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- Required Supplementary Information

Financial Section

The Financial Section includes the Department's Principal Financial Statements and the Report of the Independent Auditors. It also contains the Notes to the Principal Financial Statements, Required Supplementary Stewardship Information (RSSI) and Required Supplementary Information (RSI).

MESSAGE FROM THE CHIEF FINANCIAL OFFICER

The Department of Health and Human Services (HHS or the Department) is one of the largest, most complex financial organizations in the world. This Agency Financial Report represents our accountability report for FY 2013. We will issue the FY 2013 Annual Performance Report, the *FY 2015 Congressional Budget Justification* and the *Summary of Performance and Financial Information* in February, 2014.

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

During 2013, we continued in our role as stewards of the public trust and worked together collaboratively to address our challenges. For example:

- Our CFO executives continued to work together as a community to improve financial reporting and systems. We made significant progress to improve controls surrounding governance, oversight, and systems security, reflecting our continued management commitment to maintain full financial accountability, transparency and effective stewardship. As part of this effort, we worked together with the Chief Information Officer community to monitor and remediate corrective actions designed to reduce system and security risks. We continue work to monitor and reduce system and security risks.
- Planned timeframes for correcting audit weaknesses and non-compliances can be found in the Management's Discussion and Analysis section (see "Planned Action Plan and Impact of Material Weakness").
- We continued to refine our reporting processes and successfully performed our annual, internal control assessment as required by OMB Circular A-123, *Management's Responsibility for Internal Control*. We present the Secretary's annual Statement of Assurance in the Management's Discussion and Analysis section of this report, which reflects the results of our assessment and planned corrective actions.
- We successfully launched release two of the Enterprise Financial Business Intelligence System which moved the Department towards improved reporting and management controls. This system provides a business analytics tool to users and management for strategic decision-making at the enterprise level.

This year we obtained a clean opinion on our Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position and the Combined Statement of Budgetary Resources. However, the auditors did not audit nor express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. These statements were developed using information from the *2013 Medicare Trustees Report*, reflect current law, and, are prepared in accordance with the standards issued by the Federal Accounting Standards Advisory Board. Please refer to the Financial Section of this *Agency Financial Report* for further information.

I want to thank our employees and partners. This report and the accomplishments it describes, is a reflection of their extraordinary dedication to our mission. Together, we look forward to further improving the Department's financial management capabilities.

/Ellen G. Murray/
Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
December 16, 2013

REPORT OF THE INDEPENDENT AUDITORS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

DEC 16 2013

TO: The Secretary

Through: DS _____
COS _____
ES _____

FROM: Inspector General Daniel R. Levinson

SUBJECT: OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2013 (A-17-13-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2013 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, 2013 and 2012, 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, 2013, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the *Government Auditing Standards*, issued by the Comptroller General of the United States; and the Office of Management and Budget (OMB) Bulletin 14-02, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2013 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 22 to the financial statements, with respect to the estimates for the Centers for Medicare & Medicaid Services (CMS) Social Insurance Program as of January 1, 2013 and 2012, CMS management

has noted that actual future costs for Medicare are likely to exceed those projections estimated to implement current law, including the Patient Protection and Affordable Care Act (P.L. No. 111-148). The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. As a result, Ernst & Young was unable to obtain sufficient evidential support for the amounts presented in the statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012, to enable them to express an opinion on whether the statements were presented fairly. Ernst & Young provided unqualified opinions on the statement of social insurance as of January 1, 2009.

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

- *Financial Information Management Systems*—Ernst & Young noted that HHS had continued to make strides to improve controls within the Information Technology infrastructure that supports the financial application systems, although additional improvements are still needed. HHS operating divisions continued to address and implement the existing governance, financial process and practices, and system tools needed to enhance controls over application information security and contingency planning. HHS established a standard operating procedure and further implemented automated tools to remediate segregation of duties conflicts among users. HHS also established system-level contingency plans and backup policies and procedures to improve redundancy and the availability of infrastructure that supports financial application systems. As in previous fiscal years, Ernst & Young indicated a focused effort is still needed to more 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, change management, and access to HHS financial systems. The deficiencies found continue to constitute a material weakness in internal control.

- *Financial Reporting Systems, Analyses, and Oversight*—During the FY 2013 audit, Ernst & Young noted continued progress in improving financial management processes. While progress continued, HHS's financial management systems were still not in compliance with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208). The audit identified internal control deficiencies that impact HHS's ability to report accurate financial information on a timely basis. Ernst & Young continued to note that HHS lacks an integrated financial management system, which impairs HHS's and its operating divisions' abilities to adequately support and analyze account balances in a timely fashion. Ernst & Young also found certain controls were not consistently performed and additional improvements were needed in financial reporting systems and processes. During control testing over the Statement of Social Insurance, Ernst & Young

also noted policies and procedures regarding documentation were not always followed. These deficiencies found collectively constitute a significant deficiency in internal control.

Also, given the significant changes in programs effective January 1, 2014, related to the continued implementation of the provisions of the Patient Protection and Affordable Care Act that include the insurance exchanges, premium subsidies, risk corridors, and reinsurance provisions, Ernst & Young also noted the importance of CMS's and HHS's developing accounting policies and procedures early in FY 2014, including internal controls related to significant processes to ensure that resources are properly utilized. In addition, Ernst & Young also noted that CMS and HHS should analyze the impact of those provisions and establish the appropriate accounting treatment in the financial statements.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2013, HHS's management identified that various operating divisions had violated certain provisions of the Anti-Deficiency Act (P.L. No. 101-508) and OMB Circular A-11 related to compensation of time-limited employees appointed under section 207 (f) and 207 (g) of the Public Health Services Act (42 U.S.C § 209 (f) and § 209 (g)). Also, HHS was not currently in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300), the Improper Payment Eliminations and Recovery Act of 2010 (P.L. No. 111-204), and section 6411 of Patient Protection and Affordable Care Act related to the implementation of recovery activities for the Medicare Advantage Program. As noted above, Ernst & Young concluded that HHS also did not comply with the Federal Financial Management Improvement Act of 1996.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 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 2013 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-17-13-00001.

Attachment

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

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

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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, 2013 and 2012, 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, the statements of social insurance as of January 1, 2009, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013, 2012 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, 2013, 2012, 2011 and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012 and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 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, 2013 and 2012, 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, the statement of social insurance as of January 1, 2009 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 22 to the financial statements, the statement of social insurance presents the actuarial present value of the CMS' Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates, and as discussed below, significant additional variability 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 (ACA).

As further described in Note 23 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2013, 2012, 2011 and 2010, management has reflected in the projections of the program the direct impact, but has not fully reflected the secondary impacts of productivity adjustments (reductions in anticipated rates of increase) indicated in the ACA and reductions in Medicare payment rates for physician services mandated in current law. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative

scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long-term sustainability of the social insurance program. In addition, legislation mandating reductions in provider payments has in the past been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. 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, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012.

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, 2013, 2012, 2011 and 2010, and the related changes in the social insurance program for the periods ended January 1, 2013 and 2012.

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, 2013 and 2012, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009, 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, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

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 December 16, 2013, 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/

December 16, 2013

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Building a better working world

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, 2013, 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, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013, and have issued our report thereon dated December 16, 2013. 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, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013.

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

DHHS continued to make strides during fiscal year (FY) 2013 to improve the controls within its supporting information technology (IT) infrastructure and financial application systems. We noted attention amongst 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.

- Established a standard operating procedure and practices to facilitate remediation and further implementation of automated tools, reports, and review mechanisms to prevent and remediate segregation of duties (SoD) conflicts among users.

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

Additionally, the Department has obtained an Agency Authorization to Operate (ATO) utilizing a FedRAMP-accredited Third-Party Assessor Organization (3PAO) for the Amazon Web Services (AWS) GovCloud, which is used by GrantSolutions.

A focused effort is still necessary to more completely remediate the long-outstanding deficiencies 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 NIH Business System (NBS). Specifically, we believe there will be a positive impact from the successful completion of these efforts in these areas.

Building a better working world

The remaining un-remediated deficiencies continue to constitute a material weakness in internal control. These deficiencies fall into the following categories:

- Segregation of Duties – efforts necessary include:
  - completely implementing role-based security
  - establishment of least privileged access considerations for all users, and
  - performance of a onetime clean-up activities for roles in conflict,
- Change management – which consists of:
  - implementation of automated mechanisms to support change management activities
  - verification that changes were not made that did not go through the change approval and management process.

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 – GrantSolutions (GS), UFMS, NBS, IMPACII, Health and Human Services Consolidated Acquisitions Solution (HCAS), Grants Administration Tracking and Evaluation System (GATES), and Enterprise Human Resources & Payroll (EHRP) systems did not document and implement adequate segregation of duties. Process Owners have not completely identified segregation of duty 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. 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 segregation of duties. We found several deficiencies that may result in a potential lack of segregation of duties at both the Medicare fee-for-service contractors and across the enterprise.
- Change Management – CM processes for NBS, HCAS, GATES, GS, and EHRP were insufficient to ensure only properly authorized changes were implemented into production systems. We also found that GATES baseline configuration is not documented for the application and database levels. Some CMS applications did not have adequate segregation of duties as it relates to implementing new program code. In addition, the documentation for authorization, testing, and approval of changes was not retained.

Several vulnerabilities in system configurations, program coding, input validation, and incident response procedures were observed for the Medicare fee-for-service network.

- 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 were not documented. At CMS, we noted that business users for one key application were able to increase their access capabilities, such as maintaining system codes and the system configuration files. Additionally, we noted inconsistent and inappropriate access was granted to certain users for several key applications at CMS, in some cases without a business justification, resulting in the risk of incorrectly configured user profiles and potentially unauthorized changes to Medicare financial data files and programs.

- 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 FY13 FISMA assessment, we performed our procedures at the following OPDIVs: (1) Indian Health Service (IHS), (2) U.S. Food and Drug Administration, (3) National Institutes of Health (NIH), (4) Centers for Medicare & Medicaid Services (CMS), and (5) HHS Office of the Secretary. Our procedures identified the following deficiencies identified across the OPDIVs reviewed:

  – Patch Management – The OPDIVs assessed do not have an effective process for timely implementation of critical system patches.

  – Identity and Access Management – Based on the OPDIVs assessed, the Department needs to standardize identification and access management procedures to provision, recertify and de-provision user accounts.

  – Remote Access Management – Based on the OPDIVs assessed, 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 VPN user account maintenance.

– Plan of Action and Milestones – The assessed OPDIVs' 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

DHHS should continue the focus achieved in FY 2013 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 are documented in a timely manner.

  – 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. In addition, password controls should be implemented consistent with DHHS policy.

  – 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 segregation of duties 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 released into the production environment. Management should periodically review the list of changes made in the production environment and confirming that the changes made have gone through the formal change management process and that only authorized changes were implemented into the production environment.

- We have performed a separate financial statement audit of CMS for FY 2013 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 noted a handful of DHHS 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 2013, our audit identified further progress as HHS continued to implement new processes, upgrade its various legacy systems, improve communication, develop new guidance, hire new experienced personnel, and provide training to address significant long-standing issues. We noted further improvements in controls within the payroll, intragovernmental and Fund Balance with Treasury reconciliation processes. 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 noted above and related processes continued to be developed throughout FY 2013 and will require additional refinements in FY 2014. Within the context of the approximately $900 billion in departmental net outlays, the ultimate resolution of our specific 2013 findings were not material to the financial statements taken as a whole. However, these matters are indicative of systemic issues that must continue to be resolved.

Lack of Integrated Financial Management System

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

- HIGLAS – developed to support the financial activities of the CMS and its Medicare contractors by integrating the CMS contractors' standard claims processing systems and CMS' mainframe-based financial system with a web-based accounting system.

- NBS – developed to support the financial activities at NIH. NIH completed certain aspects of its implementation in FY 2008 and continues to add more ancillary modules in the succeeding years.

- UFMS – developed to support the financial activities at the remaining OPDIVs with full implementation completed in FY 2008. Certain processes to refine the implementation and address systemic issues are ongoing.

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. The lack of an integrated financial management system continues to impair HHS' and its OPDIVs' abilities to adequately support and analyze account balances reported in a timely fashion. Although progress continues to be achieved, HHS' financial management systems are not yet compliant with the FFMIA. Specific deficiencies noted include the following:

- Although significant progress was made with the automation of certain transactions, including intradepartmental delegations of authority (IDDAs), during FY 2013, over 11,000 manual journal vouchers (JVs) in excess of $1.6 trillion in absolute value were required to be recorded in UFMS and NBS to post certain types of transactions – including transactions to record certain proprietary and budgetary entries, record accruals, perform adjustments between governmental and nongovernmental accounts, perform adjustments to agree budgetary to proprietary accounts, perform other reconciliation adjustments at period-end, and correct errors identified related to configuration issues within UFMS and NBS. These entries are postings to UFMS and NBS to record both the proprietary and budgetary effects of certain financial activities for which the financial system may not be configured properly to post automatically. Although these entries are required to be posted to the general ledger in order for the financial statements to be accurate and internal controls over manual vouchers were found to be operating effectively, including supervisory reviews and properly maintained documentation to support each entry, many of these entries should be configured as routine systematic entries within the systems. HHS' management indicated that it continues to develop and implement corrective actions to reduce the number of manual entries in future years. For NBS financial statement closing entries, although the entry is recorded in NBS for financial statement preparation purposes, the entry may be recorded in aggregate and reversed until such time that either the routine process captures the activity or the entries are carried forward to the next reporting period.

