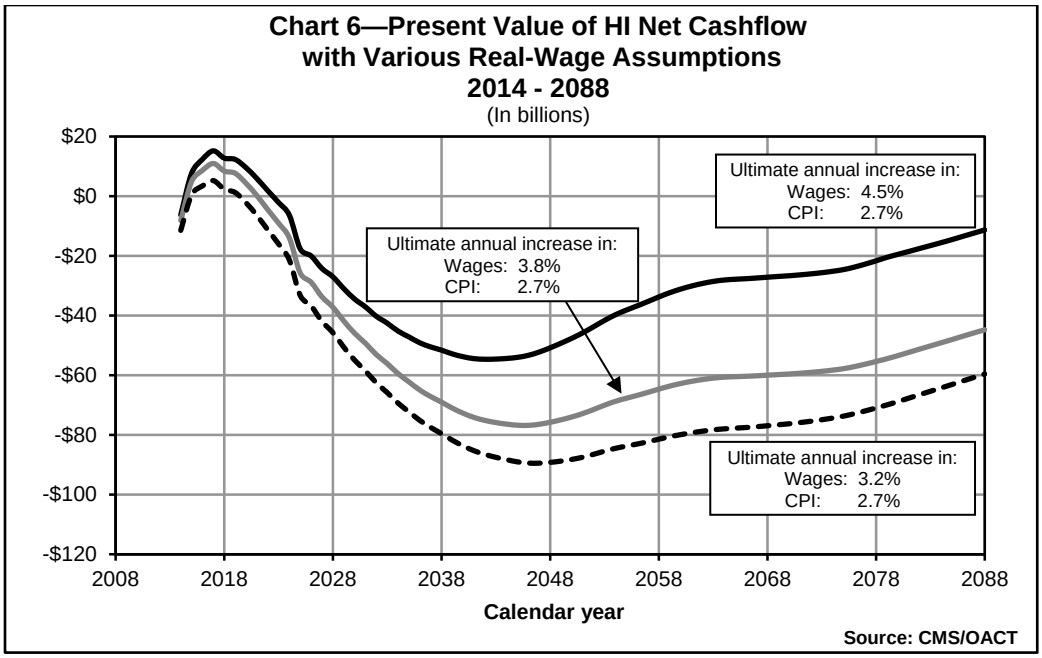
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	3.2 – 2.7	3.8 – 2.7	4.5 – 2.7
Ultimate percentage increase in real-wage differential	0.5	1.1	1.8
Income minus expenditures (in billions)	$(4,777)	$(3,823)	$(2,101)

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 $1,230 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $795 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.

[14]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 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 *Affordable Care Act* 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

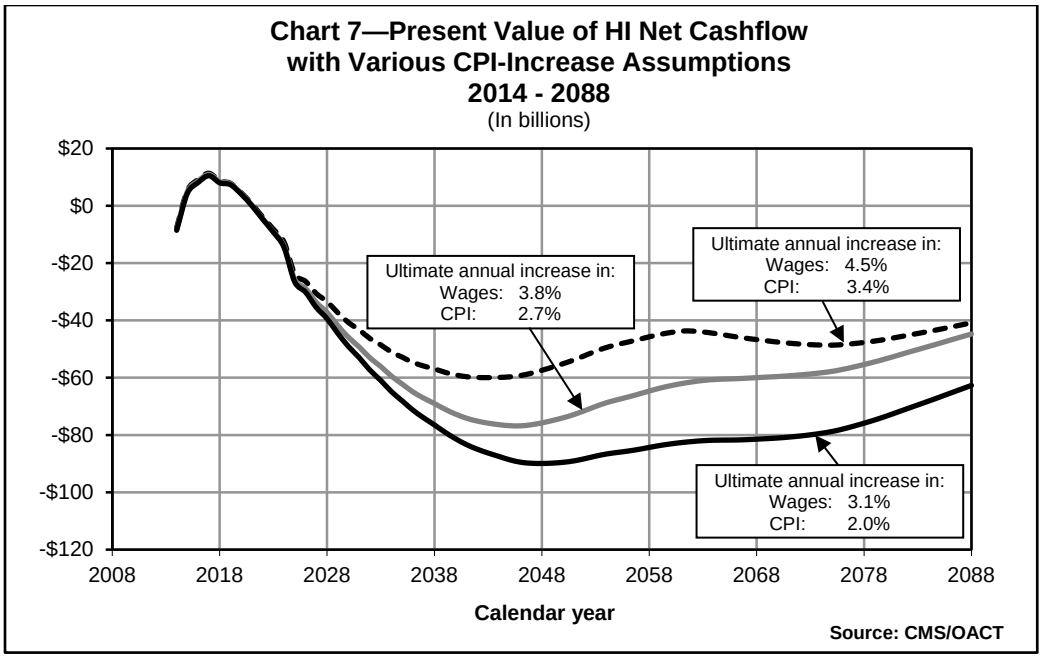
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.4, 2.7, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.1 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.5, 3.8, and 3.1 percent, respectively.

