

Agency Financial Report

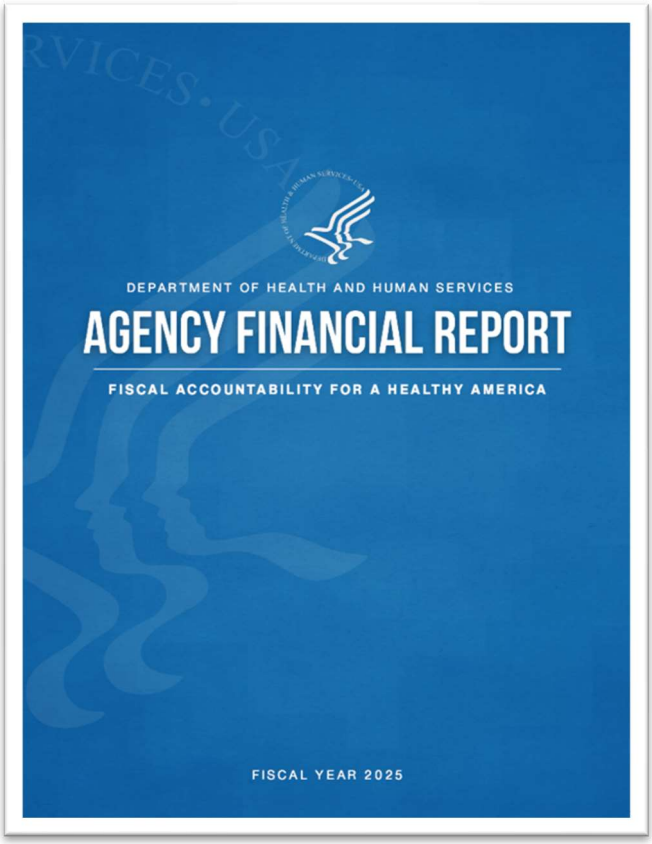
FISCAL YEAR 2026

Freedom 250

Certificate of Excellence in Accountability Reporting

The Department of Health and Human Services (HHS) promotes effective and responsible financial management by producing award-winning financial reports, aligning with its strategic plan. The AGA has recognized HHS's Agency Financial Report (AFR) for 13 consecutive years through the Certificate of Excellence in Accountability Reporting (CEAR) Program. The CEAR Program was established in collaboration with the Chief Financial Officers Council and Office of Management and Budget to assist federal government agencies with performance and accountability reporting. Through this program, agencies improve accountability by streamlining reporting and enhancing the effectiveness of reports to clearly highlight agency accomplishments during a fiscal year (FY) and to discuss any challenges that remain.

The FY 2025 Agency Financial Report exemplifies our dedication, spirit, and commitment to the HHS mission. HHS's perseverance and efforts in FY 2025 continue to demonstrate award-winning results. Thank you to everyone at HHS for making this possible.



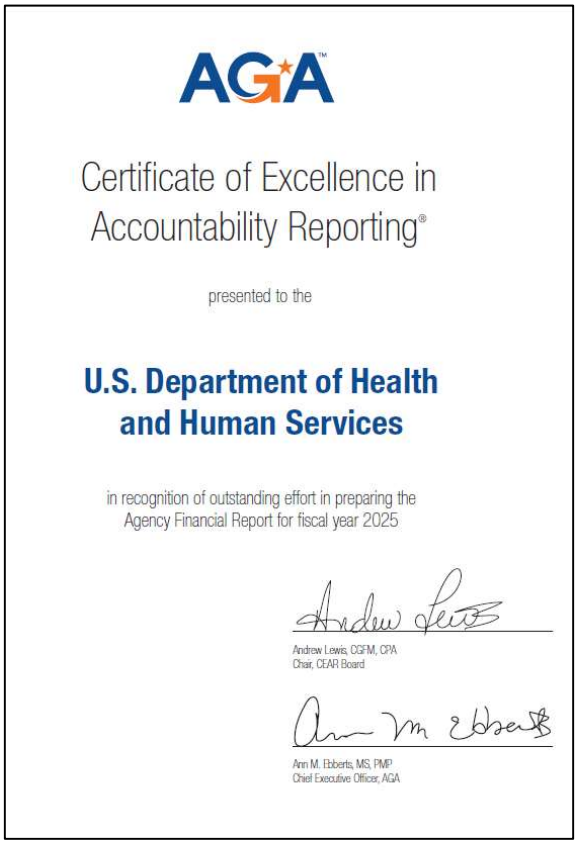


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MESSAGE FROM THE SECRETARY



I am pleased to present the U.S. Department of Health and Human Services (HHS) Fiscal Year (FY) 2026 Agency Financial Report.

The mission of HHS is to promote and protect the health and well-being of the American people. Fulfilling that mission requires more than administering programs and spending appropriated funds. It requires us to ask if those programs work, if those dollars produce results, and if the American people are healthier because of those investments.

That principle of accountable results guided our work throughout FY 2026. We continued to confront the chronic disease epidemic by putting prevention and nutrition at the center of our health agenda. We strengthened our commitment to gold-standard science and accelerated innovation. We worked with and invested in states, tribes, communities, healthcare providers, and other partners to bring solutions closer to the people we serve. And we used modern technology and stronger oversight to protect taxpayer resources from fraud, waste, and abuse.

Across these efforts, our objective is straightforward: fulfill President Trump's directive to Make America Healthy Again while demanding greater accountability for every dollar entrusted to this Department.

PREVENTION STARTS WITH HEALTH

Our health system has devoted enormous resources to treating disease after it develops while giving too little attention to preventing disease in the first place. Addressing America's chronic disease crisis requires us to change that equation by confronting the underlying drivers of poor health and giving Americans the tools to live healthier lives.

Nutrition is fundamental to that effort. In FY 2026, HHS released an updated Food Pyramid and revised Dietary Guidelines for Americans with a clear message: Eat Real Food. We worked with major food companies to remove artificial dyes and additives from the food supply and strengthened our oversight of food ingredients. Through Operation Stork Speed, we are expanding infant formula testing protocols, reviewing formula nutrients, and improving research to help ensure that infants receive the highest-quality nutrition during a critical period of development.

Our prevention agenda extends well beyond nutrition. HHS continued to support healthier communities, strengthen primary care, improve maternal and child health, and expand behavioral health services. We launched GetActive.gov and supported the return of the Presidential Fitness Test for school-aged children to encourage Americans to make physical activity and lifelong healthy habits a priority.

These efforts reflect a basic principle: the measure of a health system should not simply be how much illness it treats, but how much illness it prevents. Better health improves lives, strengthens families and communities, and reduces the long-term burden of disease on taxpayers and federal health programs.

RESTORING GOLD-STANDARD SCIENCE AND ACCELERATING INNOVATION

Prevention must be supported by science the American people can trust. HHS is working to restore rigorous, transparent, reproducible science as the foundation of federal health policy and biomedical research — and to ensure that scientific investment translates into meaningful improvements in human health.

In FY 2026, we launched the Intelligent Generator of Research program to accelerate biomedical breakthroughs through super intelligence (SI)-powered research and develop better models of complex and chronic health conditions. We also continued our work to improve vaccine research, expand vaccine options, and examine the timing and sequencing of childhood vaccines, consistent with President Trump's Executive Order, Delivering Gold-Standard Childhood Vaccine Recommendations for Americans, which emphasizes scientific evidence, informed consent, and public trust.



Scientific innovation must also reach patients. HHS took steps to streamline the development of biosimilar medicines, strengthen drug supply chains, and lower prescription drug costs. Through TrumpRx, Americans gained access to more than 800 brand-name and generic prescription drugs at lower cost, producing more than $700 million in savings.

Across HHS, we are working to ensure that science serves people — not institutions, entrenched assumptions, or process for its own sake. Americans deserve clear evidence, honest information, meaningful choices, and a health system that continually tests whether its policies are producing better results.

PARTNERSHIPS THAT DELIVER RESULTS

The federal government cannot solve America's health challenges alone. Durable progress depends on strong partnerships with states, tribes, territories, local communities, healthcare providers, faith communities, nonprofit organizations, and others who understand the people and communities they serve.

In FY 2026, HHS strengthened those partnerships while placing greater emphasis on outcomes and accountability. We invested more than $1 billion in funding opportunities to support President Trump's Great American Recovery, a value-based care model that brings together government, healthcare, faith communities, tribal nations, nonprofits, and other partners to put those afflicted with the scourge of addiction on the path to lasting recovery.

We also directed $1 billion toward priority health care facilities infrastructure projects in tribal communities and awarded $10 billion to states through the Rural Health Transformation Program. Those awards — averaging $200 million per state — are expanding access to care in rural communities, strengthening the rural health workforce, modernizing facilities and technology, and supporting innovative models that bring dependable, high-quality care closer to the Americans who need it.

Partnership does not mean relinquishing stewardship of federal funds; it means combining local knowledge and innovation with clear standards, strong oversight, and accountability for results. When we align those elements, we can extend the reach of every federal dollar and better serve communities across the country.

MODERNIZING GOVERNMENT AND PROTECTING TAXPAYER DOLLARS

The same commitment to results must govern how HHS operates internally. Modern technology, better data, and stronger financial controls are essential not only to making government more efficient, but also to protecting the resources the American people have entrusted to us.

Across the Department, investments in technology, data systems, cybersecurity, and SI are improving operations, strengthening program oversight, and enabling our employees to devote more of their time to serving the American people. Modern, integrated systems also provide a stronger foundation for financial management, better decision-making, and greater accountability.

These capabilities are especially important in our fight against fraud, waste, and abuse. HHS is using advanced data and analytic tools to move beyond identifying improper or fraudulent payments after the fact toward preventing losses before they occur. Since January 2025, HHS has uncovered more than $96 billion in fraud, recovered more than $32 billion in fraudulent payments, and prevented more than $46 billion in resources from being lost. We are building on that work in conjunction with the White House Task Force to Eliminate Fraud and through initiatives such as the Comprehensive Regulations to Uncover Suspicious Healthcare initiative, a federal-state partnership designed to strengthen enforcement against fraudsters.

Taxpayer dollars are finite. Every dollar lost to fraud, wasted through inefficiency, or spent without producing meaningful results is a dollar that cannot be used to improve the health and well-being of the American people. Protecting those resources is therefore inseparable from accomplishing our mission.



STEWARDSHIP

This report shows how HHS is aligning its financial management with a broader strategy focused on prevention, accountability, and transparency. For the 28th consecutive year, HHS received an unmodified (clean) audit opinion on its FY 2026 Consolidated Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, and Combined Statement of Budgetary Resources.



The auditors issued a disclaimer of opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, meaning they did not express an opinion on those statements. This was due to uncertainties surrounding provisions of the Patient Protection and Affordable Care Act and how potential changes in law could affect the assumptions used in financial projections. HHS prepared these statements under current law, using information from the 2026 Medicare Trustees Report. More details are available in the "Financial Section" of this report. The independent auditors reported no material weaknesses or significant deficiencies related to financial information systems for FY 2026.

HHS assessed the effectiveness of its internal controls over reporting in accordance with Office of Management and Budget Circular A-123, Management's Responsibility for Internal Control. Based on these assessments, and except for an identified instance of material noncompliance with the Payment Integrity Information Act of 2019, I can provide reasonable assurance that the financial and performance information in this report is complete, reliable, and accurate.



CONCLUSION

The work described in this report reflects a larger responsibility. HHS administers programs that touch the lives of virtually every American, and the public has a right to expect that we will manage those programs with discipline, transparency, and accountability.



We will continue to challenge approaches that do not produce results, strengthen those that do, and demand that the resources entrusted to HHS advance the health of the American people. Our success will not be measured by how much government spends or how many programs it administers. It will be measured by healthier Americans, stronger communities, trustworthy science, responsible stewardship, and results that the American people can see in their own lives.

The “Management’s Discussion and Analysis” section of this report provides further detail on the Department’s performance, financial position, and management priorities.

I am grateful to the dedicated public servants across HHS and to our partners at the federal, state, tribal, territorial, and local levels who carry out this mission every day. Together, we will continue to protect taxpayer resources, restore accountability and trust, and fulfill our responsibility to restore trust in our public health institutions and improve the lives of the American people.

/Robert F. Kennedy, Jr./

Robert F. Kennedy, Jr.
Secretary of Health and Human Services
November 13, 2026

INTRODUCTION

About the Agency Financial Report

The Department of Health and Human Services (HHS) fiscal year (FY) 2026 Agency Financial Report (AFR) provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2025, through September 30, 2026.

This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We prepared this report in accordance with the requirements of Office of Management and Budget Circular A-136, Financial Reporting Requirements. The AFR consists of three primary sections and a supplemental section for the appendices.

1 MANAGEMENT'S DISCUSSION AND ANALYSIS

Who are we, what did we achieve, and how did we manage our resources?

2 FINANCIAL SECTION

How did we perform financially?

3 OTHER INFORMATION

What risks and challenges remain?

4 APPENDICES

Where can I find more information?

Management's Discussion and Analysis

- HHS at a Glance: Organization, Financial Condition, and Performance
- Systems, Legal Compliance, and Internal Control
- Management Assurances

HHS at a Glance: Organization, Financial Position, and Performance

Our Mission

The United States (U.S.) Department of Health and Human Services (HHS) is the federal government's principal agency dedicated to promoting and protecting the health and well-being of the American people. HHS provides essential human services and public health leadership across a wide range of areas including disease prevention, health care delivery, food and drug safety, biomedical research, and social services for those least able to help themselves. Fulfilling this mission requires more than administering programs and spending appropriated funds — it requires the Department to continually ask whether those programs work, if taxpayer dollars produce measurable results, and whether the American public is healthier because of these efforts. This commitment to accountable results guides every aspect of HHS's work and is reflected throughout this report.