- As discussed in further detail above, reviews of general and application controls over financial management systems identified certain departures from requirements specified

in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

- Within a decentralized complex organization like HHS, an integrated financial system with strong internal controls is required for up-to-date accurate financial information needed for certain decision-making responsibilities. Many of the OPDIVs within HHS have their own financial management systems with individual data structures. Accordingly, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. With the implementation of CFRS, certain program, financial, and budgetary consolidated and OPDIV information is pulled into a common system on a quarterly basis; however, more timely and standard information is necessary to respond to congressional requests and for decision-making purposes. In certain cases, the department is required to use surveys or data calls to the OPDIVs or to the specified programs to obtain information for specific requests. Management indicated that with the expansion of certain aspects of CFRS and its continued implementation of the Financial Business Intelligence System, which started in FY 2012, it is working to improve upon its readily available information to support information analysis and to address potential requests from Congress, OMB, the President, and other entities.

- Certain subsidiary systems are not fully integrated with the Unified Financial Management System (UFMS) and are not complemented by sufficient manual preventative and detective type controls. HHS continues to resolve certain system issues within the National Institutes of Health's (NIH) Business System (NBS). As a result, although progress was made in FY 2013, NIH's NBS continues to have certain transactions which are captured incorrectly as compared to the Treasury Standard General Ledger at the transaction level and require adjustments to the accounting records. Additionally, CMS continues its efforts to implement a web-based accounting system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), which integrates the reporting of financial data related to the CMS contractors' standard claims processing systems. HIGLAS is the system of record and CMS is preparing financial statements using HIGLAS, however, the full functionality of HIGLAS may not have been implemented yet. The Medicare Administrative Contractors' (MACs) accounts receivable balances are recorded at Central Office through the manual journal voucher process. In addition, the creation of the periodic financial statements is largely system dependent; however, there is a need for system interventions to properly categorize the information within the financial statements, as required by OMB A-136. Finally, the durable medical equipment (DME) MACs have not implemented HIGLAS. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

Resource limitations and other priorities were noted as causes for delays in upgrading certain system and financial internal control processes limiting HHS' ability to comply with requirements under FFMIA. HHS will need to continue to review its available resources as resources become even more restrained with (1) potential further budget cuts expected in future years, (2) the continued implementation of the Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS) and (3) the continued implementation of new laws, regulations, and policies.

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 differences were properly identified, researched, and resolved in a timely manner, and that account balances were complete and accurate. We noted the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required:

Department/Operating Division Periodic Analysis and Reconciliation

When deficiencies exist in financial systems, as discussed above, management must compensate by implementing and strengthening other manual controls to ensure that errors and irregularities are prevented or detected in a timely manner. These manual and compensating controls would 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 we noted that need enhanced periodic reconciliation and analysis procedures:

- *Departmental Review of OPDIV Financial Statements* – We noted that although desk officers have been assigned the responsibility of reviewing specific OPDIV financial reporting, the desk officers do not consistently review the supporting documentation to ensure that the submissions are accurate or fully supported. In our review of the OPDIV and Department-level draft financial statements, we identified approximately $1.2 billion in differences that could not be identified or were not identified on a timely basis and inconsistencies in disclosures reported within the AFR. Further, we found that certain OMB and Treasury required submissions contained mistakes that were ultimately identified through controls and edit checks located outside of HHS. For example, for the fourth quarter Intergovernmental Reporting submission, HHS had reported $2.8 billion against an incorrect trading partner which was identified when the Treasury system performed the match between agencies.

- *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 2013. Finally, we noted differences (1) between the property subsidiary ledgers and the amounts reported on the financial statements and (2) when the operating division rolled forward its beginning balances to balances reported at year-end.

Policies and Procedures

During our internal control documentation and testing phases, we noted that, although various internal control processes had been changed or updated, the Department had not completed its updating of procedural manuals to ensure sufficient knowledge of financial management systems/processes or consistency and adequacy of internal control exist. 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.

Finally, given the significant changes in programs effective January 1, 2014, related to the continued implementation of the provisions of the ACA (for example, the insurance exchanges, premium subsidies, risk corridors, re-insurance provisions), it is important that HHS and CMS develop accounting policies and procedures early in FY 2014, including internal controls related to the significant processes to ensure that the resources are properly utilized. In addition, HHS and CMS should analyze the impact of the provisions and establish the appropriate accounting treatment in the financial statements.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal

government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters. In general, states pay for the health benefits provided, and the Federal government in turn matches qualified state expenditures based on the Federal medical assistance percentage. The Federal government controls over Medicaid expenditures were designed assuming that the states would have their own set of procedures and controls over program costs and that the states would have an incentive to enforce compliance with their procedures and controls to protect the integrity of their own program costs as well as the expenditures shared by the Federal government.

In recent years, as CMS has separately identified and reconciled the states' annual funds, there has been an increase in the number of adjustments, which have become more difficult to resolve timely, highlighting the weaknesses of their oversight of the program expenditures. As of September 30, 2013, a $1.9 billion accounts receivable and a $1.6 billion accounts payable balance were recorded in the CMS financial statements related to the Medicaid program, some of which dates back to FY 2009 and prior. In FY 2013, CMS has established a protocol to address negative balances and implemented review procedures to compare the quarterly expenditures, budgeted grant awards and quarterly draws. Although the FY 2012 grant finalizations were performed more consistently and timely for the states in 2013, our analyses of this process still identified deficiencies in the Medicaid program.

CMS has been working on a multi-year project to define data and analytics to improve its program and financial management. That program is not operational at a level that it currently provides controls supporting program integrity. CMS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures.

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 December 9, 2013. In that report, we outlined details of deficiencies noted and made recommendations for improvement in their financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies and those related to Medicaid oversight, business partner risk management, and Statement of Social Insurance (SOSI) noted elsewhere in this report to be a significant deficiency for the CMS internal control over financial reporting. Our observations related to financial management controls included:

- CMS failed to timely record, report and return to Treasury approximately $2.2 billion in unobligated borrowing authority for the Consumer Operated and Oriented Plan (CO-OP) program as of September 30, 2012. Although CMS identified the error in January 2013,

the unobligated borrowing authority was not identified and returned to Treasury timely. In addition, the unobligated borrowing authority was not reported correctly in the FACTS II submission to Treasury for fiscal year 2012. In this example, CMS had not implemented appropriate controls around the evaluation of the final amounts of unobligated authority required to be recorded, reported and returned to Treasury.

- 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, for example: (i) identify and document the reasons behind the changes in program expenditures and (ii) corroborating analysis between the changes in Medicare Part C and Part D beneficiaries and the changes in the monthly plan payments.

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 Medicare Administrative Contractors (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), Statement on Standards for Attestation Engagements No. 16, *Reporting on Controls at a Service Organization*, (SSAE 16), 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 relating to: (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 and

are not investigated, as to why they are returned, as there currently is no existing CMS policy that addresses the actions in this circumstance; (3) the claims outstanding greater than one year, as there is no policy or procedure in place to periodically review, track or monitor those aged claims; and (4) the provider records as there are no procedures in place to reconcile, review and monitor provider records, and eligibility status on a periodic basis to verify that all changes were timely, accurately and completely processed.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from or on behalf of those same individuals.

The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model. In recognition of the importance of the underlying data, CMS has developed and implemented a change management process over the SOSI model, which applies to significant changes or changes in the methodology of each model. In addition, CMS' policies and procedures require that the input or output data within the SOSI model are documented to properly understand the flow of the data. During our control testing, we noted that one significant change made to a model and a few instances where the input and output data within the models were not properly documented in accordance with the policy.

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

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

- Continue to advance management initiatives to streamline the processes for responding to financial information requests through implementation of the Enterprise Federal Business Intelligence System and IT system consolidation or standardization to more effectively

utilize CFRS to provide for more timely and up-to-date financial and business information.

- Perform specific and high-level analysis, including the corroboration of the results, over the Medicaid account balances and related expenditures. In addition, the accounts receivable and payable Medicaid balances should be analyzed and validated through the use of a subsidiary ledger.

- Challenge whether the newly implemented protocol and detect controls address the underlying root cause of why states continue to have negative balances within their PMS subaccounts. Evaluate the current protocol and determine if additional procedures and controls should be implemented to continuously monitor the state Medicaid draws and perform grant oversight activities to ensure that the states deposit the funds back after a deferral is issued and report timely, accurately, and consistently on the funds drawn to both CMS and PMS. In addition, CMS should encourage the states to reconcile the FFR, CMS-64 and PMS subaccounts on a timely manner so that they can perform the grant close out process timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority.

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

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the approximately $27.6 billion accrual.

- Establish a policy individual or group to analyze the accounting and reporting of unique, non-routine or significant transactions, enhance the financial reporting process, address or identify transactions that required cross-functional input as well as to develop robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. Enhancement of this process may assist to develop, document and validate the new critical accounting matters that are identified during the year and improve the timeliness, accuracy and completeness of the white papers. Prepare required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders. The internal controls and financial reporting implications of the significant provisions of ACA that commence in fiscal year 2014 require management's attention and may need to be addressed prior to formalizing further changes to the white paper process.

- Continue to develop and implement policies and procedures within the budget and financial reporting process to ensure that the unobligated authority required to be returned to Treasury is determined and finalized timely.

- Revise and enhance the design of the financial review guidance provided to the various Centers, regional offices and MACs to incorporate more analyses and scrutiny in the review of the financial information.

- Improve the contingent liability process to ensure that sufficient documentation is maintained to support or corroborate management's conclusions and to evidence that the controls are operating effectively and as designed.

- Consider expediting the CERT, PERM, Part C and Part D error rate development, analysis, and reporting so that a more thorough analysis of the findings and plans for remediation can be completed prior to the required reporting deadline. Error rate results should be developed at a sufficient level of detail to analyze specific causes, scrutinize contributing factors and identify anomalies to begin investigations of the root causes of the errors and prevention, mitigation and recovery plans.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are consistently documented. Adherence to these policies will ensure that the model is evaluated to verify that the input/output data is appropriate based on the expected results of the data and spreadsheet changes and the model is accurate and complete.

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.

Building a better working world

Status of Prior-Year Findings

In the reports on the results of the FY 2012 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	• Non-CMS OPDIV Financial Management Information Systems • Non-CMS OPDIV Application Security Management • CMS Information Systems Controls	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, including improvements within the payroll, intra-governmental and Fund Balance with Treasury Reconciliation areas. However, certain issues identified require continued focus. Modified Repeat Condition

HHS' Response to Findings

HHS' response to the findings identified in our audit and examination are included in its letter dated December 16, 2013, 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/

December 16, 2013

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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, 2013, 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, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013, and have issued our report thereon dated December 16, 2013. 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, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013.

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 year (FY) 2013, HHS' management determined that various operating divisions had violated certain provisions of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to compensation of time-limited employees appointed under sections 207(f) and 207(g) of the Public Health Service Act (42 U.S.C. § 209(f) and § 209(g), respectively.

Additionally, the Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300) as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 (P.L. 111-204) 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. 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); and the Medicare Fee-For-Service error rate is greater than the statutorily required maximum of 10 percent. As for improper payment estimates in the TANF program, HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement due to Section 411 of the Social Security Act which specifies the data elements that HHS may require states to report and Section 417 of the same Act dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS feels that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the Act. In addition, 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. To date, HHS has received and analyzed comments related to a Part C recovery audit contractor program, continues to explore implementation options and anticipates executing a contract in FY 2014.

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

- Certain subsidiary systems are not fully integrated with the Unified Financial Management System (UFMS) and are not complemented by sufficient manual preventative and detective type controls. HHS continues to resolve certain system issues within the National Institutes of Health's (NIH) Business System (NBS). As a result, although progress was made in FY 2013, NIH's NBS continues to have certain transactions which are captured incorrectly as compared to the Treasury Standard General

Ledger at the transaction level and require adjustments to the accounting records. Additionally, although CMS has determined its Healthcare Integrated General Ledger Accounting System (HIGLAS) to be substantially compliant with FFMIA, the Medicare Administrative Contractors' (MACs) accounts receivable balances are being recorded at Central Office through the manual journal voucher process. In addition, the creation of the periodic financial statements is largely system dependent; however, there is a need for system interventions to properly categorize the information within the financial statements, as required by OMB A-136. Finally, the durable medical equipment (DME) MACs have not implemented HIGLAS. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

- During fiscal year 2013, thousands of manual journal vouchers were required to be recorded in UFMS/NBS to post certain types of transactions, including budgetary and proprietary, not currently configured correctly within UFMS and for the purpose of developing monthly financial statements.

- Certain reconciliations and clearance of differences are not completed timely due to the use of ad hoc inquiries and system limitations on matching debits and credits to resolve certain issues.

- Although progress was noted, reviews of general and application controls over financial management systems identified certain departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*. Additionally, the Office of Inspector General (OIG) identified certain issues, including access control deficiencies related to systems as part of its Federal Information Security Management Act and other OIG engagements. Finally, HHS management has identified certain weaknesses within its information technology general and application controls during its assessment of corrective action status and its OMB A-123 processes.

- Currently, accurate information needed for decision-making at all levels of the organization may not be readily available on a day-to-day or even monthly basis as required by FFMIA. HHS is currently working on implementing the Enterprise Financial Business Intelligence System (FBIS) to provide access to more timely information to support decision-making.

* * * * *

HHS' Response to Findings

Our Report on Internal Control dated December 16, 2013, 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 December 16, 2013. We did not audit management's comments and, accordingly, we express no opinion on them. Additionally, HHS is updating its agency-wide corrective action plan to address FFMIA and other financial management issues.

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/

December 16, 2013

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 2013 Financial Statement Audit

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

We appreciate the opportunity to comment on the draft reports provided to us. We generally concur with the findings in the Final Report which has been included in this FY 2013 *Agency Financial Report*. In response to your reports, we will prepare corrective action plans to address the identified findings within the next 60 days.