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

Ultimate percentage increase in wages – CPI	4.5 – 3.4	3.8 – 2.7	3.1 – 2.0
Income minus expenditures (in billions)	$(3,055)	$(3,823)	$(4,780)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.4 percent, the deficit decreases by $767 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $957 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.



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 *Affordable Care Act* 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

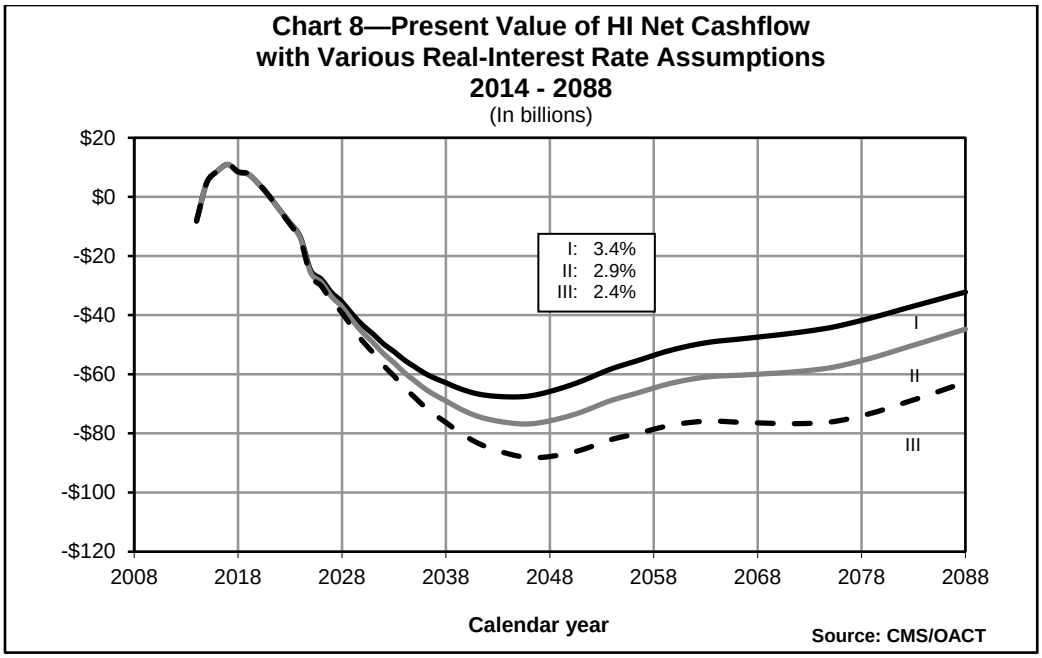
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, which results in ultimate annual yields of 5.1, 5.6, and 6.1 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)	$(4,626)	$(3,823)	$(3,204)

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $140 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.



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 2030. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

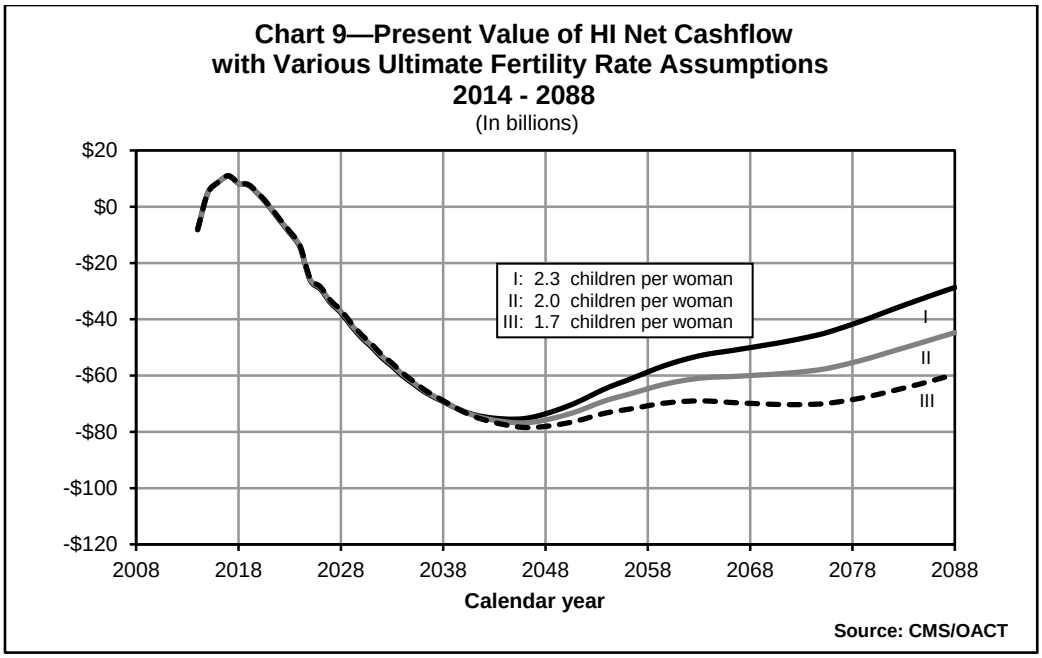
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	$(4,211)	$(3,823)	$(3,426)

[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 $390 billion.