Our Structure

HHS carries out its mission through the Office of the Secretary (OS) and 12 Divisions, which administer the Department's programs and conduct life-saving research that protects and serves all Americans. Staff Divisions within OS provide leadership, direction, and policy and management guidance to the Department. Twelve Divisions are components of the U.S. Public Health Service. Together, these components form an integrated Department that pairs centralized leadership with the specialized expertise needed to serve the American people.

Our Priorities, Risks, and Opportunities

Reflecting Secretary Kennedy's priorities, HHS continues to place prevention, accountability, and the protection of taxpayer resources at the center of its work. Throughout Fiscal Year (FY) 2026, the Department strengthened its focus on preventing disease before it develops, restoring gold-standard science as the foundation for health policy, and deepening partnerships with states, tribes, and communities, while demanding greater accountability for every dollar entrusted to HHS.

Guided by the Government Accountability Office (GAO) Green Book and Office of Management and Budget's (OMB) Circular A-123, *Management's Responsibility for Internal Control*, HHS evaluates significant risks and opportunities across the Department and uses this information to guide management priorities and actions. These include financial and operational risks, as well as risks related to cybersecurity, human capital, grants management, acquisitions, supply chains, research, and program implementation. Grants management and acquisitions are particularly significant given the volume of HHS financial assistance and contract activity and the Department's reliance on recipients, contractors, and other partners to deliver programs and services. HHS also takes calculated risks when opportunities exist to improve mission delivery while maintaining appropriate safeguards and accountability.

Independent oversight further informs HHS's management of risks. The Department works diligently with HHS's Office of Inspector General (OIG) and GAO to address audit findings and recommendations, strengthen controls, and improve program and operational effectiveness. OIG's FY 2026 Top Management and Performance Challenges, presented in the "Other Information" section of this report, highlights program integrity risks in the following areas:

- Medicare and Medicaid programs;
- Managing complex risks and exploitation in grants and contracts;
- Preventing and fighting chronic disease and ensuring preparedness for and response to disasters and public health emergencies;

- Protecting beneficiary health and safety; and
- Managing risks from rapid technological advancement and improving cybersecurity for HHS programs.

These same areas present meaningful opportunities to strengthen efficiency and effectiveness. Grants management can strengthen recipient accountability and reduce administrative burden through improved recipient and program partner experiences, stronger departmental coordination, improved use of recipient and audit data, modernized processes and technology, and more effective monitoring and closeout. In acquisitions, HHS can further leverage its purchasing power, advance strategic planning and post-award management, and pursue innovative acquisition approaches that deliver needed goods and services more quickly and at lower cost. Together, these improvements can help HHS direct resources toward higher-value activities, identify emerging problems earlier, and support better decisions.

Technology and data are central to HHS's approach to managing risks and improving outcomes. Super intelligence (SI) and advanced analytics can help HHS identify emerging risks and unusual activity earlier, target oversight and resources to areas of greatest need, and make more timely and informed decisions. For example, HHS's Audit Enforcement and Risk Oversight initiative has adopted SI to strengthen accountability for audit resolution and improve stewardship of federal assistance to deliver stronger outcomes. At the same time, these technologies require appropriate governance, security, and human oversight. Department-wide governance led by the Chief Information Officer supports the responsible SI adoption and continued strengthening of cybersecurity, including policies, safeguards, and oversight designed to protect HHS data, systems, and operations as technologies and threats evolve.

Together, HHS's risk management, internal control, oversight, and governance processes help the Department balance risk and opportunity as it carries out the priorities of its mission. These efforts reflect HHS's unwavering commitment to being responsible stewards of American taxpayer resources. By identifying and acting on emerging risks, following through on independent oversight findings, strengthening accountability, and leveraging advance technologies and partnerships, HHS works every day to combat fraud, waste, and abuse to ensure every dollar entrusted to the Department is used effectively, efficiently, and in service of the American people.

Financial Position

This section is presented as an interpretation of the principal financial statements, as well as selected notes to the principal financial statements, which HHS presents in Section 2, "Financial Section". Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist readers in establishing the relevance of the financial statements to the operations of HHS.

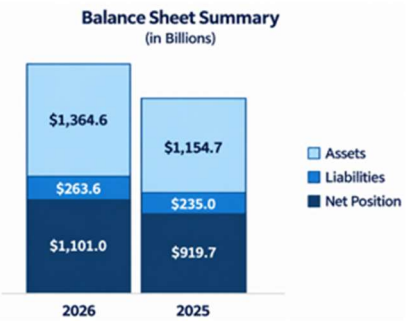
As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2025 Financial Report of the United States Government*, HHS's net operating cost was the largest across the entire federal government.[1] A similar relationship exists within HHS, where the Department is significantly represented by one Division, Centers for Medicare & Medicaid Services (CMS). CMS alone consistently stewards the largest share of HHS's resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

Balance Sheets

To communicate performance for HHS at FY-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by HHS (Net Position). The table below summarizes the major components of the FY 2026 and FY 2025 year-end balances of HHS's assets available for use, the liabilities owed by HHS, and the equity retained by HHS.

Balance Sheet Summary
(in Billions)

	2026	2025	$ Change (2026-2025)	% Change (2026-2025)
Fund Balance with Treasury	$ 831.7	$ 659.4	$ 172.3	26%
Investments, Net	452.7	414.3	38.4	9%
Accounts Receivable, Net	49.8	50.0	(0.2)	0%
Other Assets	30.4	31.0	(0.6)	(2)%
Total Assets	**$ 1,364.6**	**$ 1,154.7**	**$ 209.9**	**18%**
Entitlement Benefits Due and Payable	181.7	164.0	17.7	11%
Pensions and Other Post-Employment Benefits	22.4	22.6	(0.2)	(1)%
Accrued Liabilities	18.4	18.0	0.4	2%
Contingencies & Commitments	22.8	17.8	5.0	28%
Other Liabilities	18.3	12.6	5.7	45%
Total Liabilities	**$ 263.6**	**$ 235.0**	**$ 28.6**	**12%**
Net Position	**$ 1,101.0**	**$ 919.7**	**$ 181.3**	**20%**
Total Liabilities and Net Position	**$ 1,364.6**	**$ 1,154.7**	**$ 209.9**	**18%**

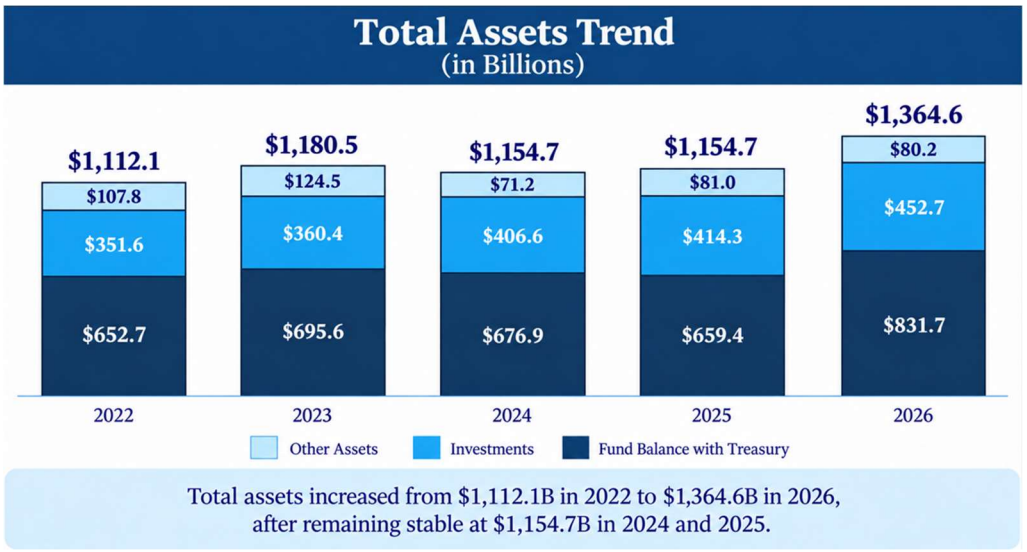


[1]HHS's net cost is 26 percent of the federal government's total costs, Social Security Administration's net cost is 23 percent, Department of Defense's net cost is 17 percent, and Interest on Treasury Securities held by the Public cost is 13 percent. All remaining agencies combined only represent 21 percent. Source: *FY 2025 Financial Report of the U.S. Government*.

HHS at a Glance: Organization, Financial Condition, and Performance

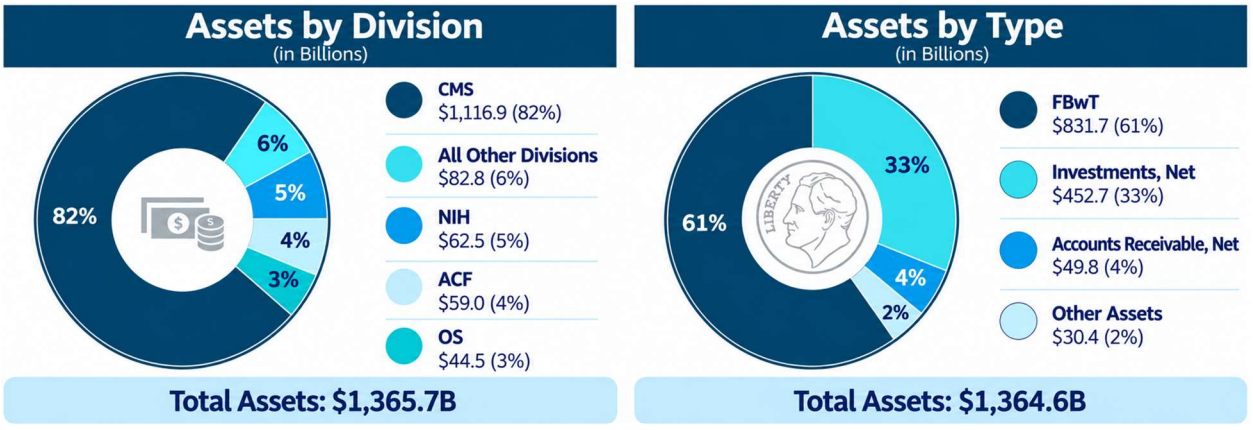
Assets

The total assets for HHS were $1,364.6B at year-end, representing the value of what HHS owns and manages. This is an increase of $209.9B or 18 percent over September 30, 2025. Fund Balance with Treasury (FBwT) and Investments comprise $1,284.4B or 94 percent of HHS's total assets.



FBwT had an increase of $172.3B or 26 percent over FY 2025, primarily due to increases in Supplementary Medical Insurance (SMI) of $117.0B from Payments to the Health Care Trust Funds (PTF) transfer to ensure enough funds in case of a shutdown, Medicaid of $47.0B and Children's Health Insurance Program (CHIP) of $7.0B. Investments had an increase of $38.4B or 9 percent over 2025, which is due to increases in SMI of $23.0B and Hospital Insurance (HI) of $15.0B.

The HHS "Assets by Division" chart shows asset distribution within HHS, excluding eliminations. The Division asset balances ranged from $423M for Agency for Healthcare Research and Quality (AHRQ) (shown in All Other Divisions) to $1,116.9B for CMS. CMS had the largest change, an increase of $214.1B or 24 percent primarily due to increase in FBwT as mentioned above.

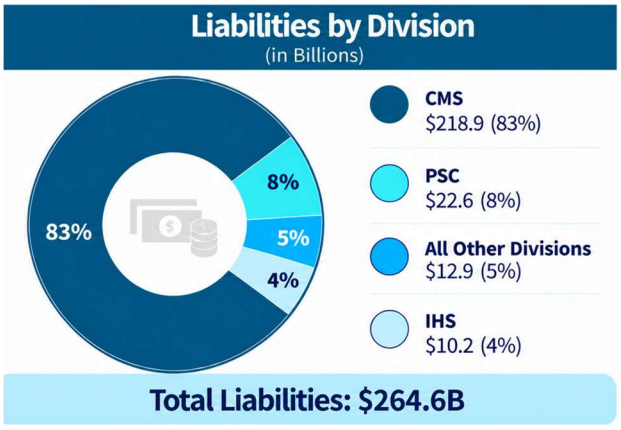


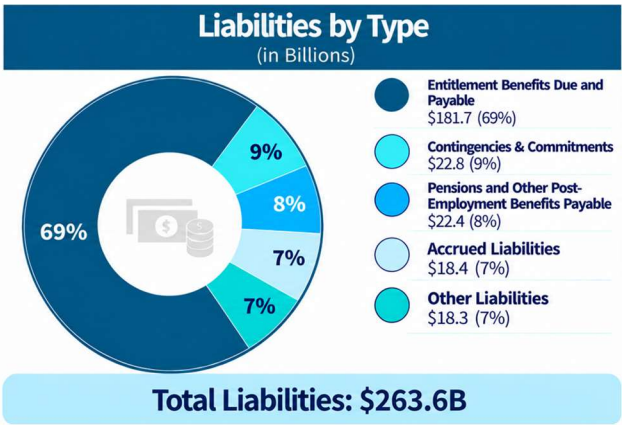
Liabilities

The total liabilities for HHS were $263.6B at year-end, representing the amounts HHS owes from past transactions or events. Liabilities had an increase of approximately $28.6B or 12 percent over September 30, 2025.