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

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
December 16, 2013

PRINCIPAL FINANCIAL STATEMENTS

U.S. Department of Health and Human Services

Consolidated Balance Sheet

As of September 30, 2013 and 2012

(in Millions)

	2013	2012
Assets (Note 2)		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 3)	$ 159,192	$ 197,348
Investments, Net (Note 4)	281,723	306,381
Accounts Receivable, Net (Note 5)	3,649	820
Advances (Note 8)	103	48
Total Intragovernmental Assets	444,667	504,597
Accounts Receivable, Net (Note 5)	10,933	10,943
Inventory and Related Property, Net (Note 6)	8,602	8,072
General Property, Plant and Equipment, Net (Note 7)	5,364	5,401
Advances (Note 8)	34	1,244
Other Assets	655	396
Total Assets	$ 470,255	$ 530,653
Stewardship Property, Plant and Equipment (Note 1)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 565	$ 659
Other Liabilities (Note 13)	2,009	1,430
Total Intragovernmental Liabilities	2,574	2,089
Accounts Payable	662	425
Entitlement Benefits Due and Payable (Note 10)	77,277	72,493
Accrued Grant Liability (Note 12)	3,949	3,748
Federal Employee and Veterans' Benefits (Note 11)	11,566	11,008
Contingencies and Commitments (Note 14)	8,900	6,766
Other Liabilities (Note 13)	2,581	2,962
Total Liabilities	107,509	99,491
Net Position		
Unexpended Appropriations - Funds from dedicated collections (Note 21)	4,469	20,418
Unexpended Appropriations - Other funds	105,728	135,768
Unexpended Appropriations, Total	110,197	156,186
Cumulative Results of Operations - Funds from dedicated collections (Note 21)	243,996	267,009
Cumulative Results of Operations - Other funds	8,553	7,967
Cumulative Results of Operations, Total	252,549	274,976
Total Net Position	362,746	431,162
Total Liabilities and Net Position	$ 470,255	$ 530,653

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, 2013 and 2012
(in Millions)

	2013	2012
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 848,967	$ 802,301
Exchange Revenue (Note 16)	(69,745)	(65,078)
CMS Net Cost of Operations	779,222	737,223
Other Segments:		
Administration for Children and Families (ACF)	50,566	49,143
Administration for Community Living (ACL)	1,449	1,488
Agency for Healthcare Research and Quality (AHRQ)	606	635
Centers for Disease Control and Prevention (CDC)	10,771	10,380
Food and Drug Administration (FDA)	3,394	3,250
Health Resources and Services Administration (HRSA)	8,720	8,653
Indian Health Service (IHS)	5,551	6,726
National Institutes of Health (NIH)	30,691	31,834
Office of the Secretary (OS)	3,900	3,684
Program Support Center (PSC)	1,636	1,774
Substance Abuse and Mental Health Services Administration (SAMHSA)	3,432	3,480
Other Segments Gross Cost of Operations before Actuarial Gains and Losses	$ 120,716	$ 121,047
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan (Note 11)	230	497
Other Segments Gross Cost of Operations after Actuarial Gains and Losses	$ 120,946	$ 121,544
Exchange Revenue (Note 16)	(3,918)	(3,220)
Other Segments Net Cost of Operations	117,028	118,324
Net Cost of Operations (Note 16)	$ 896,250	$ 855,547

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
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2012
(in Millions)

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

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

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2013 and 2012
(in Millions)

	2013		2012	
	Budgetary	Non-Budgetary Credit Reform Financing Account	Budgetary	Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated Balance, Brought Forward, Oct 1	$ 80,780	$ 3,175	$ 51,730	$ 71
Recoveries of Prior Year Unpaid Obligations	24,598	-	25,746	-
Other Changes in Unobligated Balance	(1,221)	(1)	(4,524)	-
Unobligated Balance from Prior Year Budget Authority, Net	104,157	3,174	72,952	71
Appropriations (Discretionary and Mandatory)	1,193,733	-	1,191,860	-
Borrowing Authority (Discretionary and Mandatory) (Note 17)	-	(2,064)	-	3,194
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	25,409	(685)	20,122	1,636
Total Budgetary Resources	$ 1,323,299	$ 425	$ 1,284,934	$ 4,901
Status of Budgetary Resources:				
Obligations Incurred (Note 18)	$ 1,281,722	$ 314	$ 1,204,154	$ 1,726
Unobligated Balance, End of Year:				
Apportioned	29,993	40	71,919	3,134
Exempt from Apportionment	2,059	-	184	-
Unapportioned	9,525	71	8,677	41
Total Unobligated Balance, End of Year	41,577	111	80,780	3,175
Total Budgetary Resources	$ 1,323,299	$ 425	$ 1,284,934	$ 4,901
Change in Obligated Balance:				
Unpaid Obligations:				
Unpaid Obligations, Brought Forward, Oct 1	$ 180,754	$ 1,602	$ 188,534	$ -
Obligations Incurred (Note 18)	1,281,722	314	1,204,154	1,726
Outlays (Gross)	(1,249,330)	(668)	(1,186,188)	(124)
Actual Transfers, unpaid obligations	106	-	-	-
Recoveries of Prior Year Unpaid Obligations	(24,598)	-	(25,746)	-
Unpaid Obligations, End of Year	$ 188,654	$ 1,248	$ 180,754	$ 1,602
Uncollected Payments:				
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (10,103)	$ (1,587)	$ (10,360)	$ -
Change in Uncollected Customer Payments from Federal Sources	(915)	1,051	257	(1,587)
Uncollected Payments from Federal Sources, End of Year	$ (11,018)	$ (536)	$ (10,103)	$ (1,587)
Memorandum (non-add) Entries:				
Obligated Balance, Start of Year	$ 170,651	$ 15	$ 178,174	$ -
Obligated Balance, End of Year	$ 177,636	$ 712	$ 170,651	$ 15
Budget Authority and Outlays, Net:				
Budget Authority, Gross (Discretionary and Mandatory)	$ 1,219,142	$ (2,749)	$ 1,211,982	$ 4,830
Actual Offsetting Collections (Discretionary and Mandatory)	(24,812)	(366)	(20,291)	(48)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	(915)	1,051	257	(1,587)
Budget Authority, Net (Discretionary and Mandatory)	$ 1,193,415	$ (2,064)	$ 1,191,948	$ 3,195
Outlays, Gross (Discretionary and Mandatory)	$ 1,249,330	$ 668	$ 1,186,188	$ 124
Actual Offsetting Collections (Discretionary and Mandatory)	(24,812)	(366)	(20,291)	(48)
Outlays, Net (Discretionary and Mandatory)	1,224,518	302	1,165,897	76
Distributed Offsetting Receipts	(336,655)	-	(317,777)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 887,863	$ 302	$ 848,120	$ 76

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

U.S. Department of Health and Human Services

Statement of Social Insurance

75-Year Projection as of January 1, 2013 and Prior Base Years
(in Billions)

	Estimates from Prior Years				
	(unaudited) 2013	(unaudited) 2012	(unaudited) 2011	(unaudited) 2010	2009
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 22 and 23)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 8,147	$ 7,929	$ 7,581	$ 7,216	$ 6,348
SMI Part B	15,227	14,431	13,595	12,688	16,323
SMI Part D	5,871	5,866	6,438	6,355	6,144
Have attained eligibility age (age 65 and over)					
HI	301	302	262	248	209
SMI Part B	2,620	2,395	2,122	1,972	1,924
SMI Part D	722	694	695	646	595
Those expected to become participants					
HI	7,744	7,367	7,260	6,944	5,451
SMI Part B	3,530	3,333	3,223	3,077	4,909
SMI Part D	2,617	2,568	2,817	2,714	2,632
All current and future participants					
HI	16,192	15,598	15,104	14,408	12,008
SMI Part B	21,377	20,159	18,940	17,737	23,156
SMI Part D	9,211	9,128	9,950	9,715	9,371
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 22 and 23)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 14,629	$ 14,919	$ 12,887	$ 12,032	$ 18,147
SMI Part B	15,075	14,303	13,489	12,587	16,342
SMI Part D	5,871	5,866	6,438	6,355	6,144
Have attained eligibility age (age 65 and over)					
HI	3,422	3,369	2,923	2,648	2,958
SMI Part B	2,887	2,646	2,343	2,166	2,142
SMI Part D	722	694	695	646	595
Those expected to become participants					
HI	2,913	2,891	2,546	2,411	4,673
SMI Part B	3,415	3,211	3,108	2,984	4,672
SMI Part D	2,617	2,568	2,817	2,714	2,632
All current and future participants					
HI	20,963	21,179	18,356	17,090	25,778
SMI Part B	21,377	20,159	18,940	17,737	23,156
SMI Part D	9,211	9,128	9,950	9,715	9,371
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 22 and 23)					
HI	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)	$ (13,770)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 22 and 23)					
HI	$ (4,772)	$ (5,581)	$ (3,252)	$ (2,683)	$ (13,770)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	220	244	272	304	321
SMI Part B	66	80	71	76	59
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 22 and 23)					
HI	$ (4,551)	$ (5,337)	$ (2,980)	$ (2,378)	$ (13,449)
SMI Part B	66	80	71	76	59
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)
75-Year Projection as of January 1, 2013 and Prior Base Years
(in Billions)

	Estimates from Prior Years				
	(unaudited) 2013	(unaudited) 2012	(unaudited) 2011	(unaudited) 2010	2009
Medical 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)	$ 3,643	$ 3,391	$ 3,079	$ 2,866	$ 2,729
Expenditures	7,031	6,709	5,961	5,459	5,695
Income less expenditures	(3,388)	(3,319)	(2,882)	(2,593)	(2,967)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	29,244	28,227	27,615	26,259	28,815
Expenditures	35,574	35,088	32,814	30,974	40,634
Income less expenditures	(6,330)	(6,861)	(5,199)	(4,715)	(11,819)
Actuarial present value of estimated future income (excluding interest) less Expenditures (closed-group measure)	(9,718)	(10,180)	(8,081)	(7,308)	(14,786)
Combined Medicare Trust Fund assets at start of period	288	325	344	381	381
Actuarial present value of estimated future income (excluding interest) less Expenditures plus Trust Fund assets at start of period	(9,430)	(9,855)	(7,737)	(6,927)	(14,405)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	13,891	13,268	13,300	12,735	12,991
Expenditures	8,945	8,669	8,471	8,109	11,976
Income less expenditures	4,946	4,599	4,829	4,626	1,016
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,772)	(5,581)	(3,252)	(2,683)	(13,770)
Combined Medicare Trust Fund assets at start of period	288	325	344	381	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus Trust Fund assets at start of period	$ (4,484)	$ (5,256)	$ (2,908)	$ (2,302)	$ (13,390)

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 September 30, 2013

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 24)*					
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 24)*					
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 24)*					
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 24)*					
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.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (unaudited)
For the Two Year Period Ending September 30, 2013
Medicare Hospital and Supplementary Medical Insurance
(in Billions)

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

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

NOTES TO THE PRINCIPAL FINANCIAL STATEMENTS

For the years ended September 30, 2013 and 2012

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 eleven 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:

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

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

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' financial records using an accrual basis in conformity with accounting principles generally accepted in the United States (U.S.). The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants (AICPA) as federal GAAP. These statements are, therefore, different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on an accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed, without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 250 appropriations and fund accounts. The fund accounts include accounts used for suspense, collection of receipts and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheet and Statements of Net Cost and Changes in Net Position. The Combined Statements of Budgetary Resources are presented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from these statements. Supplemental information is accumulated from the OPDIVs' reports, regulatory reports and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

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.

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.

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

E. Reclassifications and Adjustments

Certain FY 2012 balances have been reclassified to conform to FY 2013 financial statement presentations. The effects are immaterial. In accordance with OMB Circular A-136, the format of the Combined Statement of Budgetary Resources changed in FY 2013; therefore, the FY 2012 balances have been presented in the FY 2013 format.

F. Funds from Dedicated Collections

On June 1, 2012 the Federal Accounting Standards Advisory Board (FASAB) issued Statement of Federal Financial Accounting Standard (SFFAS) Number 43, *Funds from Dedicated Collections: Amending Statement of Federal Financial Accounting Standard 27, Identifying and Reporting Earmarked Funds.* This Statement amended SFFAS Number 27 by changing the term "earmarked funds" to "funds from dedicated collections" and clarifying certain aspects of the requirements.

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources which remain available over time. Dedicated collections must meet the following criteria:

- 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;
- Explicit authority for the dedicated collections 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
- A requirement to account for and report on the receipt, use and retention of the revenues and other financing sources that distinguishes the dedicated collections from the Federal Government's general revenues.

HHS' 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 Internal Revenue Service, Employer's Quarterly Federal Tax Return, as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Medicare SMI Trust Fund. Medicare contractors are paid by HHS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end–stage renal disease treatment, rural health clinics, laboratory services and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. A portion of HHS payments to Medicare Advantage Plans is also charged to this fund. The financial statements include SMI Trust Fund activities administered by the Treasury. The SMI Trust Fund has permanent indefinite authority.

SMI benefits and administrative expenses are 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 Supplementary Medical Insurance Trust Fund – Part D, Prescription Drug Benefit. The Prescription Drug Benefit makes a prescription drug benefit available to all Medicare beneficiaries who opt into the program. 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 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 three programs with borrowing authority: the CMS Consumer Operated and Oriented Plan (CO-OP) Loan Program, the Health Center Loan Program and the Health Education Assistance Loan Program.