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



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, 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

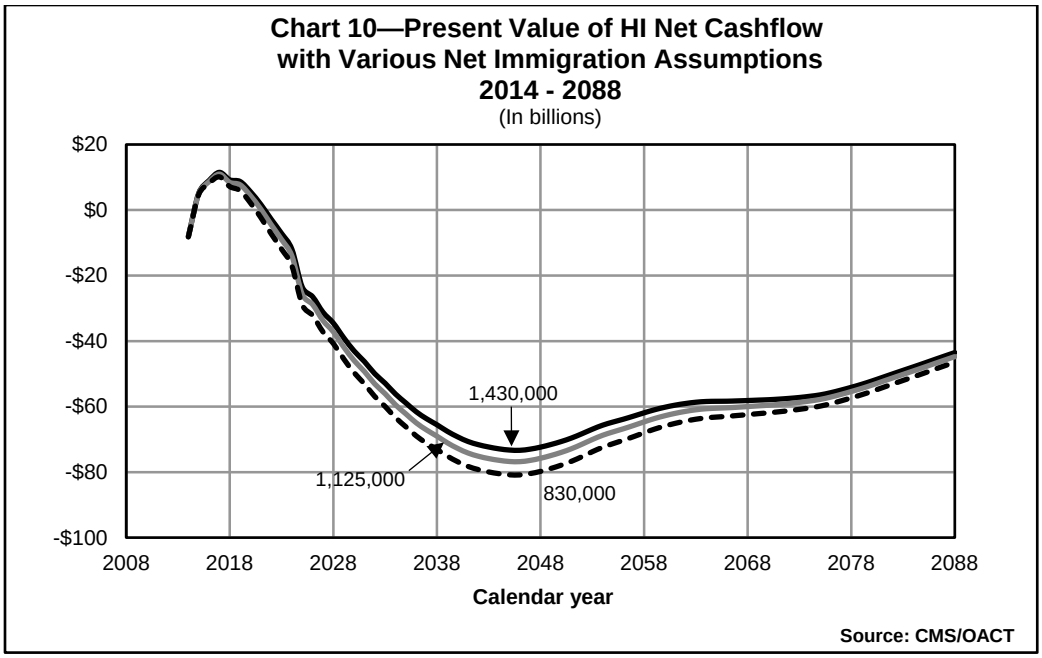
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 830,000 persons, 1,125,000 persons, and 1,430,000 persons per year.

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

Average annual net immigration	830,000	1,125,000	1,430,000
Income minus expenditures (in billions)	$(4,039)	$(3,823)	$(3,654)

As indicated in Table 6, if the average annual net immigration assumption is 830,000 persons, the deficit—expressed in present-value dollars—increases by $216 billion. Conversely, if the assumption is 1,430,000 persons, the deficit decreases by about $168.5 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.



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 estimated depletion date for the HI Trust Fund is 2030, 4 years later than in the 2013 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 2013 were slightly higher than last year's estimate; after 2013, however, projections of earnings throughout the period are lower mostly due to lower assumptions for the GDP deflator and real GDP. HI expenditures in 2013 were significantly lower than the previous estimate, and through 2016 the projected level grows more slowly than shown in last year's report largely due to reductions in utilization assumptions, reflecting recent trends. HI expenditures have exceeded income annually since 2008 and are projected to continue doing so through 2014. The Trustees project slight surpluses in 2015-2022, with a return to deficits thereafter until the fund becomes depleted in 2030. 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. To date, 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-*Affordable Care Act*, 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 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

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 2014 is adequate to cover 2014 expected expenditures and to maintain the financial status of the account in 2014 at a satisfactory level. No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are lower than previously estimated. The difference is primarily attributable to a lower projected drug cost trend, and higher drug rebates, consistent with recent experience.

The Part B and Part D accounts in the SMI Trust Fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and dedicated financing sources[15] is projected to exceed 45 percent of total Medicare outlays under current law within the next 7 fiscal years (2014-2020). If this level is attained within the 7-year timeframe, Federal law requires a determination of projected excess general revenue Medicare funding. For the 2014 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2014-2020 (the first 7 years of the projection), and therefore, the Trustees are not issuing this determination.

The projections shown in this section continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI Trust Fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative, then these further policy reforms will have to address much larger financial challenges than those assumed under the projected baseline scenario. In their 2014 annual report to Congress, the Medicare Board 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 such reforms should not be delayed."

[15] 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.