Entitlement Benefits had an increase of $17.7B or 11 percent over FY 2025, which is due to Medicare Prescription Drug Benefit (Part D) Incurred But Not Reported (IBNR) of $8.1B due to a new manufacturer discount program and unsettled reconciliations for inactive plans from FY 2024. In addition, Medicaid IBNR increased by $6.8B, and Medicare IBNR increased by $2.5B. Contingencies and Commitments had an increase of $5.0B or 28 percent over FY 2025, primarily due to an increase of $5.5B for the Medicaid State Plan Amendment (SPA) accrual.

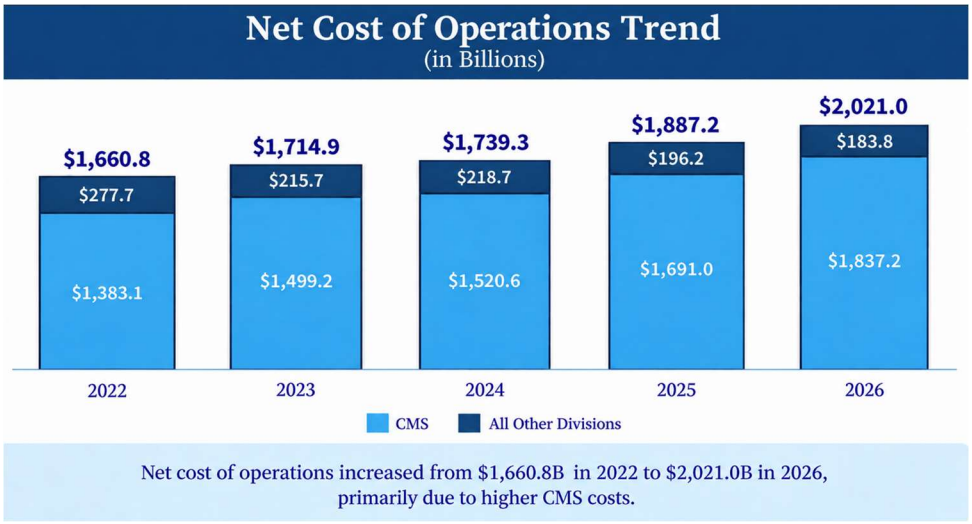




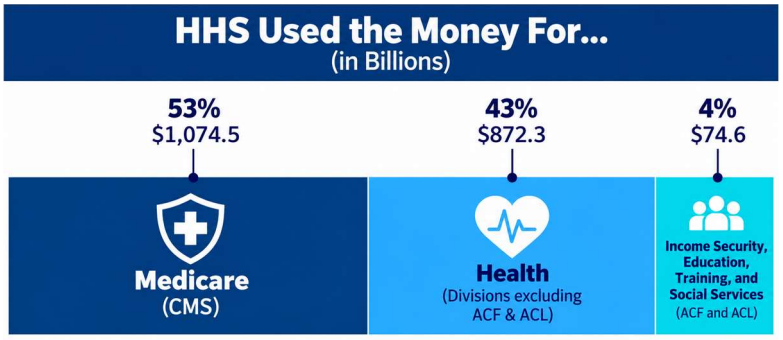
The HHS "Liabilities by Division" chart shows liability distribution within HHS, excluding eliminations. The Divisions with the largest and smallest asset balances are also the Divisions with the largest and smallest liabilities. With the majority share, CMS reports $218.9B or 83 percent of the HHS liabilities, while AHRQ (shown in All Other Divisions) has liabilities of $12M. CMS had the largest Division dollar value increase in liabilities over FY 2025 of $27.3B due to increases in Entitlement Benefits Due and Payable and Contingencies and Commitments, as mentioned previously.

Statements of Net Cost

The Consolidated Statements of Net Cost represents how HHS spent the money. This can also be stated as the difference between the costs incurred by HHS's programs less associated revenues. The Net Cost of Operations for the year ended September 30, 2026, totaled $2,021.0B.



The "HHS Used the Money For" chart shows consolidating costs by major budget function[2], which are the categories displayed in the Federal Budget. Most agencies have one or two budget functions, where HHS has many. HHS classifies costs by major budget functions such as Medicare, Health, Income Security, and Education, Training, and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in Section 3, "Other Information". In FY 2026, total net costs for Medicare of $1,074.5B and Health of $872.3B account for 96 percent of HHS's annual net costs.



[2]Totals in the chart are exclusive of intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section 3, "Other Information".

HHS at a Glance: Organization, Financial Condition, and Performance

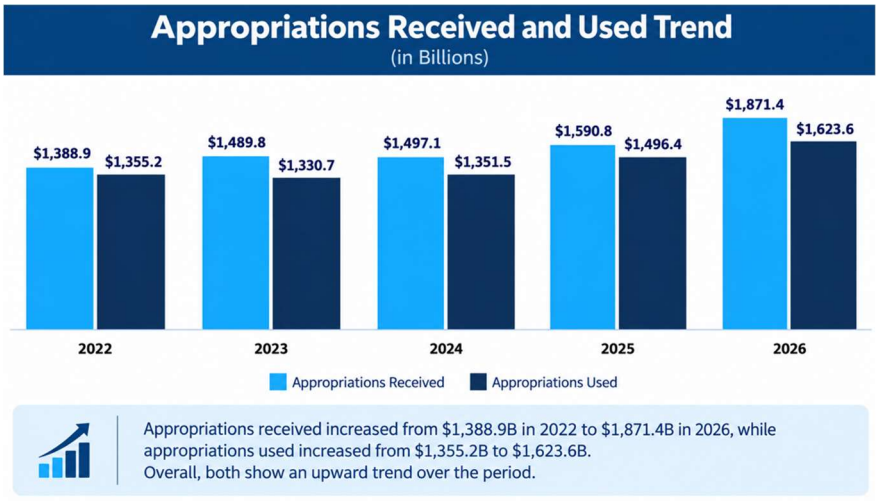
The following table presents FY 2026 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining Divisions in Other Segments. Net cost for CMS increased by $146.2B or 9 percent over FY 2025, which included increases in Medicare SMI and HI and Medicaid. SMI Medical Insurance (Part B) expenses increased by $43.4B primarily due to increase in benefit and IBNR expenses and change in Medicare Contractor receivables. SMI Part D expenses increased by $37.6B primarily due to an increase of benefit expenses and change in receivables. In addition, SMI had an increase in Premiums for the Aged and Disabled of $18.7B. Medicare HI increased by $25.4B primarily due to increased benefit expenses and the reduction of the 2025 contingency which resulted in decreased expenses. Medicaid expenses increased by $60.9B due to increases in benefit expenses and audit and program disallowances.

Net Cost of Operations
(in Billions)

	2026	2025	$ Change (2026-2025)	% Change (2026-2025)
Responsibility Segments:				
CMS Gross Cost	$ 2,035.1	$ 1,867.9	$ 167.2	9%
CMS Earned Revenue	(197.9)	(176.9)	(21.0)	12%
CMS Net Cost of Operations	**$ 1,837.2**	**$ 1,691.0**	**$ 146.2**	**9%**
Other Segments:				
Other Segments Gross Cost	$ 192.1	$ 204.4	(12.3)	(6)%
Other Segments Earned Revenue	(8.3)	(8.2)	(0.1)	1%
Other Segments Net Cost of Operations	**$ 183.8**	**$ 196.2**	**(12.4)**	**(6)%**
Net Cost of Operations	**$ 2,021.0**	**$ 1,887.2**	**$ 133.8**	**7%**

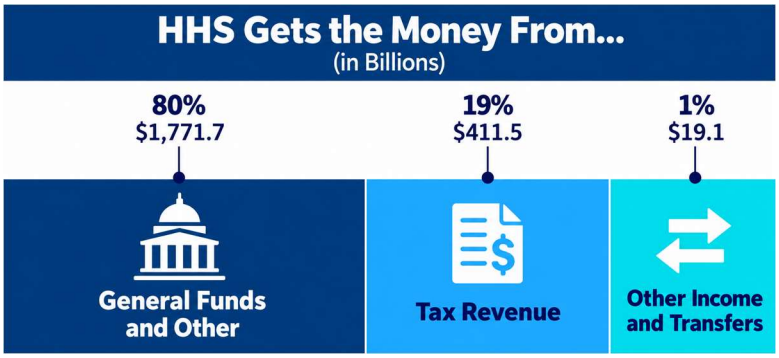
Statement of Changes in Net Position

The Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities. Changes in assets are shown by identifying where HHS gets the money from, known as financing sources.



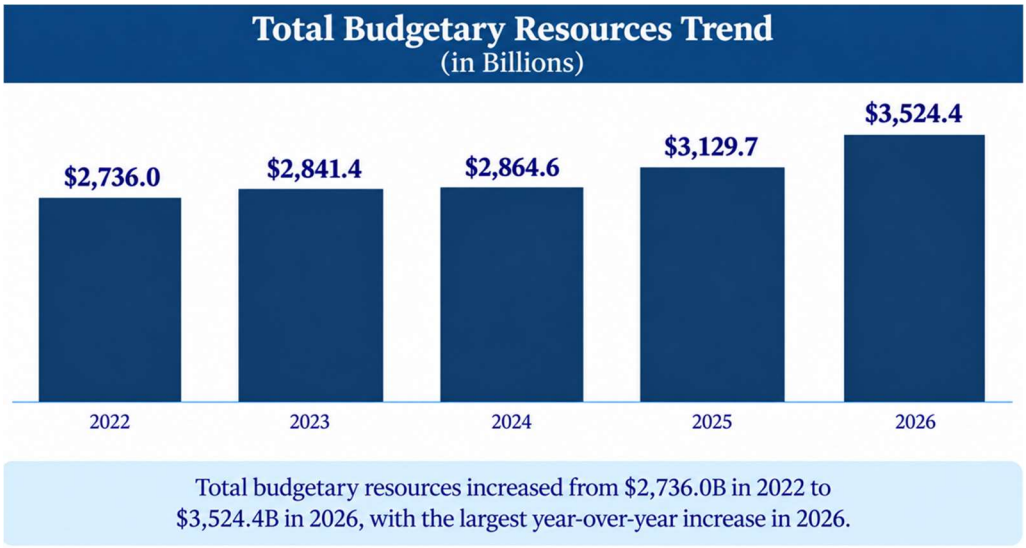
HHS at a Glance: Organization, Financial Condition, and Performance

HHS receives the majority of the funding through Congressional appropriations (General Funds from the U.S. Government) and reimbursement for the provision of goods or services to other federal agencies. HHS's largest finance source, General Funds and Other, increased $324.4B or 22 percent over FY 2025 and is primarily due to appropriation increases in Medicare SMI and HI, Medicaid, and CHIP. The fluctuation in Tax Revenue of $10.9B or 3 percent is related to higher *Federal Insurance Contribution Act* tax revenue due to the rise in wages and low unemployment rate.

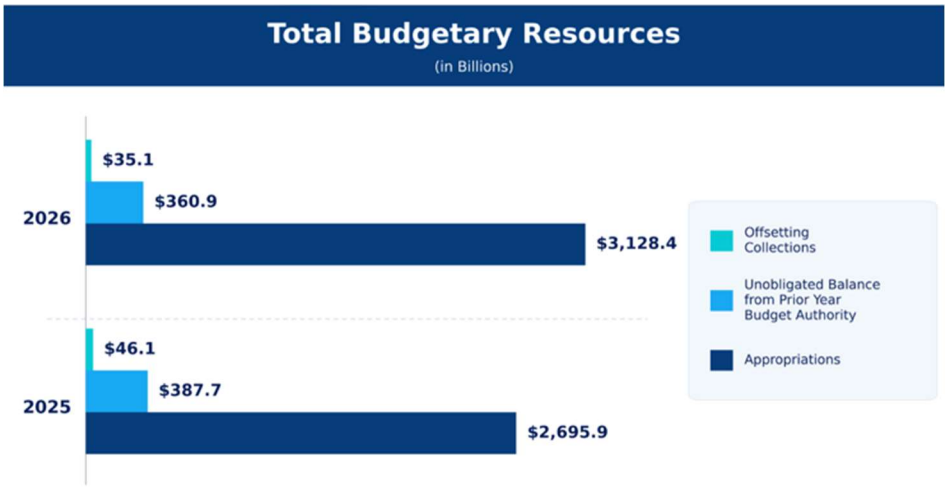


Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2026 and FY 2025, and the status of those resources at the FY-end.



FY 2026 Budgetary Resources increase of $394.7B or 13 percent over FY 2025. The following graph highlights trends in these balances over the past two FYs.



Statement of Social Insurance

The Statement of Social Insurance (SOSI) presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected to arise for current and future program participants. This projection is considered important information in evaluating the potential future cost of the programs. These projected potential future obligations are not included in the Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statements of Changes in Net Position, or Combined Statements of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. With two exceptions, the projections are based on the *Social Security Act's* current-law provisions as of the date of the release of the Medicare Trustees Report.