- **Direct Loans.** Under the *Patient Protection and Affordable Care Act*, 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.
- **Loan Guarantees**. HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loan Programs. Loans receivable represent defaulted guaranteed loans which have been paid to lenders under these programs and also include interest due to HHS on the defaulted loans. The liabilities for loan guarantees are valued at the present value of the cash outflows from HHS less the present value of related inflows.

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

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' 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' 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 Treasury, 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 and 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 Internal Revenue Service for outlay to the States for child support. This funding represents delinquent child support payments withheld from federal tax refunds. The FDA custodial activity involves collections of Civil Monetary Penalties (CMP) assessed by the Department of Justice 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 Bills issued by the Bureau of Public Debt. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS' intent to hold investments to maturity.

The *Children's Health Insurance Program Reauthorization Act* (CHIPRA) established a Child Enrollment Contingency Fund to provide additional funding to States that experience shortfalls in their Children's Health Insurance Programs (CHIP). The *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 (SSFs) for sale to HHS components and other federal entities. Inventories Held for Sale are valued at historical cost using the weighted average valuation method for the PSC SSF's inventories and using the moving average valuation method for the NIH SSF's inventories.

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

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Vaccines for Children (VFC) and Avian Influenza (H5N1). The H5N1 vaccine stockpile is held in reserve to respond to an avian pandemic declaration. The stockpile contains several million doses of vaccine in bulk which 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.

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' 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' 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' 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. Fiduciary Activities

Effective FY 2009, the SFFAS Number 31, *Accounting for Fiduciary Activities*, requires federal entities to distinguish the information relating to fiduciary activities of the federal entity from all other activities. The fiduciary activities are Federal Government activities that relate to the collection or receipt and the subsequent management, protection, accounting, investment and disposition of cash or other assets in which non-federal individuals or entities have an ownership interest that the Federal Government must uphold. HHS does not have reportable activities as defined by SFFAS Number 31.

U. 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.

V. Entitlement Benefits Due and Payable

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

Medicare

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

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

HHS develops estimates for medical costs IBNR using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption and other medical cost trends. HHS estimates liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, HHS re-examines previously established medical cost payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, HHS adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, HHS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

Medicaid

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

W. 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.

X. 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.

Y. Statement of Social Insurance

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic and health care-specific conditions. The projected potential future income and expenditures under current law are not included in the accompanying Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position or Combined Statement of Budgetary Resources.

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the Trust Funds will continue to operate under the law in effect 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 SOSI actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2013*. 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.

Z. 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.

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

Pre-existing Condition Insurance Plan Program

This program offers coverage to uninsured Americans who have been unable to obtain health coverage because of a pre-existing health condition. This program is administered directly by States or by the Federal Government in those states that do not operate their own programs. Congress appropriated $5 billion for the life of this interim program, which enables coverage until the Marketplaces become operational in 2014.

The *Affordable Care Act* provides the HHS Secretary significant authorities to ensure the financial sustainability of this program, including, under Section 1101 Paragraph (g) (2), the authority to eliminate deficits under the program if available funds are less than estimated expenses. The Secretary also has the authority under Paragraph (g) (4) to stop taking applications to comply with funding limitations, and in February 2013, CMS announced it would stop accepting applications in both the Federally-run and State-run programs.

Early Retiree Reinsurance Program

Pursuant to the *Affordable Care Act*, HHS established a temporary reinsurance program to reimburse a portion of the employer cost of providing health insurance coverage for early retirees. The *Affordable Care Act* imposes limitations on the amounts of such reimbursements per claim. Congress appropriated $5 billion for the life of this program. The *Affordable Care Act* authorizes the HHS Secretary to stop taking applications for participation in the program based on the availability of funding. On June 29, 2010, HHS began accepting applications from employers. The program permits approved applicants to submit for reimbursement expenses incurred after June 1, 2010. Based on the large number of approved applications and the rate of reimbursement, and in anticipation of the complete distribution of Early Retiree Reinsurance Program (ERRP) funds, the program ceased accepting applications for participation in the program on May 6, 2011. The program will end in 2014, and CMS issued a Federal Register notice on March 21, 2012, indicating that plan sponsors are expected to use ERRP funds by December 31, 2014.

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, 2013, HHS has awarded about $4.1 billion to date in cumulative Marketplace grants to states, including Establishment grants to 37 states and D.C.

Consumer Operated and Oriented Plan Program

The CO-OP Program fosters qualified non-profit health insurance issuers created to offer qualified health plans to the individual and small group markets. 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. Congress appropriated $6 billion to carry out this program under the *Affordable Care Act*. In the last two years, Congress has rescinded $4.9 billion from the original appropriations. The FY 2011 April Continuing Resolution rescinded $2.2 billion, the FY 2012 December Omnibus Appropriation rescinded an additional $0.4 billion, and the American Taxpayer Relief Act rescinded $2.3 billion. CO-OP Program loans have been awarded in 24 states.

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

	2013	2012
Non-Entity Intragovernmental Assets		
Fund Balance with Treasury	$ -	$ 1
Accounts Receivable	11	6
Total Non-Entity Intragovernmental Assets	11	7
Accounts Receivable With the Public	30	22
Total Non-Entity Assets	41	29
Total Entity Assets	470,214	530,624
Total Assets	$ 470,255	$ 530,653

Note 3. Fund Balance with Treasury (in Millions)

Fund Balance with Treasury	2013	2012
Trust Funds	$ 9,916	$ 23,544
Revolving Funds	1,263	1,205
Appropriated Funds	147,965	171,893
Other Funds	48	706
Total	$ 159,192	$ 197,348

Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 32,092	$ 75,237
Unavailable	9,596	8,718
Obligated Balance not yet Disbursed	178,348	170,666
Non-Budgetary Fund Balance with Treasury	(60,844)	(57,273)
Total	$ 159,192	$ 197,348

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 $13.0 billion and $16.3 billion as of September 30, 2013 and September 30, 2012, respectively. The restricted amount is primarily for the *Affordable Care Act* programs, Children's Health Insurance Program, CMS Program Management, State Grants and Demonstrations and the Recovery Act Health Information Technology Program. In FY 2013, $21.5 billion was apportioned under the *Affordable Care Act*, of which $9.6 billion is restricted for future use.

The Non-Budgetary FBWT negative balances reported for September 30, 2013 and 2012 are primarily due to CMS Medicare Trust Funds temporarily precluded from obligation.

Note 4. Investments, Net (in Millions)

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

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

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, 2014 through June 30, 2026, with interest rates ranging from 1.75 percent to 6.5 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2014, with an interest rate of 2.375 percent.

Securities held by the Vaccine Injury Compensation Trust Fund (funds from dedicated collections) will mature through fiscal year 2019. The Market-Based Notes paid from 1.0 percent to 4.125 percent during October 1, 2012 to September 30, 2013 and 1.875 percent to 4.125 percent during October 1, 2011 to September 30, 2012. The Market-Based Bonds pay 9.125 percent through FY 2018.

The Market Based Bills held in the NIH gift funds during the fiscal year ended September 30, 2013, yielded from 0.04 percent to 0.15 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, 2013, 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)

2013	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees 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	4,580	13	2	4,595	(908)	3,687
Non-Entity	52	2	-	54	(24)	30
Total With the Public	$ 13,443	$ 15	$ 2	$ 13,460	$ (2,527)	$ 10,933

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

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

	2013	2012
Inventory Held for Current Sale, Net	$ 8	$ 12
Operating Materials and Supplies Held for Use	113	129
Stockpile Materials Held for Emergency or Contingency	8,481	7,931
Inventory and Related Property, Net	$ 8,602	$ 8,072

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

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 (Note 15)	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

2012

	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 52	$ -	$ 52
Construction in Progress	-	-	704	-	704
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	5,648	(2,282)	3,366
Equipment	Straight Line	3-20 Yrs	1,783	(999)	784
Internal Use Software	Straight Line	7-10 Yrs	1,131	(732)	399
Assets Under Capital Lease (Note 15)	Straight Line	1-30 Yrs	119	(46)	73
Leasehold Improvements	Straight Line	*Life of Lease	49	(26)	23
Totals			$ 9,486	$ (4,085)	$ 5,401

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

Note 8. Advances (in Millions)

	2013	2012
Intragovernmental		
Advances to Other Federal Entities	$ 103	$ 48
With the Public		
Travel Advances & Emergency Employee Salary Advances	$ 1	$ 1
Part D Prescription Drug Plan	-	1,188
Other Prepayments & Deferred Charges	33	55
Total With the Public	$ 34	$ 1,244

The decrease in advances is primarily due to the advance payments of $1.2 billion made in September of FY 2012 for Part D Prescription Drug Plan services provided in October of FY 2013. This advance payment was not necessary in FY 2013.

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

	2013	2012
Intragovernmental		
Accrued Payroll and Benefits	$ 63	$ 62
Other	174	170
Total Intragovernmental	$ 237	$ 232
Federal Employee and Veterans' Benefits (Note 11)	11,566	11,008
Accrued Payroll and Benefits	603	638
Contingencies and Commitments (Note 14)	8,900	6,766
Other	165	110
Total Liabilities Not Covered by Budgetary Resources	$ 21,471	$ 18,754
Total Liabilities Covered by Budgetary Resources	86,038	80,737
Total Liabilities	$ 107,509	$ 99,491

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

	2013	2012
Medicare	$ 48,614	$ 46,436
Medicaid	27,588	24,955
Other	1,075	1,102
Totals	$ 77,277	$ 72,493

Medicare benefits payable consists of a $38.7 billion estimate ($38.8 billion in FY 2012) of Medicare services incurred, but not paid as of September 30, 2013, calculated by the CMS Office of the Actuary.

Medicare Advantage and Prescription Drug Program benefits payable consists of $8.2 billion in FY 2013 ($5.3 billion in FY 2012) consists of a $4.5 billion estimate ($2.8 billion in FY 2012) for amounts owed to plans relating to risk and other payment-related adjustments and $3.7 billion in FY 2013 ($2.5 billion in FY 2012) owed to plans after the completion of the Prescription Drug payment reconciliation.

The Medicare Retiree Drug Subsidy (RDS) consists of a $1.7 billion estimate ($2.4 billion in FY 2012) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2013. As part of the *Medicare Modernization Act*, the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen employer- and union-based retiree prescription drug plans.

Medicaid benefits payable of $27.6 billion as of September 30, 2013 ($25.0 billion in FY 2012) is an estimate of the net federal share of expenses that have been incurred by the states but not yet reported to HHS. This estimate incorporates claim activity tracked under *Recovery Act* of $0.2 billion ($0.2 billion in FY 2012). An estimated CHIP benefits payable of $0.7 billion has been recorded as of September 30, 2013, ($0.7 billion in FY 2012) for the net federal share of expenses that have been incurred by the states but not yet reported to HHS as of September 30, 2013.

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

	2013	2012
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 10,712	$ 10,131
PHS Commissioned Corp Post-retirement Health Benefits	561	603
Workers' Compensation Benefits (Actuarial FECA Liability)	293	274
Total, Federal Employee and Veterans' Benefits	$ 11,566	$ 11,008

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,778 active duty officers and 6,330 retiree annuitants and survivors. As of September 30, 2013, the actuarial accrued liability for the retirement benefit plan was $10.7 billion and $0.6 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commission Corp Retirement System and Post-Retirement Benefits are not funded. Therefore, in accordance with SFFAS Number 33, the discount rate should be based on long-term assumptions, for marketable securities (such as Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cashflow. A single discount rate may be used for all the projected cashflows, if the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2013 and September 30, 2012, were:

	2013	2012
Interest on federal securities	4.68 percent	4.88 percent
Annual basic pay scale increase	2.90 percent	2.92 percent
Annual inflation	2.40 percent	2.42 percent

The following shows key valuation results as of September 30, 2013 and 2012, 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, 2013 and actuarial assumptions. The September 30, 2013 valuation includes an increase in liabilities of $539 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.

	2013	2012
Beginning Liability Balance	$ 10,734	$ 9,950
Expense		
Normal Cost	$ 263	$ 240
Interest on the liability balance	491	475
Actuarial (Gain)/Loss		
From experience	(18)	182
From assumption changes		
Change in discount rate assumption	282	294
Change in inflation/salary increase assumption	(29)	(87)
Change in Others	(5)	108
Net Actuarial (Gain)/Loss	230	497
Total expense	$ 984	$ 1,212
Less amounts paid	(445)	(428)
Ending Liability Balance	$ 11,273	$ 10,734

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 2013, 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 2013, projected annual payments were discounted to present value based on OMB's interest rate assumptions which were interpolated to reflect the average duration in years for income payments and medical

payments. In FY 2012 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, 2013 and September 30, 2012 appear below.

	2013	2012
Wage Benefits	2.727% in Year 1 3.127% in Year 2 and thereafter	2.293% in Year 1 3.138% in Year 2 and thereafter
Medical Benefits	2.334% in Year 1 2.860% in Year 2 and thereafter	2.293% in Year 1 3.138% 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
2013	N/A	N/A
2014	1.67%	3.46%
2015	1.80%	3.82%
2016	2.20%	3.83%
2017	2.20%	3.82%
2018	2.20%	3.82%

Note 12. Accrued Grant Liability (in Millions)

	2013	2012
Estimated Accrual for Amounts Due to Grantees	$ 22,410	$ 21,994
Offsetting Grant Advances	(18,461)	(18,246)
Net Accrued Grant Liability	$ 3,949	$ 3,748

Note 13. Other Liabilities (in Millions)

	2013		2012	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Accrued Payroll & Benefits	$ 101	$ 983	$ 115	$ 1,103
Advances from Others	360	98	315	125
Deferred Revenue	-	445	-	455
Capital Lease Liability (Note 15)	59	19	63	20
Custodial Liabilities	930	18	736	15
Other	559	1,018	201	1,244
Total Other Liabilities	$ 2,009	$ 2,581	$ 1,430	$ 2,962

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

The Medicaid amount of $6.1 billion ($3.9 billion in FY 2012) consists of Medicaid audit and program disallowances of $3.0 billion ($1.9 billion in FY 2012) and of $3.1 billion ($2.0 billion in FY 2012) 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 7,124 cases (5,041 in FY 2012) remaining on appeal as of September 30, 2013. In FY 2013, a total of 3,907 new cases were filed (652 in FY 2012). The PRRB rendered decisions on 210 cases in FY 2013 (98 in FY 2012); and 1,623 additional cases (2,215 in FY 2012) 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.

Obligations Related to Canceled Appropriations

Payments may be required of up to one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been canceled pursuant to the *National Defense Authorization Act*. The total potential payments related to canceled appropriations are estimated at $1.1 billion as of both September 30, 2013 and 2012.

Note 15. Leases (in Millions)

Capital Leases

HHS has entered into various capital leases with private entities and with the General Services Administration (GSA) for offices and laboratory space. Lease terms vary from one to 30 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments. Assets under Capital Lease amounts are reported in Note 7, General Property, Plant and Equipment.

Operating Leases

HHS has commitments under various operating leases with private entities and GSA for offices, laboratory space and land. Leases with private entities have initial or remaining non-cancelable lease terms from 1 to 50 years. The GSA leases, in general, are cancelable with 120 days' notice and not included in the table below. Under an operating lease, the cost of the lease is expensed as incurred.

Future Minimum Payments

	2013	2012
Year 1	$ 89	$ 85
Year 2	93	81
Year 3	90	81
Year 4	69	80
Year 5	70	79
After 5 Years	444	482
Total Operating Lease Liability	$ 855	$ 888

Note 16. Revenue (in Millions)

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

2012 Consolidated Gross Cost and Exchange Revenue by Budget Function Classification

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

Exchange Revenue

HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $73.7 billion and $68.3 billion through September 30, 2013 and 2012, respectively. HHS' exchange revenue consists primarily of Medicare premiums collected from beneficiaries. HHS also charges user fees and collects revenues related to reimbursable agreements with other government entities.

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

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

Requirements for Repayments of Borrowings

Borrowings are repaid on nonexpenditure transfers as maturity dates become due. For financing accounts, maturity dates are based on the period of time used in the subsidy calculation, not the contractual term of the loans. There has been repayment of debt in the amount of $0.2 billion FY 2013 (none in FY 2012). As of September 30, 2013, HHS had borrowing authority available of $0.2 billion ($3.1 billion in FY 2012).

Financing Sources for Repayments of Borrowings

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

Other Terms of Borrowing Authority Used

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

Non-Budgetary Credit Reform Financing Account

The negative balance for borrowing authority of $2.1 billion under the FY 2013 Non-Budgetary Credit Reform Financing Account column on the Combined Statement of Budgetary Resources reflects an adjustment occurring in the current year to return FY 2012 indefinite borrowing authority of $2.2 billion that should have been made at September 30, 2012. In addition, the negative balance of $0.7 billion for spending authority from offsetting collections under that column represents a reduction to unfilled orders for a $0.9 billion overstatement at September 30, 2012. These adjustments were immaterial to the HHS financial statements and do not warrant a restatement.

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

	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

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

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the OMB 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 $93.3 billion of budgetary resources obligated for undelivered orders as of September 30, 2013 and $96.8 billion as of September 30, 2012.

Note 19. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances at year end on the Combined 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 Combined 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 Combined 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 $245.0 billion as of September 30, 2013, ($245.4 billion in FY 2012) are included in Investments on the Consolidated Balance Sheet.

Note 20. 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 2013, has not been published, therefore, no comparisons can be made between FY 2013 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2015 President's Budget* is expected to be released in February 2014 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 2012 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2012 from the Appendix in the *FY 2014 President's Budget* for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections) as presented below.

2012	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays (Gross Outlays less Offsetting Collections)
Combined Statement of Budgetary Resources	$ 1,289,835	$ 1,205,880	$ 317,777	$ 1,165,973
Expired Accounts	(8,390)	-	-	-
Other	(1,284)	(52)	(269)	(332)
Budget of the U.S. Government	$ 1,280,161	$ 1,205,828	$ 317,508	$ 1,165,641

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 Combined 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 include an adjustment made to CMS CO-OP subsidy calculation in the amount of $0.9 billion reported in the *President's Budget*, an adjustment made to reclassify credit balance in the upward adjustments of prior-year undelivered orders account to the downward adjustments of prior-year unpaid undelivered orders account, and a back dated warrant processed for the Payments to Health Care Trust Funds during the SF-133 revision window.

The Other differences in the offsetting receipts consist of General Fund Proprietary Receipts and Collections of Receivables from Canceled Accounts, and a back dated warrant processed for the Payments from the General Fund for Health Care Fraud and Abuse Control Account. In addition, NIH made adjustments 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 Intra-Departmental Delegation of Authority in the Combined Statement of Budgetary Resources.

Lastly, the Other differences in the net outlays include outlays reported on the HHS' 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 21. 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 below. The Medicare programs include the HI Trust Fund, the Medicare SMI Trust Fund, the Medicare SMI Prescription Drug Benefit – Part D and the Medicare Integrity Program. See Note 1 Section F for a description of each fund's purpose and how HHS accounts for and reports the fund. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds.

SMI benefits and administrative expenses are generally financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal Government through the General Fund Appropriation, Payments to the Health Care Trust Funds. The standard monthly SMI premium per beneficiary was $104.90 for January 1, 2013, through September 30, 2013 and $99.90 from October 1, 2012, through December 31, 2012. The funds from dedicated collections financial statement balances are shown below.

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

Consolidated Balance Sheet as of September 30

	2012		
	Medicare	Other	Total
Fund Balance with Treasury	$ 23,254	$ 1,935	$ 25,189
Investments	300,809	3,477	304,286
Other Assets	8,651	255	8,906
Total Assets	$ 332,714	$ 5,667	$ 338,381
Entitlement Benefits Due and Payable	$ 46,436	$ -	$ 46,436
Other Liabilities	3,959	559	4,518
Total Liabilities	$ 50,395	$ 559	$ 50,954
Unexpended Appropriations	$ 20,519	$ (101)	$ 20,418
Cumulative Results of Operations	261,800	5,209	267,009
Total Liabilities and Net Position	$ 332,714	$ 5,667	$ 338,381

Consolidated Statement of Net Cost for the Period Ended September 30

Gross Program Costs	$ 542,545	$ 308	$ 542,853
Less: Exchange Revenues	64,858	1,497	66,355
Net Cost of Operations	$ 477,687	$ (1,189)	$ 476,498

Consolidated Statement of Changes in Net Position for the Period Ended September 30

Net Position Beginning of Period	$ 293,197	$ 4,401	$ 297,598
Non-Exchange Revenue	$ 221,987	$ 326	$ 222,313
Other Financing Sources	244,822	(808)	244,014
Net Cost of Operations	(477,687)	1,189	(476,498)
Change in Net Position	$ (10,878)	$ 707	$ (10,171)
Net Position End of Period	$ 282,319	$ 5,108	$ 287,427

Note 22. Statement of Social Insurance (Unaudited)

The SOSI presents the projected 75-year actuarial present values of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel. Please see Note 23 below for further information on this panel ("the Panel").

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

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on May 31, 2013, and do not reflect any actual or anticipated changes subsequent to that date. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI Trust Fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI Trust Fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI Trust Fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from state governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The HI Trust Fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the "closed group" of participants. The "closed group" of participants consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of future income over future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors that are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program. Please see Note 23 below for important information on the further uncertainty, resulting from the provisions in the *Affordable Care Act*, associated with the current-law projections presented in the SOSI. In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on May 31, 2013. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, wages, and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The most significant underlying assumptions, based on current law, used in the projections of Medicare spending displayed in this section, are included in the following table. The assumptions underlying the 2013 SOSI actuarial projections are drawn from the *Social Security and Medicare Trustees Reports for 2013*. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized on the next page reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within 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 2013

					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]
2013	1.91	1,155,000	722.2	0.87	2.67	1.80	2.2	−0.9	0.4	0.3	−0.3
2020	2.06	1,255,000	670.2	1.35	4.15	2.80	2.3	3.9	5.3	6.6	2.8
2030	2.03	1,115,000	613.0	1.20	4.00	2.80	2.0	4.7	4.9	5.5	2.9
2040	2.00	1,080,000	564.1	1.15	3.95	2.80	2.2	5.3	4.5	5.3	2.9
2050	2.00	1,065,000	521.1	1.11	3.91	2.80	2.1	4.2	4.1	5.0	2.9
2060	2.00	1,060,000	483.3	1.10	3.90	2.80	2.0	3.9	4.0	4.8	2.9
2070	2.00	1,055,000	449.7	1.10	3.90	2.80	2.1	4.1	4.0	4.7	2.9
2080	2.00	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Difference between percentage increases in wages and the CPI.
[5]Average annual wage in covered employment.
[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the 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 four years are summarized in Table 2 on the next page. They are based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2013-2009

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
FY 2013	2.0	1,055,000	419.8	1.1	3.93	2.8	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.1	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
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9

[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.

Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is still relatively new (having begun operations in January 2006), with relatively little actual program data currently available. The actual 2006 through 2013 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2012, have been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Note 23. Affordable Care Act and SMI Part B Physician Payment Update Factor (Unaudited)

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

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

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

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

In addition, the Medicare Part B projections reflect a reduction of almost 25 percent in payment rates for physician services in 2014, as required under current law. If lawmakers act to prevent this decrease, as they have for 2003 through 2013, then actual Part B and total SMI costs will significantly exceed the projections shown in this report.

Because knowledge of the potential long-range effects of the productivity adjustments, delivery and payment innovations, and certain other aspects of the *Affordable Care Act* is so limited, in August 2010 the Secretary of the Department of Health and Human Services, working on behalf of the Board of Trustees, established an independent group of expert actuaries and economists to review the assumptions and methods used by the Trustees to make projections of the financial status of the trust funds. The members of the Panel began their deliberations in November 2010 and were asked to focus their immediate attention on the long-range Medicare cost growth assumptions. In December 2011, the panel members unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements. Both the Office of the Actuary at CMS and the Board of Trustees support these recommendations, and they form the basis

for the long-range cost growth assumptions used in this annual report. The methodology is explained in more detail in section IV.D of the *2013 Medicare Trustees Report*:

> The Panel also recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 through 2012 Trustees Reports, for the purpose of illustrating the higher Medicare costs that would result if the reduction in physician payment rates and the productivity adjustments to most other provider payment updates are not fully implemented as required under current law.[4]

The SOSI projections must be based on current law. Therefore, the productivity adjustments are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, an approximate 25 percent reduction in Medicare payment rates for physician services in January 2014, as estimated in the *2013 Trustees Report*, is assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override this reduction. Therefore, it is important to note that the actual future costs for Medicare are likely to exceed those shown by these current-law projections.

Illustrative Scenario

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

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

Medicare Present Values
(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$ 16,192	$ 16,214
Part B	21,377	27,510
Part D	9,211	9,224
Expenditures		
Part A	20,963	25,396
Part B	21,377	27,510
Part D	9,211	9,224
Income less expenditures		
Part A	(4,772)	(9,182)
Part B	0	0
Part D	0	0

[1]These amounts are not presented in the *2013 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 from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

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

The Part B expenditure projections are significantly higher under the alternative scenario than under current law, both because of the assumed gradual phase-out of the productivity adjustments and the assumption that the scheduled physician fee reductions would be overridden and based on 0.7 percent annual increases through 2022, based on a recommendation by the 2010-2011 Medicare Technical Review Panel. The productivity adjustments are assumed to affect more than half of Part B expenditures at the time their phase-out is assumed to begin. Similarly, physician fee schedule services are assumed to be roughly 25 percent higher under the alternative scenario than under current law at that time. The combined effect of these two factors results in a present value of Part B expenditures under the alternative scenario that is approximately 29 percent higher than the current-law projection.

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

The extent to which actual future Part A and Part B costs exceed the projected current-law amounts due to changes to the productivity adjustments and physician payments depends on both the specific changes that might be legislated and on whether Congress would pass further provisions to help offset such costs. As noted, these examples only reflect hypothetical changes to provider payment rates.

It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these will likely be designed to reduce costs in an effort to make the program more affordable. In practice, it is not possible to anticipate what actions Congress might take, either in the near term or over longer periods.

Note 24. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of future income (excluding interest) for current and future participants; (2) present value of future expenditures for current and future participants; (3) present value of future noninterest income less future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of future noninterest income less future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes shows the reconciliation from the period beginning on January 1, 2012 to the period beginning on January 1, 2013, and the reconciliation from the period beginning on January 1, 2011 to the period beginning on January 1, 2012. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

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

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

1. change in the valuation period,
2. change in the projection base,
3. changes in demographic assumptions,
4. changes in economic and health care assumptions, and
5. changes in law

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

Assumptions Used for the Statement of Changes in Social Insurance Amounts

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

Period beginning on January 1, 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 assumptions are presented using the interest rates under the intermediate assumptions of the *2013 Trustees Report*.

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

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

Change in the Valuation Period

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 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.

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

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

Change in the Projection Base

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 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.

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

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

Changes in Demographic Assumptions

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 Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (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 1.03 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 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 expenditures, and also income because of the financing mechanism in place for both.