The first exception is that the Hospital Insurance (Part A) projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Medicare Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date. However, implementation was initially delayed until January 1, 2023. Since then, legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Coronavirus Disease (COVID-19) pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized and the Trustees rely more on recent experience when

developing the cost projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

The SOSI presents the following actuarial estimates:

- The present value of future income (excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future expenditures of providing benefits to those same individuals;
- The present value of future income (excluding interest) to be received from or on behalf of current participants who have not yet attained eligibility age and the future expenditures of providing benefits to those same individuals;
- The present value of future income (excluding interest) less expenditures for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;
- The present value of future income (excluding interest) to be received from or on behalf of future participants and the expenditures of providing benefits to those same individuals;
- The present value of future income (excluding interest) less expenditures for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and
- The present value of future income (excluding interest) less expenditures for all current and future participants over the next 75 years (open group measure) (deficit) increased from $(3.3)T determined as of January 1, 2025, to $(4.4)T, determined as of January 1, 2026.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2026, the actuarial present value of estimated future income (excluding interest) less expenditures plus HI and SMI trust fund assets for all current and future participants is estimated to be a $(4.0)T deficit for the 75-year valuation period. The comparable metric for the closed group of participants is estimated to be a $(15.0)T deficit for the 75-year valuation period.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive HI trust fund assets. The following table shows the HI trust fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio increases from 39 percent at the beginning of FY 2022 to 54 percent at the beginning of FY 2026. HI expenditures are projected to be relatively close to last year's projections through the short-range period.

Trust Fund Ratio Beginning of Fiscal Year[3]					
	2022	**2023**	**2024**	**2025**	**2026**
HI	39%	45%	48%	53%	54%

Short-Term Financing

The HI trust fund is deemed adequately financed for the short term when actuarial estimates of HI trust fund assets for the beginning of each calendar year (CY) are at least as large as program obligations for the year. Under the intermediate assumptions of the 2026 Medicare Trustees Report, after 2026 the HI trust fund ratio is estimated to steadily decrease for the rest of the projection period until the fund is depleted in CY 2033. The assets were $255.7B at the beginning of CY 2026, representing about 53 percent of expenditures projected for CY 2026, which is below the Trustees' minimum recommended level of 100 percent. The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003.

Long-Term Financing

This year's short-range financial outlook for the HI trust fund is slightly less favorable than what was projected last year. After 2026, the trust fund ratio declines until the fund is depleted in the second quarter of 2033, one quarter earlier than projected in 2025. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program expenditures are expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to be 89 percent in 2033 (year of depletion), 85 percent in 2050 (25th projection year), and about 93 percent in 2100 (end of the projection period).

The primary reason for the projected long-term inadequacy of financing under current law relates to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 2.7 in 2025 to about 2.0 by 2100. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $4.2T, which is 0.5 percent of taxable payroll and 0.2 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information (RSI): Social Insurance disclosures required by the Federal Accounting Standards Advisory Board.

SMI Trust Fund Solvency

The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and government contributions for Parts B and D – which are contributions of the Federal Government that the law authorizes to be appropriated and transferred from

[3]Assets at the beginning of the year to expenditures during the year.

the general fund of the Treasury – are reset each year to cover projected program costs and ensure a reserve for Part B to provide a contingency for unexpected program variation.

Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis. Under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the Part D account 5 business days before the benefit payments are due to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy. Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range.

Therefore, in the SOSI sustainability financial statements, the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is a $(60.9)T shortfall.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percentage of GDP. In 2025, SMI incurred expenditures were 2.5 percent of GDP. By 2100, SMI expenditures are projected to grow to 5.5 percent of the GDP.

Alternative SOSI Projection

The Medicare financial projections are based on current law. However, certain features of current law may result in some challenges for the Medicare program. There remains continued uncertainty regarding adherence to the current-law payment updates associated with the productivity adjustments to specific provider payment updates and the scheduled physician payment updates. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

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

Financial Challenges

These Medicare projections continue to demonstrate the need for timely and effective action to address the remaining financial challenges–including the HI trust fund's projected depletion, this fund's long-range financial imbalance, and the rapid growth in expenditures. The Medicare Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI trust fund and reduce the rate of growth in Medicare costs. The Trustees recommend that Congress and the Executive branch work closely together to quickly address these challenges. The sooner solutions are enacted, the more flexible and gradual they can be. Introducing reforms early would give affected individuals and organizations–including health care providers, beneficiaries, and taxpayers–more time to adjust their expectations and behavior.

The following table presents key amounts from CMS's basic financial statements for FY 2024 through 2026.

Table of Key Measures[4]
(in Billions)

	2026	2025	2024
Net Position (end of fiscal year)			
Assets	$ 1,116.9	$ 902.8	$ 884.4
Less Total Liabilities	218.9	191.6	169.5
Net Position (assets net of liabilities)	**$ 898.0**	**$ 711.2**	**$ 714.9**
Costs (end of fiscal year)			
Net Costs	$ 1,837.5	$ 1,691.2	$ 1,521.1
Total Financing Sources	1,869.7	1,716.5	1,548.8
Net Change in Cumulative Results of Operations	**$ 32.0**	**$ 25.3**	**$ 27.7**
Statement of Social Insurance (calendar year basis)[5]			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$ (4,446)	$ (3,301)	$ (2,618)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	$ (3,301)	$ (2,618)	$ (4,630)
Change in Present Value	**$ (1,144)**	**$ (683)**	**$ 2,012**

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income (excluding interest) less future expenditures for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2026, decreased as follows: (i) by $124B as a result of advancing the valuation date by 1 year and including the additional year 2100; (ii) by $1,007B because of changes in the demographic assumptions; and (iii) by $628B because of changes in the law. However, changes in the projection base and changes in the economic and health care assumptions increased the present value by $535B and $79B, respectively. The net overall impact of these changes is a decrease in the present value of $1,144B.

[4]The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, HHS presents the closed group measure and open group measure. Totals do not necessarily equal the sums of rounded components.

[5]A negative number indicates a shortfall of income relative to expense.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, *Accounting for Social Insurance* (as amended by SFFAS 37*, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), HHS has included information about the HI and SMI Medicare Trust Funds. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to individuals with Medicare (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2026 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.

Limitations of the Principal Financial Statements

The principal financial statements in the "Financial Section" have been prepared to report HHS's financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from HHS's books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The 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 HHS with resources and budget authority.

Performance Management Overview

HHS uses the federal performance management framework, as outlined in the *Government Performance and Results Act of 1993* (GPRA) and the *GPRA Modernization Act of 2010*, to monitor and report on program performance and direct program improvements. Full information about performance management at HHS can be found in the HHS Agency Performance Plan and Report (APPR), published annually alongside the President's budget. For additional information, including quarterly updates on Agency Priority Goals, please refer to the HHS Performance webpage.

FY 2026 performance results will be first published in the FY 2026 Agency Performance Report and FY 2028 Agency Performance Plan, alongside the FY 2028 President's Budget Request, expected in February 2027. The following sections contain a breakout of key[6] Divisions' FY 2024 – 2026 obligations[7], FY 2025 reported performance results, FY 2026 achievements, and significant changes to financial condition in FY 2026.

USASpending is the official open data source of federal spending information, including information about federal awards such as contracts, grants, and other type of awards. HHS Divisions' obligations in this Section may differ from the reported amounts on the principal financial statements in Section II, Financial Information because the grouping methodology is based on OMB assigned elements. Although USASpending data is unaudited, HHS uses

[6] Division-level information presented in this section excludes the Office of the Secretary and Program Support Center as their activities are not reported on a comparable Division-level basis for the purpose of this presentation.

[7] USASpending is an unaudited source for financial information. The following data was referenced from USASpending as of November 4, 2026.

this data to show the obligations that Divisions incurred to provide a general understanding of the resources needed to accomplish key performance results. Division level obligations include money spent on programs as well as operational costs, debt servicing, and other non-programmatic costs. Additionally, as of the date of this report, USASpending's FY 2026 figures only include activity through August 31, 2026. The complete FY 2026 data will be available after the AFR publication.

Congress finances HHS programs supporting public health and human services activities in appropriations bills that provide authority to HHS to enter into financial obligations. Congress provides HHS appropriations annually but may also enact supplemental appropriations for certain activities or allow certain appropriations to finance activities over multiple fiscal years. The obligations displayed are drawn from current-year appropriations, funds that remain available for obligation across multiple fiscal years, or funds provided in supplemental appropriations. HHS manages unobligated funds to support ongoing and future needs within legal limits.

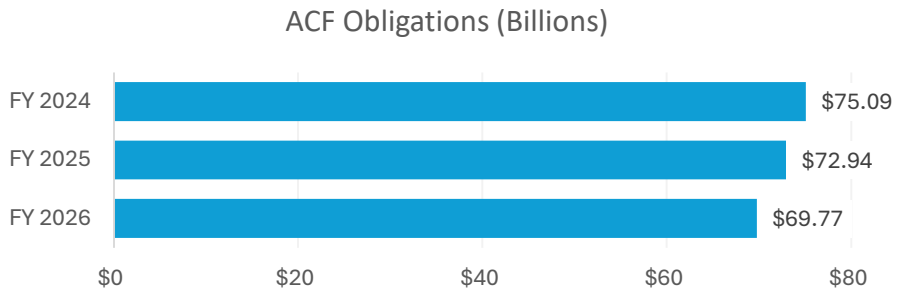
HHS USASpending Dashboard



HHS at a Glance: Organization, Financial Condition, and Performance

ADMINISTRATION FOR CHILDREN AND FAMILIES

ACF's mission is to foster health and well-being through federal leadership, partnerships, and resources for the compassionate and effective delivery of human services. ACF promotes the economic and social well-being of children, youth, families, individuals, and communities by emphasizing resilience, safety, and economic security through strategic, results-driven programs in collaboration with states, tribes, and community organizations.



FY 2025 Reported Performance Results and FY 2026 Achievements

ACF administers major programs including Temporary Assistance for Needy Families, Head Start, Child Support Enforcement, and the National Human Trafficking Hotline with a focus on three key performance areas: economic stability and family self-sufficiency, child safety and permanency, and human services program integrity. ACF demonstrated measurable progress across each of these areas:

- In FY 2025, Head Start under-enrollment fell to 8.2 percent, the fifth consecutive year of improvement, through monthly monitoring under the Full Enrollment Initiative, corrective action plans with grantees, and targeted technical assistance on recruitment and staffing. In FY 2026, ACF announced over $225M in Head Start supplemental awards to strengthen nutrition services, improve facilities, and help address critical one-time needs to better serve children and families across the nation.
- In FY 2025, approximately 9.7 million Title IV-D child support cases had support orders established, representing 86 percent of cases, maintained through Federal Parent Locator Service tools, technical assistance to states, and state-level modernization efforts.
- In FY 2025, the National Human Trafficking Hotline identified 13,623 potential trafficking situations and reported 3,643 cases to law enforcement, fielding 21 percent more signals than the prior year. The transition to a new operator in September 2025, backed by a record $35M grant, pushed the signal responsiveness rate to 99 percent with an average answer speed of 2 seconds. In FY 2026, ACF announced additional funding opportunities focused on providing long-term housing options for women and girls who have experienced sexual exploitation or abuse.

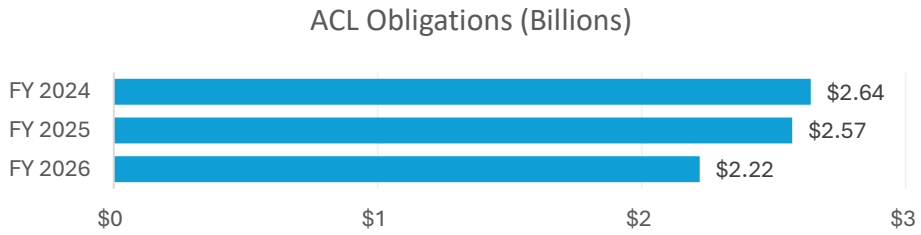
Significant Changes in Financial Condition

- Appropriations Used decreased by $4.4B, primarily due to decreases of $2.1B in Refugee programs related Operation Allies Welcome Emergency, Transitional & Medical Services, and Unaccompanied Alien Children programs; $1.1B in Child Care programs due to decreases in the Child Care and Development Block Grant and Emergency Coronavirus ARP Child Care State Stabilization Grants; and $0.9B in Children and Family Services.

HHS at a Glance: Organization, Financial Condition, and Performance

ADMINISTRATION FOR COMMUNITY LIVING

ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across their lifespan, and their families and caregivers. The Administration for Community Living (ACL) was established to create opportunities for older adults and people with disabilities to live and engage in their communities. ACL strives to remove the obstacles that limit people's choices and ability to participate in community living.



FY 2025 Reported Performance Results and FY 2026 Achievements

ACL's programs include the Senior Nutrition Program and National Family Caregiver Support Program, with a focus on reducing food insecurity and malnutrition, promoting health and social connection, and strengthening support for family caregivers. ACL highlights its progress in these areas:

- Roughly 232 million meals were delivered to older adults nationwide in FY 2025 through a network of more than 7,400 local providers, and about 62.7 million were served in congregate settings that also offered social engagement and health screenings.
- Approximately 78,900 family caregivers within FY 2025 received respite care, giving them temporary relief and, per program surveys, enabling nearly three-quarters of those served to continue providing care longer than they otherwise could. In FY 2026, a new Lifespan Respite Care Program funding opportunity became available from ACL's Administration on Aging, designed to develop and strengthen statewide respite care systems and expand support services for caregivers. Awardees will receive up to a total of $4.43M for a three-year project.