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

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

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

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

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

Changes in Economic and Health Care Assumptions

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 Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

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

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

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

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

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

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

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

- Case mix growth assumptions for inpatient hospitals were lowered.
- Utilization rate and case mix increase assumptions for skilled nursing facilities and home health agencies were increased.
- Growth in hospice services was increased.
- Increase in average pre- *Affordable Care Act* "baseline" growth rate from GDP+1% to GDP+1.4% to better account for the level of payment rate updates for Medicare (prior to the *Affordable Care Act*) compared to private health insurance and other payers of health insurance in the U.S.
- Use of the "factors contributing to growth" model, developed by the Office of the Actuary at CMS, for year-by-year growth rate assumptions in long range. The impact of this change, in association with the baseline growth rate assumption described just above, has the biggest effect on the change in the net present value of income less expenditures. It resulted in an increase in the present value of Part A and Part B expenditures of roughly $1 trillion and $570 billion, respectively. Since the present value of Part A income is unaffected by these changes and the present value of Part B income is also higher by $570 billion, the net present value of income less expenditures is lower by about $1 trillion. Therefore, approximately $1 trillion of the $2.3 trillion is due to these changes.
- Lower assumed growth rate for prescription drug expenditures in the U.S. overall.
- Explicit projection of Part B services indexed by the CPI (e.g., ASC, lab, and DME services). The impact of this change lowers the present value of Part B expenditures and income by roughly $570 billion, and has no effect on the net present value of income over expenditures.

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

Changes in Law

Period beginning on January 1, 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 zero 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 end-stage renal disease (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 expenditures and increases the present value of Part D 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 expenditures.

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

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

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

	2013	2012
Resources Used to Finance Activities:		
Budgetary Resources Obligated		
Obligations Incurred	$ 1,282,036	$ 1,205,880
Spending Authority from Offsetting Collections and Recoveries	(49,640)	(47,415)
Obligations Net of Offsetting Collections and Recoveries	1,232,396	1,158,465
Distributed Offsetting Receipts	(336,655)	(317,777)
Net Obligations	$ 895,741	$ 840,688
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	58	21
Total Resources Used to Finance Activities	$ 895,799	$ 840,709
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	$ (3,623)	$ (13,909)
Resources That Fund Expenses Recognized in Prior Periods	54	138
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations	(1,202)	(1,255)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,314	1,652
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	7,089	1,995
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	3,632	(11,379)
Total Resources Used to Finance the Net Cost of Operations	$ 892,167	$ 852,088
Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period		
Components Requiring or Generating Resources in Future Periods	$ 2,495	$ 2,870
Components Not Requiring or Generating Resources	1,588	589
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	4,083	3,459
Net Cost of Operations	$ 896,250	$ 855,547

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2013

Responsibility Segment Program	2013	2012	2011	2010	2009
Administration for Children and Families					
Administration for Intellectual and Developmental Disabilities	$ 6	$ 6	$ 11	$ 9	$ 10
Health Resources and Services Administration					
Scholarships Loan Repayments and Loans	766	705	761	691	447
National Institutes of Health					
Research Training and Career Development	1,621	1,858	1,920	1,915	1,862
Totals	$ 2,393	$ 2,569	$ 2,692	$ 2,615	$ 2,319

Investments in Human Capital are expenses incurred by federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Three HHS OPDIVs conduct education and training programs under this category: ACF, NIH and HRSA.

Administration for Children and Families

Projects of National Significance (PNS) grants are awarded to public or private non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. These monies also support the development of national and state policy to serve this community. While administered by the Administration for Community Living as part of a 2012 reorganization, funding for this and other Administration for Intellectual and Developmental Disabilities (AIDD) programs continues to be provided first to ACF and then transferred to ACL. ACF is able to estimate Investment in Human Capital for AIDD using existing data collection activities. Under AIDD, as of September 30, 2013, 20 PNS grants have been awarded for FY 2013. Grants awarded total $6 million as of September 30, 2013.

Health Resources and Services Administration

Under Clinician Recruitment and Service, the National Health Service Corps (NHSC) is a network of 8,900 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 graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. NIH's ability to maintain the momentum of recent scientific progress and international leadership in medical research depends upon the continued development of new, highly trained investigators.

Investment in Research and Development (in Millions)

As of September 30, 2013

Responsibility Segments	Basic	Applied	Develop-mental	2013 Total	2012	2011	2010	2009	Grand Total
ACF	$ -	$ 1	$ -	$ 1	$ 2	$ 7	$ 9	$ 16	$ 35
AHRQ	-	342	30	372	401	333	263	203	1,572
CDC	131	298	28	457	408	457	465	755	2,542
FDA	88	-	6	94	80	58	48	36	316
NIH	17,597	11,731	-	29,328	30,681	32,902	31,342	27,889	152,142
Totals	$ 17,816	$ 12,372	$ 64	$ 30,252	$ 31,572	$ 33,757	$ 32,127	$ 28,899	$ 156,607

The research and development programs in HHS include the following:

Administration for Children and Families

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

Agency for Healthcare Research and Quality

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

Centers for Disease Control and Prevention

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

Food and Drug Administration

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

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. An orphan product is a drug, biological product, medical device or medical food

that is intended to treat a rare disease or condition (i.e., one with a prevalence of fewer than 200,000 people in the United States).

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

National Institutes of Health

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

REQUIRED SUPPLEMENTARY INFORMATION

Combining Statement of Budgetary Resources (in Millions)

As of September 30, 2013

	CMS					
Budgetary Resources:	Medicare HI	Medicare SMI	Medicaid	Other Agency Budgetary Accounts[5]	Agency Combined Totals	Non-Budgetary Credit Reform Financing Account
Unobligated Balance, Brought Forward, Oct 1	$ -	$ -	$ 21,090	$ 59,690	$ 80,780	$ 3,175
Recoveries of Prior Year Unpaid Obligations	141	97	18,132	6,228	24,598	-
Other Changes in Unobligated Balance	(54)	20	9	(1,196)	(1,221)	(1)
Unobligated Balance from Prior Year Budget Authority, Net	87	117	39,231	64,722	104,157	3,174
Appropriations (Discretionary and Mandatory)	276,583	252,305	245,836	419,009	1,193,733	-
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	-	(2,064)
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	439	11	528	24,431	25,409	(685)
Total Budgetary Resources	$ 277,109	$ 252,433	$ 285,595	$ 508,162	$ 1,323,299	$ 425
Status of Budgetary Resources:						
Obligations Incurred	$ 277,109	$ 252,433	$ 283,313	$ 468,867	$ 1,281,722	$ 314
Unobligated Balances, End of Year:						
Apportioned	-	-	2,282	27,711	29,993	40
Exempt from Apportionment	-	-	-	2,059	2,059	-
Unapportioned	-	-	-	9,525	9,525	71
Total Unobligated Balance, End of Year	-	-	2,282	39,295	41,577	111
Total Status of Budgetary Resources	$ 277,109	$ 252,433	$ 285,595	$ 508,162	$ 1,323,299	$ 425
Change in Obligated Balance:						
Unpaid Obligation:						
Unpaid Obligations, Brought Forward, Oct 1	$ 24,209	$ 24,404	$ 26,837	$ 105,304	$ 180,754	$ 1,602
Obligation Incurred	277,109	252,433	283,313	468,867	1,281,722	314
Outlays (Gross)	(276,074)	(252,049)	(262,141)	(459,066)	(1,249,330)	(668)
Actual Transfers, unpaid obligations (net)	-	-	-	106	106	-
Recoveries of Prior Year Unpaid Obligations	(141)	(97)	(18,132)	(6,228)	(24,598)	-
Unpaid Obligations, End of Year	$ 25,103	$ 24,691	$ 29,877	$ 108,983	$ 188,654	$ 1,248
Uncollected Payments:						
Uncollected Customer Payments from Federal Sources, Brought Forward, Oct 1	$ (1)	$ -	$ -	$ (10,102)	$ (10,103)	$ (1,587)
Change in Uncollected Customer Payments from Federal Sources	1	-	-	(916)	(915)	1,051
Uncollected Payments from Federal Sources, End of Year	$ -	$ -	$ -	$ (11,018)	$ (11,018)	$ (536)
Memorandum (non-add) Entries:						
Obligated Balance, Start of Year	$ 24,208	$ 24,404	$ 26,837	$ 95,202	$ 170,651	$ 15
Obligated Balance, End of Year	$ 25,103	$ 24,691	$ 29,877	$ 97,965	$ 177,636	$ 712

[5] "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 net 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[6]	Agency Combined Totals	Non-Budgetary Credit Reform Financing Account
Budget Authority and Outlays, Net:						
Budget Authority, Gross (Discretionary and Mandatory)	$ 277,022	$ 252,316	$ 246,364	$ 443,440	$ 1,219,142	$ (2,749)
Actual Offsetting Collections (Discretionary and Mandatory)	(440)	(11)	(528)	(23,833)	(24,812)	(366)
Change in Uncollected Customer Payments from Federal Sources (Discretionary and Mandatory)	1	-	-	(916)	(915)	1,051
Budget Authority, Net (Discretionary and Mandatory)	$ 276,583	$ 252,305	$ 245,836	$ 418,691	$ 1,193,415	$ (2,064)
Outlays, Gross (Discretionary and Mandatory)	$ 276,074	$ 252,049	$ 262,141	$ 459,066	$ 1,249,330	$ 668
Actual Offsetting Collections (Discretionary and Mandatory)	(440)	(11)	(528)	(23,833)	(24,812)	(366)
Outlays, Net (Discretionary and Mandatory)	275,634	252,038	261,613	435,233	1,224,518	302
Distributed Offsetting Receipts	(29,435)	(306,366)	-	(854)	(336,655)	-
Agency Outlays, Net (Discretionary and Mandatory)	$ 246,199	$ (54,328)	$ 261,613	$ 434,379	$ 887,863	$ 302

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 51,744	$ 51,744	$ 49,606
ACL	1,445	1,445	1,440
AHRQ	416	416	319
CDC	10,905	10,905	10,388
CMS	378,532	378,532	319,897
FDA	4,941	4,941	1,576
HRSA	9,066	9,066	8,644
IHS	6,469	6,469	4,272
NIH	33,799	33,799	31,104
OS	5,695	5,695	3,446
PSC	1,603	1,603	461
SAMHSA	3,547	3,547	3,226
Totals	$ 508,162	$ 508,162	$ 434,379

[6] "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 net 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, 2013 and 2012

FASAB issued SFFAS Number 40, *Definitional changes to Deferred Maintenance; Amending SFFAS Number 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.

Category of Asset (in Millions)	Condition	Estimated Cost to Return to Acceptable Condition 2013	2012
General PP&E			
Buildings	1-4	$ 2,249	$ 2,038
Equipment	3-4	12	14
Other Structures	1-4	13	30
Total		$ 2,274	$ 2,082

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 Property, Plant and Equipment 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, 2013

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 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, 2013, 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 2013 Consolidated 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, 2013.

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

RSI material is generally drawn from the *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this report incorporate the sequestration of non-salary Medicare expenditures as required by 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. Under the sequestration, Medicare benefit payments are reduced by an estimated 2 percent and administration expenses are reduced by an estimated 5 percent. The reduction in benefit payments will end on March 31, 2022, and the administrative expense reductions will end on September 30, 2021.

The projections shown here also incorporate the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the *"Affordable Care Act,"* 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. It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Whether these provisions of current law can be sustained is debatable due to substantial uncertainty about the adequacy of future Medicare payment rates. Without fundamental changes in current health care delivery systems, these adjustments would probably not be viable indefinitely. For these reasons, the estimates shown under current law should be used cautiously in evaluating the overall financial obligation created by Medicare and in assessing the financial status of the individual trust fund accounts. However, the effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees Report, which must be based on current law. In addition, the FASAB rules governing the Statement of Social Insurance also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, a reduction in Medicare payment rates for physician services of almost 25 percent is assumed to be implemented beginning in 2014 as

required under current law, despite the virtual certainty that Congress will override the reduction, as they have every year since 2003.

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

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, the Medicare Board of Trustees, in their annual report to Congress, reference two alternative scenarios to illustrate where possible the potential understatement of Medicare costs and projection results. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under hypothetical modifications to current law. No endorsement of the illustrative alternatives by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on the hypothetical alternatives to current law is provided in Note 23 in these financial statements, in Appendix C of this years' 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 one of the most critical determinants of the projected cost of Medicare-covered health care services in the more distant future. Starting with the *2001 Medicare Trustees Report*, the assumed average increase in expenditures per beneficiary for the 25th through 75th years of the projection has been based in whole or in part on the growth in per capita GDP plus 1 percentage point.[7] This assumption was recommended by the 2000 Medicare Technical Review Panel and confirmed as reasonable by the 2004 panel. Beginning with the 2006 report, the Trustees adopted a slight refinement of the long-range growth assumption that provided a more gradual transition from current health cost growth rates, which had been roughly 2 to 3 percentage points above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future.[8]

Following enactment of the *Affordable Care Act*, the long-range Medicare cost growth assumptions for the *2010* and *2011 Medicare Trustees Reports* continued to use this same methodology to establish a pre- *Affordable Care Act* "baseline" set of annual growth rates. The Trustees then reduced these growth rates for most categories of

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

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

Medicare expenditures by the 10-year moving average increase in private, non-farm business multifactor productivity, as required under the *Affordable Care Act*.[9]

In December 2011, the 2010-2011 Medicare Technical Review Panel[10] unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements.[11] The methodology involves use of two separate means of establishing long-range growth rates. The first approach is a refinement to the traditional "GDP plus 1 percent" growth assumption, which better accounts for the magnitude of payment rate updates for Medicare (prior to the *Affordable Care Act*) compared to private health insurance and other payers of health care. Under this approach, the rate of growth in Medicare prices prior to the provisions of the *Affordable Care Act*, which was assumed to be the same as the rate of private medical price growth in earlier reports, is now assumed to be 0.4 percent faster. This change results in the long-range pre- *Affordable Care Act* "baseline" cost growth assumption being "GDP plus 1.4 percent." The second approach recommended by the Technical Panel is the "factors contributing to growth" model developed by the Office of the Actuary at CMS as a possible replacement for the existing process.

The Technical Panel did not specify a process for how to establish one set of growth rate assumptions from the two separate and independent techniques. For the 2012 report, the Trustees decided (i) to base the average ultimate growth rate on the updated "GDP plus 1.4 percent" baseline assumption and (ii) to use the "factors contributing to growth" model to create the specific, year-by-year declining growth rates during the last 50 years of the projection.

For the *2013 Medicare Trustees Report*, the Trustees decided to use the factors model as the basis for determining the long-range Medicare cost growth assumption and to apply the "GDP plus" framework as a reasonableness check. The long-range Medicare cost growth assumptions under current law are established in three steps. Based on the factors model, the Trustees (i) create specific, year-by-year declining national health expenditure (NHE) growth rates over the long-range period and derive the growth in the volume and intensity of NHE services; (ii) assume, consistent with Finding III-2 of the Technical Panel's report, that the growth in the volume and intensity of Medicare services prior to the effects of the *Affordable Care Act* is identical to the growth in the volume and intensity of overall NHE services; and (iii) determine the Medicare payment rate updates required by the *Affordable Care Act* and their estimated effects on increases in the volume and intensity of services. For Medicare services for which the *Affordable Care Act* permanently reduces the annual increases in Medicare payment rates by the increase in economy-wide productivity, the Trustees adjust the growth rates in the volume and intensity of services by −0.1 percent annually. This assumption is consistent with Recommendation III-3 of the Technical Panel's report.

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

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

[11] For convenience, the assumed increase in Medicare expenditures per beneficiary, before consideration of demographic effects, is referred to as the "Medicare cost growth" and is often expressed in relation to the per capita increase in GDP, with the result characterized simply as "GDP plus X percent."

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

1. All HI, and some SMI Part B (primarily outpatient hospital, home health, and dialysis), services that are updated annually by provider input price increases, less the increase in economy-wide productivity, have on average an ultimate growth rate of 4.3 percent or "GDP plus 0.2 percent." The year-by-year increases for these provider services start at 4.5 percent in 2037, or "GDP plus 0.4 percent," and gradually decline to 3.6 percent in 2087, or "GDP minus 0.5 percent."

2. Certain SMI Part B services—such as durable medical equipment, laboratory tests, care at ambulatory surgical centers, ambulance services, and medical supplies that are updated annually by the Consumer Price Index (CPI) increase, less the increase in productivity—have on average a long-range growth assumption of 3.5 percent or "GDP minus 0.6 percent." The corresponding year-by-year growth rates are 3.6 percent in 2037, or "GDP minus 0.5 percent," declining to 2.8 percent in 2087, or "GDP minus 1.3 percent."

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

4. All other Part B outlays, which constitute an estimated 11.0 percent of total Part B expenditures in 2022, have on average a long-range per beneficiary cost growth rate of 5.1 percent, or "GDP plus 1 percent." The corresponding year-by-year growth rates from the factors model are 5.3 percent in 2037, or "GDP plus 1.2 percent," declining to 4.4 percent by 2087, or "GDP plus 0.3 percent."

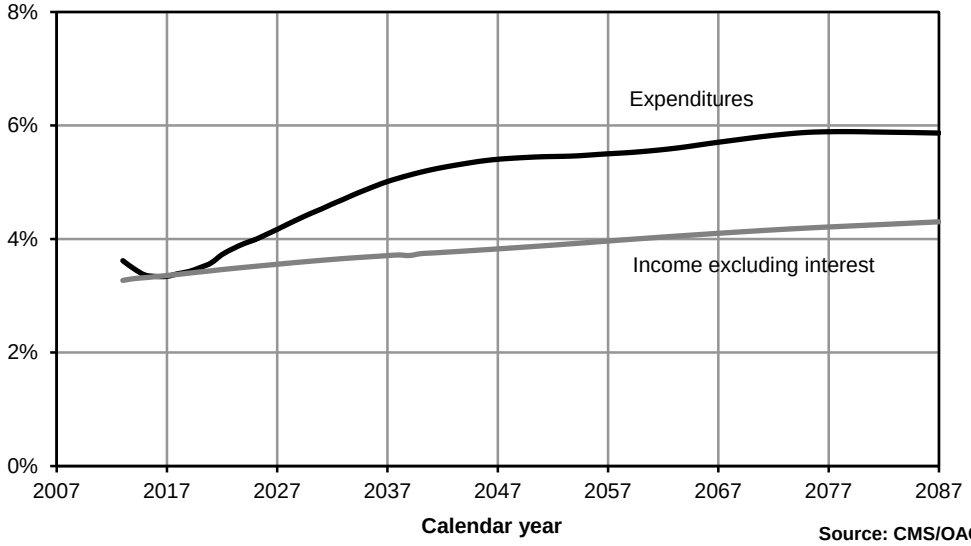
After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 4.1 percent per year for the last 50 years of the projection period, or "GDP plus 0 percent," on average. When Parts A, B, and D are combined, the weighted average growth rate for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

HI Cashflow as a Percentage of Taxable Payroll

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected long-range HI cost rates shown in this report are lower than those from the 2012 report. The primary reasons for the difference are (i) lower projected spending for most HI service categories—especially for skilled nursing facilities—to reflect lower-than-expected spending in 2012 and other recent data; (ii) 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; and (iii) a refinement in projection methods that reduces assumed per beneficiary cost growth during the transition period between the short-range projections and the long-range projections.

Chart 1—HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll 2013 - 2087



Source: CMS/OACT

Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Under the *Affordable Care Act*, however, high-income workers will pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. 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 economic recovery, the savings provisions of the *Affordable Care Act*, and the 2 percent reduction in all Medicare expenditures for 2013-2022, as required by the *Budget Control Act of 2011* and amended by the *American Taxpayer Relief Act of 2012*. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. Under the 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 5.2 percent in 2035 and 9.2 percent in 2085. These levels are about 8 percent and 57 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

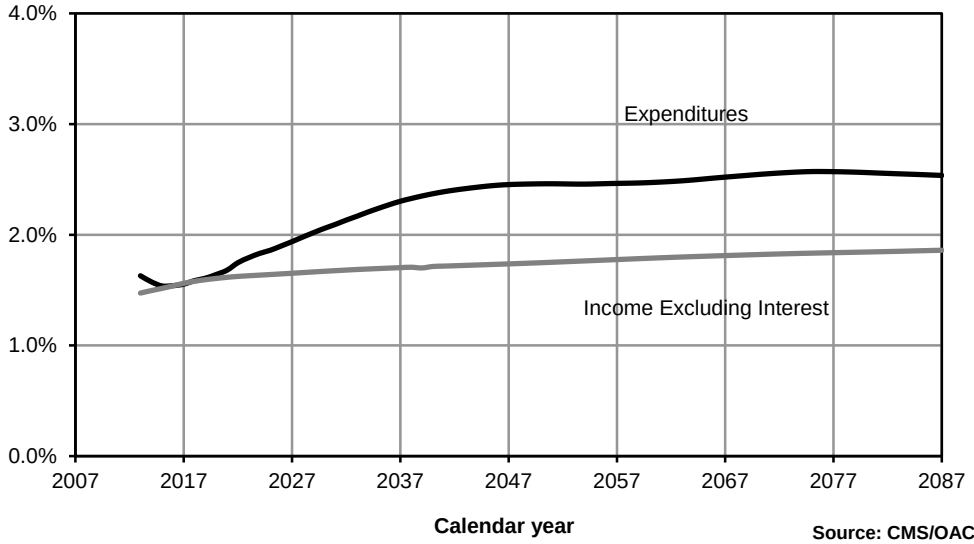
HI and SMI Cashflow as a Percentage of GDP

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

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2012, the expenditures were $266.8 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections,[12] HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2087.

Chart 2—HI Expenditures and Income Excluding Interest as a Percentage of GDP 2013 - 2087



Source: CMS/OACT

[12] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under hypothetical alternatives to current law, which assumes that (i) the SGR-mandated physician fee schedule payment reductions are replaced with a 0.7-percent annual increase during 2014-2022 and then gradually rise to the per capita increase in health spending in the US overall by 2037; (ii) the *Affordable Care Act* reductions in Medicare payment rates are partially phased out from 2020-2034; and (iii) the Independent Payment Advisory Board requirements are not implemented. A summary of the illustrative alternative projections is contained in appendix V.C. of the *2013 Trustees Report*. No endorsement of the illustrative alternatives to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

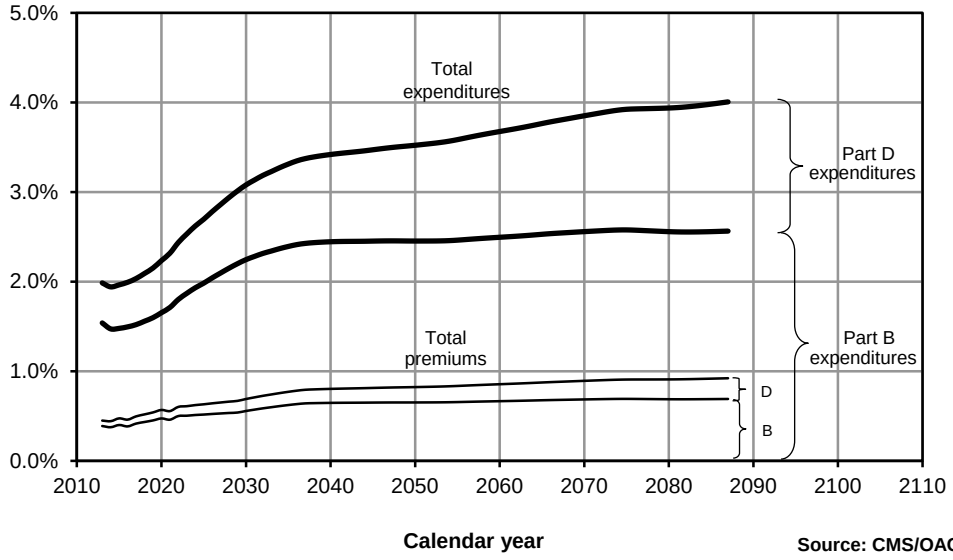
SMI

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.

Under the intermediate assumptions, annual SMI expenditures were $307.4 billion, or about 2.0 percent of GDP, in 2012. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to 4.0 percent by the end of the projection period. Total SMI expenditures in 2087 would be 4.7 percent of GDP if physician payment rates were set as assumed under the illustrative alternative projections. Such costs would represent 5.7 percent of GDP under the full illustration, including larger payment updates for most other categories of Part B providers.

Chart 3—SMI Expenditures and Premiums as a Percentage of GDP 2013 - 2087



Source: CMS/OACT

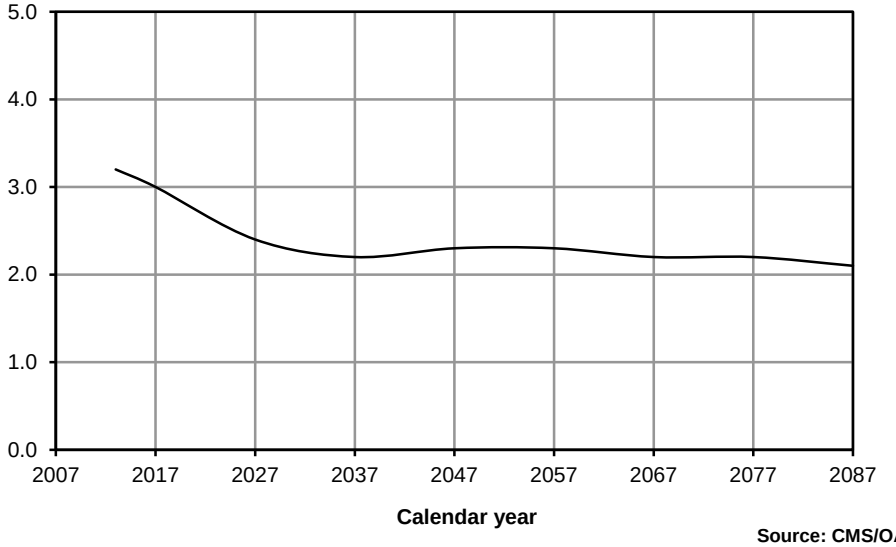
To match the faster growth rates for SMI expenditures under current law, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2013 by about 4.4 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI Trust Fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2012, every beneficiary had 3.3 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2087.

Chart 4—Number of Covered Workers per HI Beneficiary 2013 - 2087



Source: CMS/OACT

Sensitivity Analysis

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. 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.[13] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[14]

For this analysis, the intermediate economic and demographic assumptions in the *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2013 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 2045 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

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

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

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$1,242	$(4,772)	$(14,352)

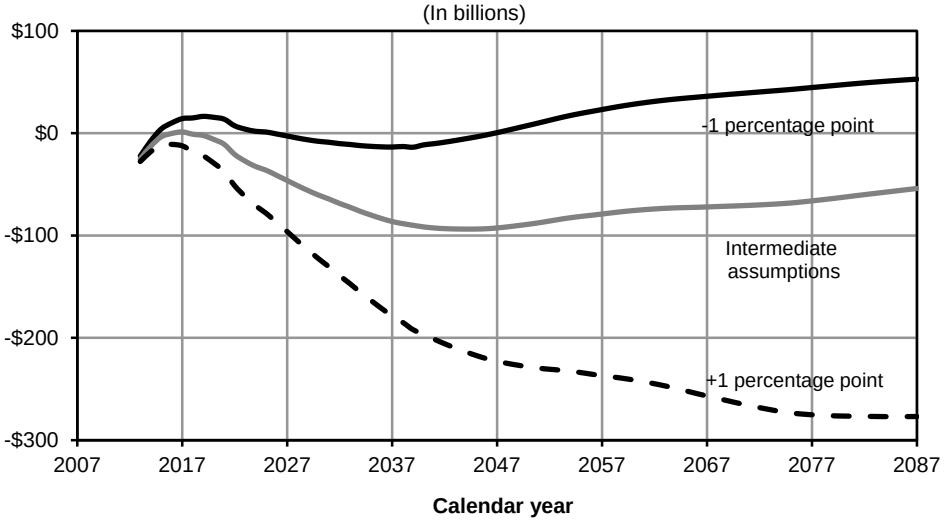
[13] Sensitivity analysis is not done for Parts B or D of the SMI Trust Fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

[14] 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.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $6,014 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 $9,580 billion.