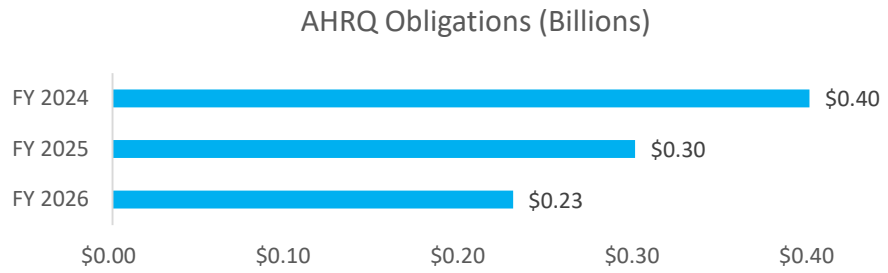
Significant Changes in Financial Condition

- Appropriations Used decreased by $0.5B, primarily due to decreases of $0.2B in Nutrition Services programs, $0.1B in Home and Community Based Services, and $0.1B in Elder Justice programs.
- Outlays decreased by $0.7B, primarily due to decreases of $0.2B in Medicare Improvements for Patients and Providers, $0.2B in Nutrition Services Programs, and $0.1B in Home and Community-Based Supportive Services.

HHS at a Glance: Organization, Financial Condition, and Performance

ADMINISTRATION FOR HEALTHCARE QUALITY AND RESEARCH

AHRQ's mission is to enhance the quality, appropriateness, and effectiveness of health services and access to such services, through scientific research and the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions. AHRQ works to fulfill its mission by conducting and supporting health services research, both within AHRQ and across HHS as well as in leading academic institutions, hospitals, physicians' offices, healthcare systems, and many other settings across the country. The Agency has a broad research portfolio that touches on nearly every aspect of healthcare.



FY 2025 Reported Performance Results and FY 2026 Achievements

AHRQ's programs and initiatives include the Medical Expenditure Panel Survey (MEPS), support for the U.S. Preventive Services Task Force (USPSTF), the Comprehensive Unit-based Safety Program (CUSP) for Telemedicine, and the Patient Safety Organization (PSO) program, with a focus on three key performance areas: expanding access to healthcare data and understanding economic outcomes, informing evidence-based preventive care, and strengthening patient safety. AHRQ demonstrated measurable progress across each of these areas:

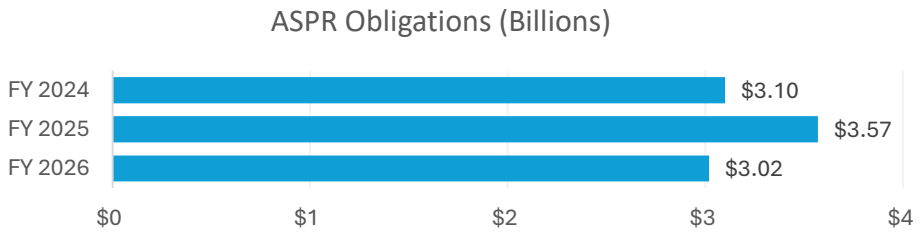
- The MEPS Table Compendia was expanded to bring the number of tables available to users to over 176,000 expanded.
- A one-time supplemental questionnaire on economic outcomes was fielded as part of the MEPS Healthcare Cost survey from January-July 2025 and new family debt questions were added. This data was released in 2026, contributing to an understanding of the effects of health and healthcare on individuals' and families' economic outcomes.
- Using a five-step process beginning with Topic Nomination and ending with Review Public Comments and Finalize Recommendation, the USPSTF: maintained recommendation statements for 90 preventive service topics; received and reviewed 19 topic nominations; posted 4 draft research plans for public comment; posted 7 draft evidence reviews and draft recommendation statements for public comment; and published 5 final evidence reviews and recommendation statements. The CUSP for Telemedicine completed implementation in over 450 telemedicine practices. The project will result in a toolkit to be posted on the website after it is completed in 2026.
- As of January 2026, there are 127 entities listed as PSOs. This is the highest number of PSOs in program history and reflects a 35 percent increase in the number of listed PSOs since the end of CY 2020.

Significant Changes in Financial Condition

- AHRQ had no significant fluctuations in FY 2026.

ASPR ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE

ASPR's mission is to lead the nation's medical and public health preparedness for, response to, and recovery from disasters and other public health emergencies. ASPR collaborates with healthcare systems, government partners, and communities to improve readiness, deploy clinical response teams, manage critical response tools, and strengthen national health security against current and emerging threats.



FY 2025 Reported Performance Results and FY 2026 Achievements

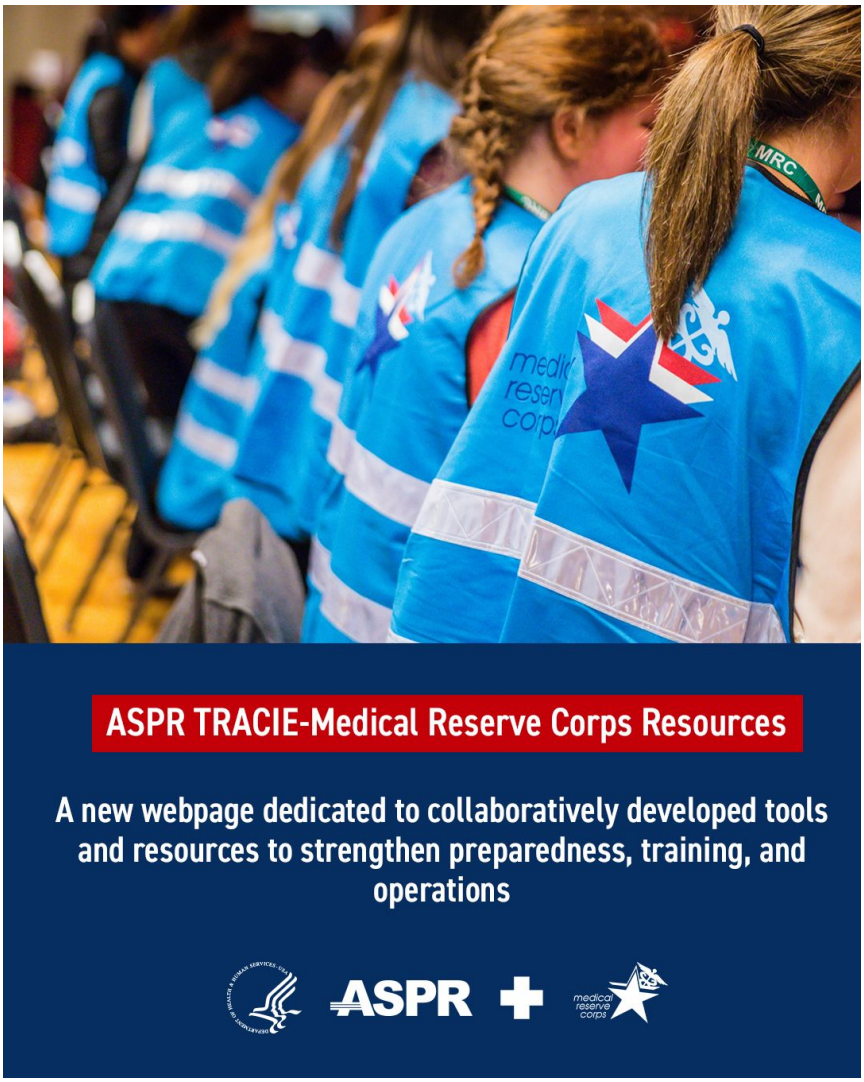
ASPR administers major programs and capabilities including the Biomedical Research and Development Authority (BARDA), Strategic National Stockpile (SNS), and emPOWER Program, with a focus on three key performance areas: advancing and securing medical countermeasures, maintaining critical medical supplies for emergency response, and strengthening data-driven preparedness and response for at-risk populations. ASPR demonstrated measurable progress across each of these areas:

- As of October 2026, BARDA-supported products have achieved 116 FDA total approvals. A complete list of FDA approvals can be found on BARDA's website. The 116 approvals include, for example, 10 Food and Drug Administration (FDA) approvals of medical countermeasures (MCMs) reported during 2025. These MCMs address multiple threat areas, including first-in-class oral antibiotics, a diagnostic distinguishing bacterial from non-bacterial respiratory infections, and SI-enabled imaging for nuclear-blast injuries. The results are based on both supplemental and base appropriations. In FY 2026, BARDA announced nine winners of the Small Molecule Approaches for Rapid and Robust Treatment Antiviral Prize Concept Stage and an additional $50M investment, expanding the competition to $150M to accelerate development of broad-spectrum antiviral therapeutics. The selected approaches target viruses including dengue, Zika, West Nile, and Chikungunya, with each winning team receiving $2.5M to advance promising antiviral candidates toward the next phase of development.
- SNS sustained a 99.98 percent inventory accuracy rate and 100 percent financial accuracy across its $11.9B inventory, with no product lost to manufacturing-practice noncompliance or noncompliance with FDA Current Good Manufacturing Practice (cGMP). In FY 2025, the SNS closed two warehouses that previously held PPE and one warehouse that housed ultra-cold chain products. Closing these three warehouses allowed SNS to redirect almost $38M in FY 2025 and $48M in FY 2026 to other priority projects. In FY 2026, ASPR continued to strengthen SNS by prioritizing the transition and replenishment of critical medical countermeasures.
- In FY 2025, HHS emPOWER Program public resources were accessed more than 1.4M times and public health authorities requested emPOWER Response Outreach Datasets to support life-saving response outreach for 26 events. In FY 2026, HHS emPOWER Program public resources were accessed more than 1.47 million times and public health authorities requested HHS emPOWER Emergency Response Outreach Datasets to support life-saving outreach in 41 events, a 58 percent increase from FY 2025. The events

included winter storms in Texas, Maryland, Virginia and North Carolina, critical infrastructure failures and power outages in Wyoming and Idaho, tornadic storms in Missouri, hurricanes in Hawaii, typhoons in Alaska, and wildfires in Colorado, South Dakota, Oregon, and Utah.

Significant Changes in Financial Condition

- FBwT increased by $1.1B due to an increase in carryover funds from the prior year.
- Inventory increased by $1.1B, primarily due to increases in the SNS and Project BioShield.

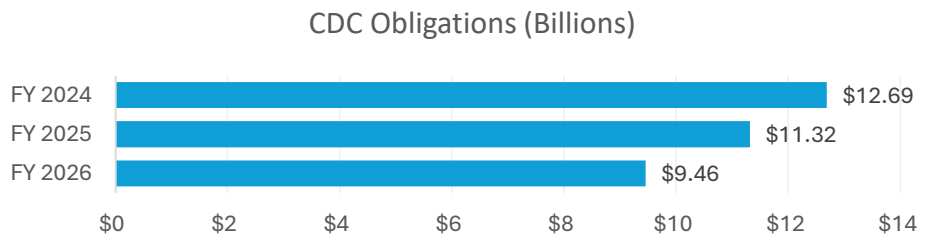


Explore the new webpage at https://lnkd.in/e3suHq3u

HHS at a Glance: Organization, Financial Condition, and Performance

CDC | CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC's mission is to protect the health, safety, and security of Americans by preventing and responding to public health threats, both domestic and global. CDC advances health through science, technology, and innovation; provides timely, evidence-based guidance; and strengthens public health systems to ensure rapid, transparent, and effective responses to emerging challenges.



FY 2025 Reported Performance Results and FY 2026 Achievements

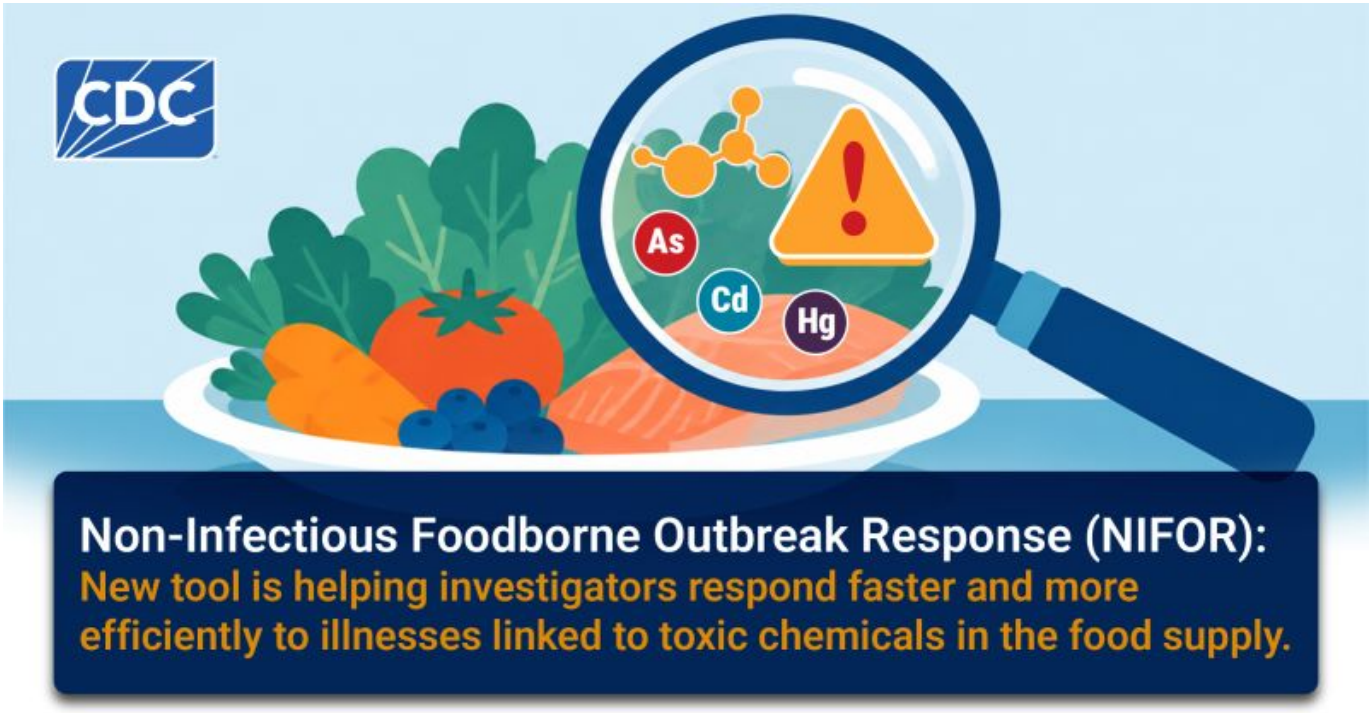
CDC administers major programs and capabilities including the National Syndromic Surveillance Program (NSSP), Antimicrobial Resistance Laboratory Network (AR Lab Network), PulseNet, and Healthcare-Associated Infection and Antimicrobial Resistance (HAI/AR) Programs, with a focus on three key performance areas: strengthening public health surveillance and emergency response, detecting and responding to antimicrobial resistance, and improving laboratory capacity to identify and prevent infectious disease outbreaks. CDC demonstrated measurable progress across each of these areas:

- In FY 2025, 84 percent of non-federal emergency departments participated in the NSSP, providing near-real-time insight during responses to H5 influenza, measles, mpox, overdoses, and mass gatherings; growth came from dedicated onboarding staff and customer service to jurisdictional partners. In FY 2026, CDC continued to expand NSSP participation, with 85 percent of U.S. emergency departments now contributing data and more than 7,500 health care facilities across all 50 states, the District of Columbia, and Guam providing data daily. This data is generally available within 24 hours of an emergency department visit, supporting near-real-time detection and monitoring public health threats.
- Seventy-four percent of AR Lab Network laboratories tested samples of carbapenem-resistant Enterobacterales (CRE) within the target time. CRE are bacteria that resist an important group of antibiotics. Seven regional labs helped with specialized testing and periods of high demand, but heavy workloads and staffing shortages limited further improvement. As the network marked its 10th anniversary in FY 2026, CDC reported that it had conducted more than 1.5 million tests through the end of 2025, including more than 520,000 isolate characterizations, 530,000 colonization screenings, and 664,000 whole genome sequences.

- PulseNet laboratories identified 197 priority pathogen clusters in FY 2025, with 11 multistate investigations leading to public outbreak notices, aided by the transition to the cloud-based PulseNet 2.0 platform. More than 16,000 healthcare-associated infections were prevented in U.S. hospitals in the prior reporting year. In FY 2026, CDC continued to modernize PulseNet's outbreak detection capabilities through expanded use of whole genome sequencing in state laboratories and development of advanced methods to detect outbreaks using culture-independent diagnostic tests. As PulseNet marked its 30th anniversary, CDC estimated that the network helps prevent approximately 270,000 foodborne illnesses annually from Salmonella, E. coli, and Listeria.

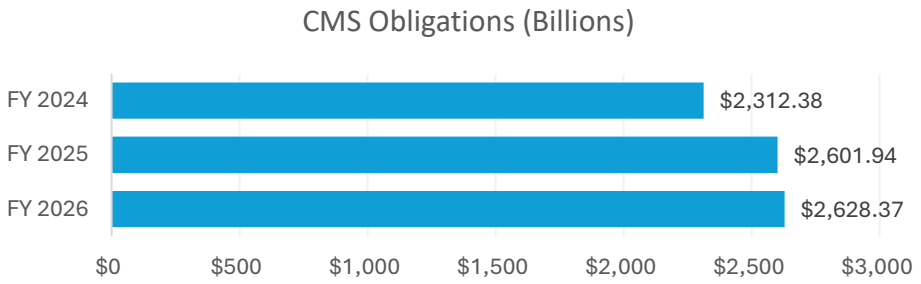
Significant Changes in Financial Condition

- Appropriations Used decreased by $2.0B, primarily due to a $1.2B decrease in the use of COVID-19-related funding, a $0.2B decrease in the Vaccines for Children (VFC) Program, and $0.5B across other CDC programs.
- Outlays decreased by $1.9B, primarily due to the timing of liquidating obligations in COVID-19 supplemental funding, $0.5B in the Vaccines for Children program, and $0.2B across other CDC programs.



Explore the new webpage at https://bit.ly/4BxcO70.

CMS's mission is to ensure the most vulnerable receive high-value care by leading all payors and supporting providers. CMS collaborates across the health system to improve care quality, promote health equity, and drive innovation. CMS also manages one of the largest collections of health care data in the country, using it to inform evidence-based policy and system-wide improvements.



FY 2025 Reported Performance Results and FY 2026 Achievements

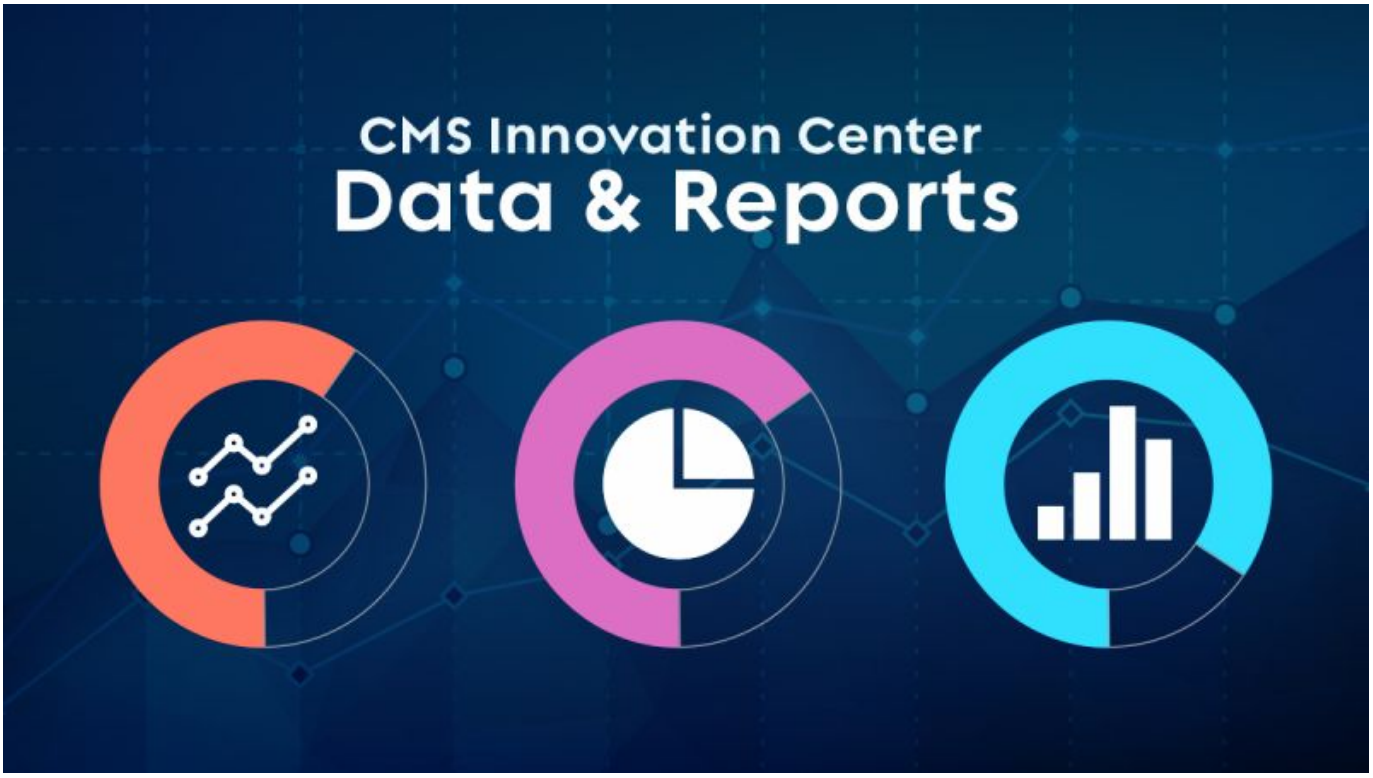
CMS administers major programs and initiatives including Medicare, Medicaid, the CHIP, the Fraud Prevention System, and nursing home quality and staffing oversight, with a focus on three key performance areas: strengthening program integrity and payment accuracy, maintaining access to health coverage and quality care, and improving oversight and accountability across federal health care programs. CMS demonstrated measurable progress across each of these areas:

- The Medicare Fee-for-Service improper payment rate improved to 6.55 percent, driven by strengthened documentation, predictive analytics, and program integrity work. In FY 2026, CMS continued strengthening Medicare program integrity through advanced analytics, including SI and machine-learning models, to identify unusual billing patterns and potentially fraudulent activity. These efforts helped stop more than $1.6B in potentially improper Medicare laboratory payments.
- The Fraud Prevention System saved $303.1M by automatically identifying and stopping problematic claims, supported by agile edit-logic revisions, advanced predictive modeling, and law enforcement partnerships. Across all integrity measures, CMS identified roughly $93.5B in estimated IP. In FY 2026, CMS expanded its data-driven program integrity efforts, with the Medicaid Fraud War Room stopping more than $203M in potentially improper Medicaid payments during its first 88 days. The initiative coordinated federal and state enforcement actions against 50 high-risk providers identified through advanced data analytics.
- In FY 2025, CHIP and Medicaid together covered 45 million low-income children, funding check-ups, dental care, and major medical needs, even as states resumed routine Medicaid renewals after the pandemic-era continuous-enrollment period ended. In FY 2026, CMS launched a new partnership with 37 states to strengthen quality measurement across Medicaid and CHIP, prioritizing health outcomes in prevention, chronic disease management, and behavioral health. The initiative is designed to shift quality measurement toward demonstrating meaningful improvements in beneficiary health outcomes.
- 98.5 percent of long-term care facilities submitted complete staffing data through the Payroll-Based Journal (PBJ), supported by secure electronic submission platforms and automated verification. In FY 2026, CMS continued to modernize PBJ reporting, launching PBJ functionality in the Internet Quality Improvement

and Evaluation System in August 2026. The updated system also added an automated control preventing reported staffing hours from exceeding 22.5 hours per day for a single system employee ID.

FY 2026 Significant Changes in Financial Condition

- Appropriations increased by $432.0B, primarily due to increases of $207.3B in the PTF account; $97.8B in Medicaid; $45.2B in SMI; $42.8B in Medicare Part D; $25.6B in HI; $11.7B in CHIP, mainly from the Rural Health Transformation Program; and $1.7B in Other Health programs.
- Obligations increased by $272.8B and Outlays increased by $248.5B, driven by the increased appropriations received for PTF, Medicaid, SMI, Part D, HI, CHIP, and Other Health programs.

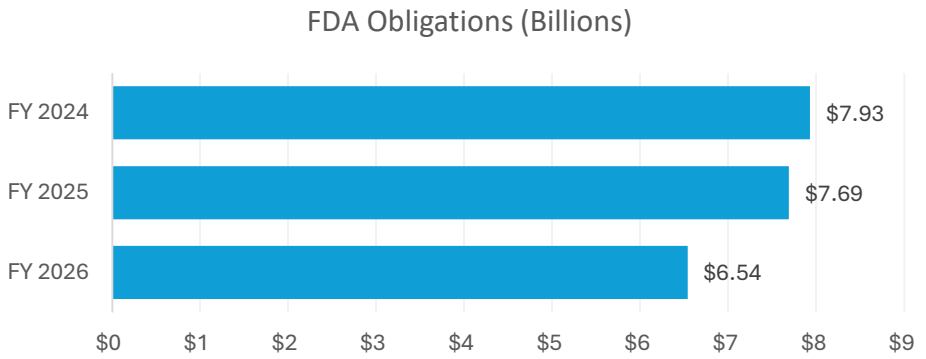


Source new research hub available: https://lnkd.in/e3suHq3u

HHS at a Glance: Organization, Financial Condition, and Performance

FDA | FOOD AND DRUG ADMINISTRATION

FDA's mission is to protect public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices, as well as the safety of the nation's food supply, cosmetics, dietary supplements, radiation-emitting products, and tobacco. FDA advances health by accelerating innovation, supporting the development of medical products, and providing science-based information to help the public make informed decisions and respond to both routine and emerging health threats.



FY 2025 Reported Performance Results and FY 2026 Achievements

FDA administers major programs and activities including the Voluntary National Retail Food Regulatory Program Standards, global inspection and regulatory oversight activities, and the Generic Drug Program, with a focus on three key performance areas: strengthening food safety and regulatory partnerships, ensuring the safety and quality of imported FDA-regulated products, and supporting timely access to safe and effective generic drugs. FDA demonstrated measurable progress across each of these areas:

- FDA reported 995 state, local, and tribal regulatory agencies in the Voluntary National Retail Food Regulatory Program Standards in FY 2025, reflecting sustained engagement, outreach, training, and technical assistance. In FY 2026, FDA continued to support state, local, tribal, and territorial partners through dedicated Retail Food Regulatory Program Standards workshops, providing training on program requirements, self-assessments, and verification audits. FDA also issued the 2026 Food Code to provide regulators with updated, science-based guidance for safeguarding food at retail and food service establishments.
- The Office of Global Policy and Strategy conducted 367 foreign inspections in FY 2025, completing assignments with investigators stationed in China, India, and Mexico verifying compliance with current Good Manufacturing Practice (cGMP) requirements for FDA-regulated products before they reach the U.S. market. In FY 2026, FDA continued strengthening foreign manufacturing oversight by expanding its use of unannounced inspections. Unannounced inspections increased to 87 percent of inspections conducted by FDA's India Office and 61 percent of those conducted by its China Office during FY 2026 year-to-date, strengthening FDA's ability to assess manufacturing quality and regulatory compliance.
- FDA met review timeline requirements for 97 percent of standard original Abbreviated New Drug Applications (ANDA) for applications submitted in FY 2024. Meeting the required timeframes for reviewing and acting on standard original ANDAs under the Generic Drug User Fee Amendments (GDUFA) facilitates

the timely identification and resolution of any application deficiencies and helps drive timely access to generic medicines. FY 2025 results are preliminary with a significant number of pending submissions undergoing review. In FY 2026, FDA continued efforts to streamline generic drug development and ANDA assessment by publishing additional product-specific guidance (PSGs). In August 2026, FDA issued 55 new and revised PSGs to clarify the evidence and information needed to support generic drug applications and facilitate more efficient generic drug development.