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

Chart 5—Present Value of HI Net Cashflow with Various Health Care Cost Factors 2013 - 2087



Source: CMS/OACT

This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI Trust Fund as a result of the *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 1.7 percentage points.[15] In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.3, 3.9, and 4.5 percent, respectively.

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

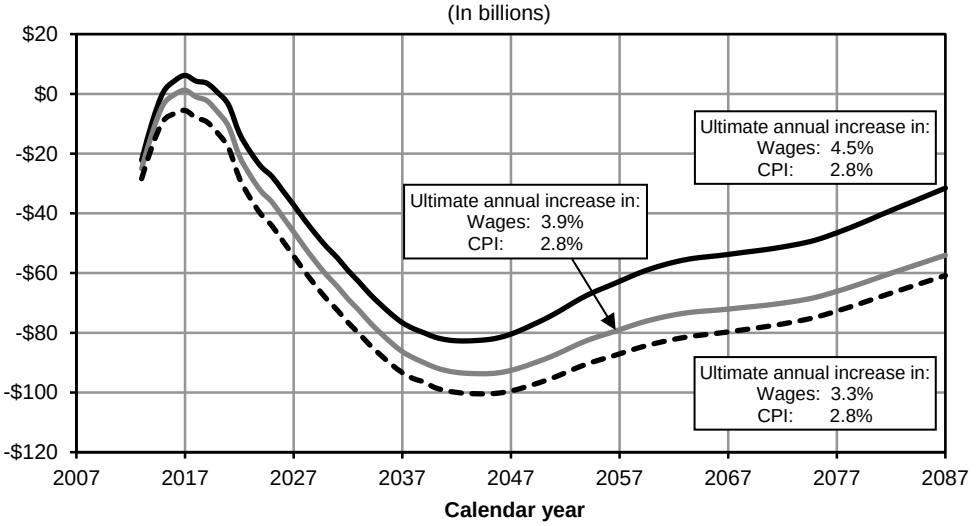
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	3.3 – 2.8	3.9 – 2.8	4.5 – 2.8
Ultimate percentage increase in real-wage differential	0.5	1.1	1.7
Income minus expenditures (in billions)	$(5,310)	$(4,772)	$(3,753)

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 $850 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $450 billion.

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

Chart 6—Present Value of HI Net Cashflow with Various Real-Wage Assumptions 2013 - 2087



Source: CMS/OACT

As illustrated in Chart 6, faster real-wage growth results in smaller HI cashflow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI Trust Fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI Trust Fund under the *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: 1.8, 2.8, and 3.8 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 2.9, 3.9, and 4.9 percent, respectively.

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

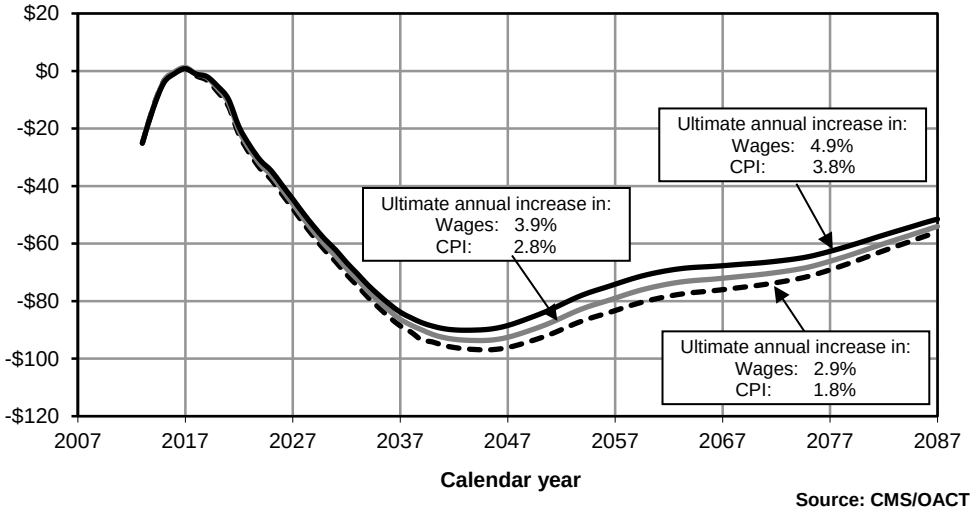
Ultimate percentage increase in wages − CPI	2.9 − 1.8	3.9 − 2.8	4.9 − 3.8
Income minus expenditures (in billions)	$(4,976)	$(4,772)	$(4,548)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $204 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $224 billion.

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

Chart 7—Present Value of HI Net Cashflow with Various CPI-Increase Assumptions 2013 - 2087

(In billions)



Source: CMS/OACT

As Chart 7 indicates, this assumption has a small impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the *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 2.8 percent, which results in ultimate annual yields of 5.2, 5.7, and 6.2 percent, respectively.

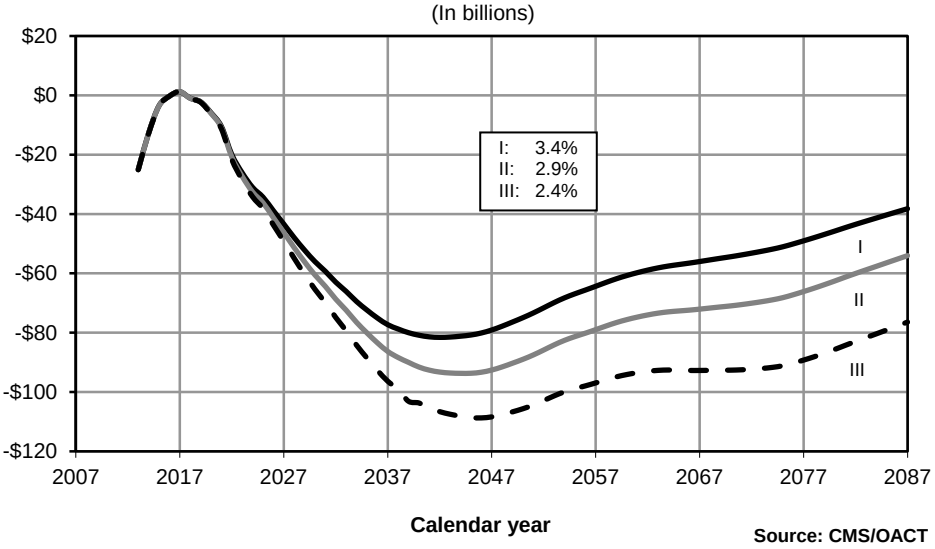
Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures (in billions)	$(5,800)	$(4,772)	$(3,954)

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $185 billion.

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

Chart 8—Present Value of HI Net Cashflow with Various Real-Interest Rate Assumptions 2013 - 2087



Source: CMS/OACT

As shown in Chart 8, the projected HI cashflow when expressed in present values is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI Trust Fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026. 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

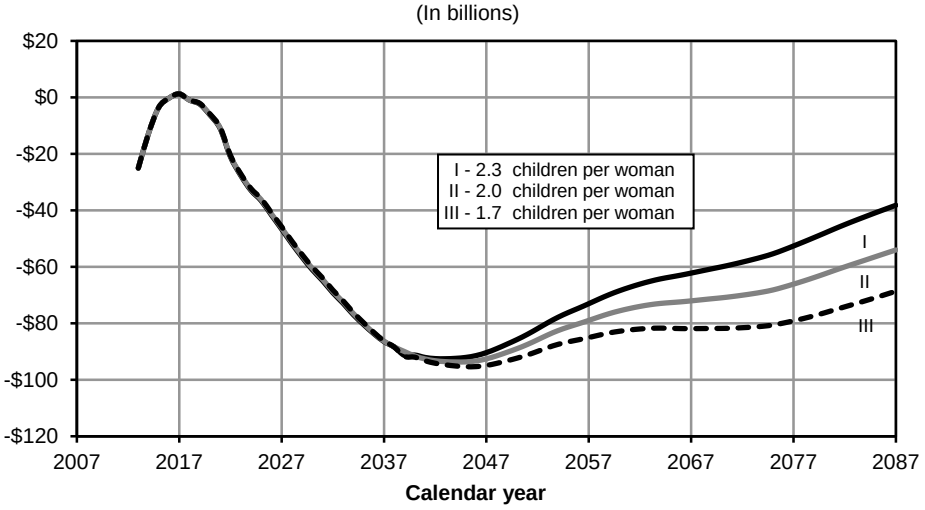
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	$(5,159)	$(4,772)	$(4,378)

[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.

Chart 9—Present Value of HI Net Cashflow with Various Ultimate Fertility Rate Assumptions 2013 - 2087



Source: CMS/OACT

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

Net Immigration

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 800,000 persons, 1,095,000 persons, and 1,400,000 persons per year.

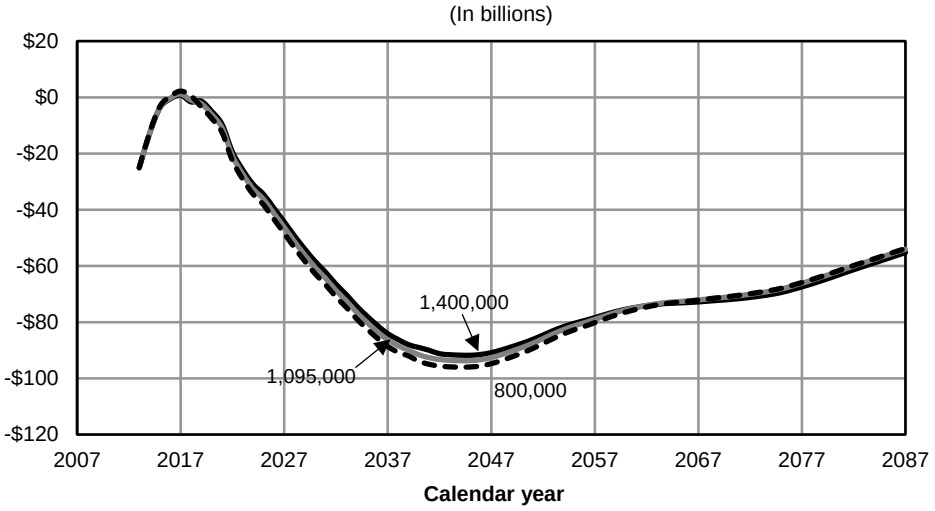
Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	800,000	1,095,000	1,400,000
Income minus expenditures (in billions)	$(4,848)	$(4,772)	$(4,731)

As indicated in Table 6, if the average annual net immigration assumption is 800,000 persons, the deficit—expressed in present-value dollars—increases by $76 billion. Conversely, if the assumption is 1,400,000 persons, the deficit decreases by $41 billion.

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

Chart 10—Present Value of HI Net Cashflow with Various Net Immigration Assumptions 2013 - 2087



Source: CMS/OACT

Higher net immigration results in smaller HI cashflow deficits, as illustrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI Trust Fund is 2026, 2 years later than in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI taxable earnings in 2012 were slightly lower than last year's estimate. The projected rate of growth in these earnings is lower in 2013 and 2014 but then exceeds last year's growth assumptions after 2014. HI expenditures in 2012 were slightly lower than the previous estimate, but after 2014, the projected level grows more rapidly than shown in last year's report because of assumed higher payment updates. HI expenditures have exceeded income annually since 2008, and projected amounts continue doing so through 2014. The Trustees then project slight surpluses in 2015 through 2020 with a return to deficits thereafter until the fund becomes depleted in 2026. The shortfalls can be met with increasing reliance on the redemption of trust fund assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI Trust Fund would initially produce payment delays but would very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security Trust Fund to become fully depleted.

It is important to note that the improved outlook for the HI Trust Fund, relative to pre- *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

Under current law, the SMI Trust Fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no authority to transfer assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2013 is adequate to cover 2013 expected expenditures and to maintain the financial status of the account in 2013 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not viable. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are lower than previously estimated. The difference is primarily attributable to the further increase of the market penetration of generic drugs, the larger than previously projected impact from patent expiration of several major drugs in 2012, and a lower projected trend for 2013.

The Part B and Part D accounts in the SMI Trust Fund are adequately financed under current law 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 under current law. 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" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2013-2019).[16] This difference is expected to exceed 45 percent of total expenditures in fiscal year 2013, which is the first year of the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. Similar determinations were made in their 2006-2012 annual reports to Congress. With this eighth consecutive finding, another "Medicare funding warning" is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning. Congress is then required to consider this legislation on an expedited basis. This requirement helps to call attention to Medicare's impact on the Federal Budget. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown in this section continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected depletion of the HI Trust Fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare cannot be sustained, then these further policy reforms will have to address much larger financial challenges than implied by the current-law projections. In their 2013 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should occur in the near future."

[16]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.