Significant Changes in Financial Condition

- FBwT increased by $0.8B, primarily due to lower disbursements overall, including payroll, and grant disbursements.
- Outlays decreased by $0.7B, reflecting FDA's concentrated effort to reduce spending by consolidating core functions and reducing infrastructure costs.

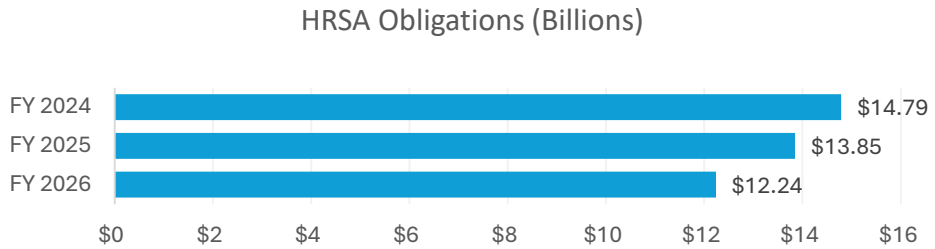


Explore the webpage at https://www.fda.gov/food

HHS at a Glance: Organization, Financial Condition, and Performance

HRSA HEALTH RESOURCES AND SERVICES ADMINISTRATION

HRSA's mission is to improve health outcomes through access to quality services, a skilled health workforce, and innovative, high-value programs. HRSA also strengthens the health care infrastructure by supporting workforce training, expanding telehealth, funding community health centers, and managing programs such as organ donation, vaccine injury compensation, and prescription drug discounts.



FY 2025 Reported Performance Results and FY 2026 Achievements

HRSA administers major programs and initiatives including the Health Center Program, National Health Services Corps (NHSC), and Federal Office of Rural Health Policy programs, with a focus on three key performance areas: expanding access to primary and preventive care, improving maternal health and health outcomes, and strengthening the health care workforce and rural health systems. HRSA demonstrated measurable progress across each of these areas:

- Health centers served 32.7 million patients, an increase of about 300,000 over the prior year. This increase was driven by expanded clinic capacity and longer operating hours across roughly 1,400 health centers and over 16,600 delivery sites. In FY 2026, HRSA continued to expand access to primary care through more than $102M in New Access Point awards to 158 health centers. These investments are expected to bring primary care services to nearly 1 million additional people across the country.
- Seventy-three percent of pregnant health center patients began prenatal care in the first trimester, supported by collaboration with technical assistance partners; health centers supported over 325,000 deliveries in 2025. In FY 2026, HRSA continued to strengthen maternal and child health services, awarding more than $525M to 56 states and jurisdictions through the Maternal, Infant, and Early Childhood Home Visiting Program. The investment expands evidence-based services that support healthy pregnancies and connect pregnant women and families with needed health and community services.
- The NHSC fielded more than 18,500 clinicians in medically underserved areas, with roughly one in three serving rural communities. The Corps was sustained by prioritizing continuation awards to retain clinicians. In FY 2024, Rural Outreach grants reached 572,000 unique individuals through strengthened rural health networks and expanded access in isolated areas. In FY 2026, HRSA continued to strengthen the rural health care workforce, awarding more than $11M to expand medical residency programs in rural and tribal communities. The investment supports the training of physicians in rural settings to help build a sustainable pipeline of clinicians serving communities with limited access to care.

HHS at a Glance: Organization, Financial Condition, and Performance

Significant Changes in Financial Condition

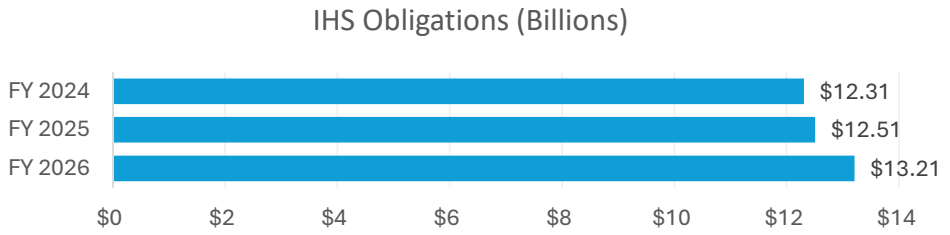
- Appropriations increased by $2.6B, primarily due to program level increased by $1.4B including $1.0B in discretionary appropriations and $0.4B in mandatory resources. In addition, $0.9B is due to funding for congressionally directed spending.
- Appropriations Transfers-In increased by $1.4B, reflecting transfers from OS to HRSA for the Community Health Centers and the National Health Service Corps Fund.
- Obligations increased by $1.0B, primarily due to additional funding received this fiscal year for congressionally directed spending.



Read the announcement: https://www.hhs.gov/press-room/

INDIAN HEALTH SERVICE

IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. The IHS vision is a health system that embraces traditional knowledge and practices to foster thriving communities for generations. As the principal federal health care provider for AI/AN, IHS delivers comprehensive health services to approximately 2.8 million individuals from 574 federally recognized tribes across 37 states.



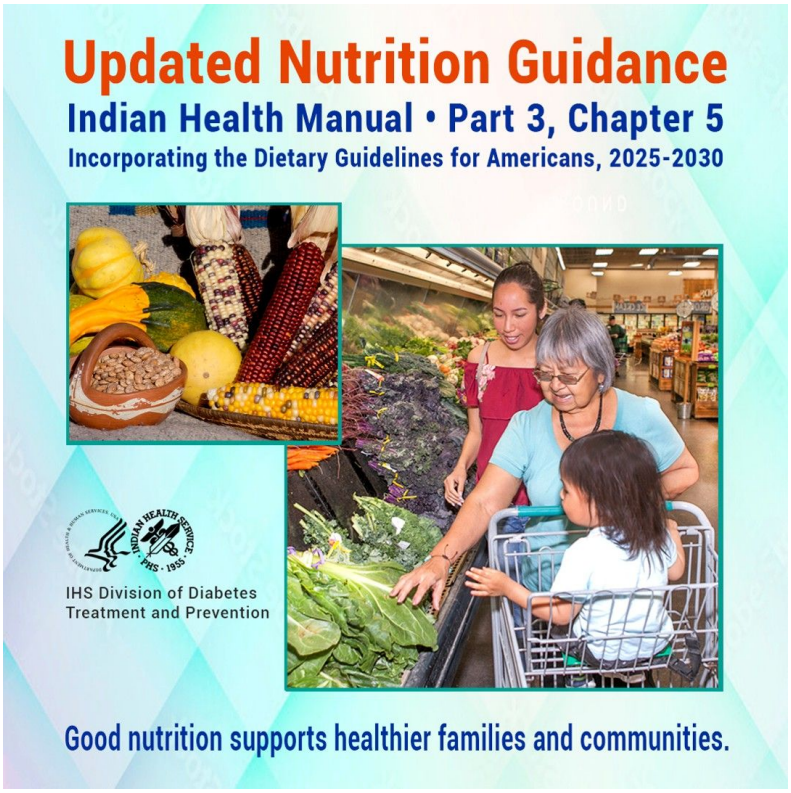
FY 2025 Reported Performance Results and FY 2026 Achievements

IHS administers major programs and initiatives including the Special Diabetes Program for Indians (SDPI), Health Professions Scholarship Program, and Tribal Epidemiology Centers (TECs), with a focus on three key performance areas: improving chronic disease prevention and management, strengthening the Indian health workforce, and building tribal public health capacity. IHS demonstrated measurable progress across each of these areas:

- In FY 2025, the percentage of AI/AN individuals with diabetes who had poor glycemic control (A1c greater than 9 percent) decreased to 11.9 percent. This improvement coincided with continued efforts through the SDPI to strengthen diabetes care, patient support, and access to services. Among AI/AN patients with diabetes in SDPI, 56.6 percent had controlled blood pressure (less than 140/90 mmHg), up from 55.8 percent in FY 2024. These gains occurred amid staffing and medication access challenges, as efforts continued to strengthen clinical training and care coordination. In FY 2026, IHS continued to strengthen diabetes prevention and treatment through the SDPI, which received $200M in funding, a $41M increase since the previous fiscal year. IHS also awarded administrative supplements to 310 SDPI grant recipients to support continued diabetes prevention and treatment efforts in AI/AN communities.
- Proactive recruitment of Health Professional Scholarship recipients drove a 49 percent placement rate of Health Professions Scholarship recipients in Indian health settings within 90 days of graduation. This effort shares upcoming graduate lists with Area Offices and tribal organizations well in advance. In FY 2026, IHS continued to strengthen the Indian health workforce pipeline by accepting applications for Health Professions Scholarship support for the 2026-2027 academic year. The program supports AI/AN students pursuing health professions education, helping increase the number of AI/AN health care professionals and address clinical workforce shortages in tribal communities.
- Tribal Epidemiology Centers (TEC) completed 542 trainings and technical assistance activities to build tribal public health capacity across twelve tribal centers. In FY 2026, IHS continued to strengthen TECs by establishing a new funding opportunity to expand public health services, epidemiologic capacity, and data-driven approaches to improving AI/AN health. The investment supports continued development of tribal capacity to identify and respond to public health priorities.

Significant Changes in Financial Condition

- Obligations increased by $2.1B, primarily due to increases of $1.4B in Contract Support Costs and $0.8B in Indian Health Services.
- Appropriations Used and Outlays increased by $1.7B, primarily due to higher expenditures for Contract Support Costs, Tribal Lease Payments, and Facilities.

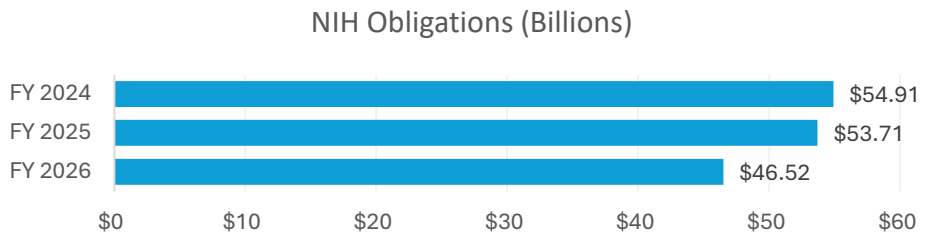


Explore the available resources: https://lnkd.in/eaAbgZzk

HHS at a Glance: Organization, Financial Condition, and Performance

NIH National Institutes of Health *Turning Discovery into Health* | NATIONAL INSTITUTES OF HEALTH

NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and to the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. NIH fosters creative discoveries and innovative research strategies, supports the development of scientific resources, and promotes the highest standards of scientific integrity and public accountability. NIH leads and funds research across a wide range of health areas to improve the health of the nation and ensure a strong return on public investment.



FY 2025 Reported Performance Results and FY 2026 Achievements

NIH supports major research programs and initiatives in infectious disease prevention and treatment, SI-enabled health research, and substance use and addiction, with a focus on three key performance areas: advancing vaccines and therapeutics for emerging infectious diseases, accelerating biomedical research through the adoption of SI, and developing interventions to prevent and treat substance use disorders. NIH demonstrated measurable progress across each of these areas:

- In FY 2025, researchers evaluated nine broadly protective influenza vaccine candidates in late preclinical and early clinical studies, expanding the pool of candidates beyond the six reported the prior year, in line with the goal of developing a universal flu vaccine. In FY 2026, NIH conducted clinical trials for universal influenza vaccine candidates, continuing efforts to develop broader and more durable protection against seasonal and pandemic influenza viruses.
- NIH advanced seven new antiviral drug candidates in FY 2025, targeting threats like enterovirus D68, yellow fever, bunyaviruses, and orthopoxviruses, and supported clinical trials for a new influenza treatment and two antibodies for treating HIV in children. In FY 2026, NIH continued to advance therapeutics against viral threats, with NIH-funded researchers identifying the first comprehensive group of human antibodies targeting the measles virus. Several antibodies reduced the virus to undetectable levels in an animal model, providing a foundation for potential antibody-based measles treatments.
- The AIM-AHEAD program supported over 40 SI research projects addressing chronic disease or improving health care outcomes through partnerships with academic institutions, healthcare providers, and non-profits. In FY 2026, NIH continued to advance SI-enabled health research, with NIH-funded researchers developing a machine-learning model capable of analyzing 3D computed tomography scans to assist with diagnosis and predict the future onset of chronic diseases. The model demonstrated the potential for SI to streamline clinical assessments and identify disease risk earlier.
- To advance treatments for opioid use disorder, researchers conducted a human validation study of a novel over-the-counter naloxone formulation intended to aid bystander overdose response in 2025. The novel

formulation is now undergoing further development to meet FDA requirements. In FY 2026, NIH continued to advance treatments for opioid use disorder, with an FDA-approved Investigational New Drug application paving the way to launch a Phase I clinical trial of purified mitragynine, the primary psychoactive compound in kratom, to evaluate its safety as a potential treatment for opioid use disorder.

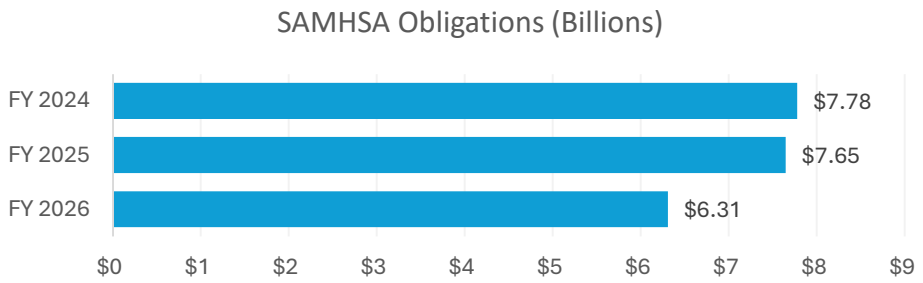
Significant Changes in Financial Condition

- Gross Cost for Research decreased by $2.6B, primarily due to decreases of $0.6B in the National Cancer Institute; $0.4B in National Institute of Allergy and Infectious Diseases; $0.4B in the Royalties and Management Fund; and $0.2B each in the National Institute on Aging, the National Institute of Child Health and Human Development, the National Institute of Neurological Disorders and Stroke, the National Institute of Mental Health, and the NIH Service and Supply Fund.
- FBwT increased by $1.5B, primarily due to higher appropriations received in FY 2026 compared to FY 2025. The most significant increases were $0.4B for the Advanced Research Projects Agency for Health, $0.3B for the National Cancer Institute, and $0.3B for the National Institute of General Medical Sciences.
- Appropriations Used decreased by $1.5B, primarily due to reduced staffing resources related to the government shutdown in early FY 2026 and the FY 2025 Reduction in Force in the Personnel Compensation and Benefits of $0.5B, the Contractual Services and Supplies for $0.6B, and the Grants and Fixed Charges for $0.6B which is offset by $0.2B in Acquisition of Assets.

HHS at a Glance: Organization, Financial Condition, and Performance

SAMHSA | SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

SAMHSA's mission is to lead public health and service delivery efforts that treat mental illness, prevent substance misuse and addiction, and provide treatments and support that foster recovery while ensuring access and better outcomes for all. SAMHSA advances the behavioral health of the nation by addressing co-occurring disorders, expanding crisis care, improving access to evidence-based treatment, and helping individuals achieve long-term recovery.



FY 2025 Reported Performance Results and FY 2026 Achievements

SAMHSA administers major programs and initiatives including the 998 Suicide & Crisis Lifeline, Community Mental Health Services Block Grant, opioid overdose prevention grant programs, and Children's Mental Health Initiative, with a focus on three key performance areas: strengthening crisis and behavioral health services, expanding substance use and overdose prevention efforts, and improving mental health services for children, families, and communities. SAMHSA demonstrated measurable progress across each of these areas:

- The 988 Suicide & Crisis Lifeline answered over 6,747,390 contacts in FY 2025, part of a trajectory that surpassed 23 million cumulative answered contacts by July 2026. The Lifeline is supported by a network of 200+ crisis centers and is garnering expanded public awareness (74 percent of Americans had heard of 988). In FY 2026, SAMHSA awarded $255M to support administration of the 988 Suicide & Crisis Lifeline, which had received more than 25 million contacts since its launch.
- The public mental health system served about 7.9 million people through the block grant, with 78 percent of adults and 73 percent of family members reporting positive outcomes from services. In FY 2026, SAMHSA distributed $319M through the Community Mental Health Services Block Grant to support comprehensive community-based mental health services for adults with serious mental illness and children with serious emotional disturbance. The funding was distributed nationwide as part of SAMHSA's annual block grant awards.
- The First Responders - Comprehensive Addiction and Recovery Act and Prevent Prescription Drug/Opioid Overdose-Related Deaths grant programs distributed 213,123 FDA-approved opioid overdose reversal kits, training first responders and community partners to carry, distribute, and administer the medications. In FY 2026, SAMHSA awarded $34.6M through the First Responders-Comprehensive Addiction and Recovery Act program for this training. SAMHSA also awarded $10.6M for community-based overdose prevention and response programs designed to expand access to FDA-approved opioid overdose reversal medications.
- Children's Mental Health Initiative grantees provided mental health services to 8,875 children and youth and, with a national technical assistance center, trained more than 71,000 individuals on children's mental

health. In FY 2026, SAMHSA awarded $44.3M through the Children's Mental Health Initiative to support comprehensive community mental health services for children, youth, and young adults with serious emotional disturbance and their families.

Significant Changes in Financial Condition

- FBwT decreased by $1.5B, primarily due to a $1.6B decrease in funds carried forward from the prior year and a $0.5B decrease in current year funding, partially offset by a $0.7B decrease in outlays.



Explore the Podcast at our website: https://www.samhsa.gov/substance-use/prevention/communities-talk/podcast

Grants Quality Service Management Office

Authorized by OMB Memorandum M-19-16, Centralized Mission Support Capabilities for the Federal Government, and through OMB's designation of HHS as the Grants Quality Service Management Office (QSMO), the Grants QSMO is responsible for establishing a marketplace of high-quality shared solutions and services, ensuring long-term sustainability, and driving the implementation of grants data standards. The Grants QSMO's vision is detailed in Figure 3. OMB continues to support the Grants QSMO, as reflected in 2 CFR 61.305.

In FY 2026, the Grants QSMO continued to lead transformative initiatives in federal grants management, working in close coordination with the OMB, the General Services Administration (GSA), Federal awarding agencies, and grants management service providers. These efforts focused on reducing reliance on custom grant systems, expanding access to qualified shared service and commercial solutions, and strengthening the use of common grants and data standards across the federal government.

Building on prior systems inventory and demand analysis, the Grants QSMO worked to translate the Administration's grants IT consolidation priority into an actionable government-wide strategy. The QSMO established priority agencies, conducted monthly reviews of active agency investments, engaged all grant awarding CFO Act agencies, and developed agency-specific data and recommended actions to support modernization and consolidation decisions. These efforts identified opportunities to potentially reduce more than 27 custom grants management systems government-wide.

A core objective of the Grants QSMO is to provide a robust marketplace of grants management solutions and services through the Grants QSMO Marketplace. In FY 2026, the QSMO partnered with GSA to establish a dedicated Grants Management Special Item Number (SIN) under the Multiple Award Schedule. The new SIN, pictured in Figure 1, provides agencies with a streamlined acquisition pathway to qualified grants management solutions, migration support, and technology operations services while strengthening competition, vendor accountability, and alignment with federal standards. The SIN was established in less than 6 months and launched through GSA Master Award Schedule Refresh 32 on June 4, 2026, with the first vendor awarded within 10 weeks of launch. Vendors awarded the SIN will join the nine federal shared services on the Grants QSMO Marketplace.

Figure 1: GM SIN Launch & Early Adoption



Throughout FY 2026, the Grants QSMO supported measurable agency progress toward shared-service adoption and grants system consolidation (See Figure 2). To help agencies plan and execute these transitions, the Grants QSMO hosted its inaugural Customer Migration Workshop, *Navigating Migration and Consolidation to Shared Grant Systems,* convening 46 participants from 13 federal agencies to share migration strategies, lessons learned, and best practices. The Grants QSMO also launched a Migration Sample Library on GSA's Acquisition Gateway containing real-world migration artifacts, published agency migration lessons learned, and facilitated collaboration among agencies and service providers to reduce implementation risk and accelerate modernization planning.

HHS at a Glance: Organization, Financial Condition, and Performance

Figure 2: Federal Grants Modernization



The Grants QSMO also continued to strengthen government-wide grants management requirements and resources in FY 2026. In partnership with representatives from 11 federal agencies, the QSMO completed 60 construction grants business capabilities aligned with the Federal Integrated Business Framework. These capabilities provide agencies with a common foundation for modernizing systems that support construction grants. The QSMO also released an SI-powered Notice of Funding Opportunity prompt template to help agencies identify potentially duplicative or overlapping funding opportunities and support applicable EO requirements.

Figure 3: Grants QSMO FY 2026 Achievements



Looking Ahead

Looking ahead to FY 2027, the Grants QSMO will focus on expanding and operationalizing the Grants Management SIN, accelerating agency modernization and consolidation, and strengthening federal grants systems data and visibility, including onboarding additional qualified vendors to the Grants Management SIN, supporting agencies as they evaluate modernization pathways, hosting another agency modernization workshop *Preparing for Modernization: Assessment, Planning, and Provider Selection*, and enhancing the Federal Grants Systems Hub and Grants IT systems inventory to better inform future modernization efforts.

Single Audit

A Single Audit is, as defined by the Uniform Guidance (Title 2 Code of Federal Regulations Part 200) and the *Single Audit Act of 1984*, a comprehensive financial and compliance audit of an organization that receives federal funding.

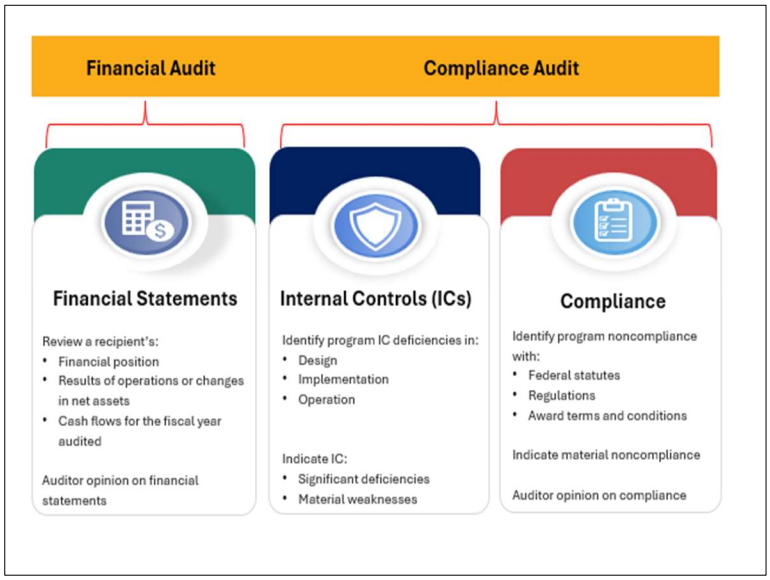
Who Needs One?

An organization must undergo a Single Audit if it spends $1M or more in Federal awards within a single fiscal year. This rule applies to State, local and tribal governments; colleges and universities, and non-profit organizations.

What Does It Check?

Instead of requiring an organization to undergo multiple, separate audits for every federal grant it receives, a Single Audit combines everything into one overarching review. It focuses on two main areas, as shown in Figure 4, a financial audit and a compliance audit.

Figure 4: Single Audit Review Process



Why Is It Important?

The Single Audit is a key Department oversight tool that covers a broad range of Federal awards and independently assesses how recipients manage those funds. The main goal is to provide assurance to the federal government that taxpayers' money is being managed responsibly and ethically. If an organization fails a Single Audit, it risks losing its federal funding.

Results

Recipients submit Single Audit reports to the Federal Audit Clearinghouse (FAC), where awarding agencies can access the results for oversight. In FY 2026, recipients of HHS funding submitted 19,592 Single Audit reports, representing 43 percent of the 45,558 reports submitted nationwide. HHS expenditures accounted for nearly half (49 percent) of the $2,211.8B in audited Federal spending (see Figures 5 and 6). Unless otherwise indicated, figures and charts in this section are sourced from the FAC.

Because Single Audits cover substantial HHS funding, timely submissions and correction of identified deficiencies are critical to effective oversight. To address persistent challenges, HHS launched the Audit Enforcement and Risk Oversight (AERO) initiative in May 2026. Led by the Office of the Assistant Secretary for Financial Resources (ASFR), AERO strengthens program integrity and accountability by promoting timely submissions and correction of audit findings.

Figure 5: Single Audit Reports Received during FY 2026

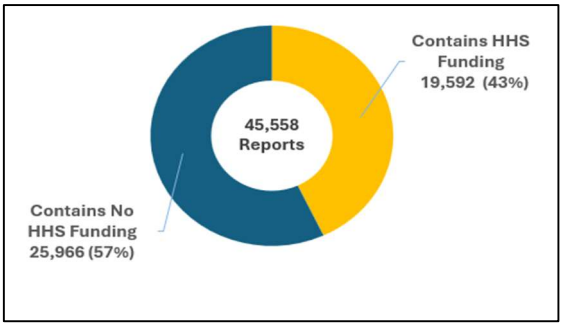
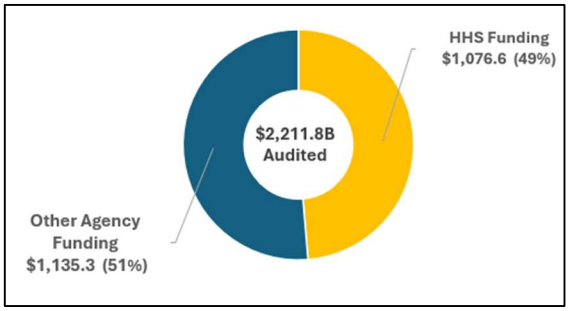


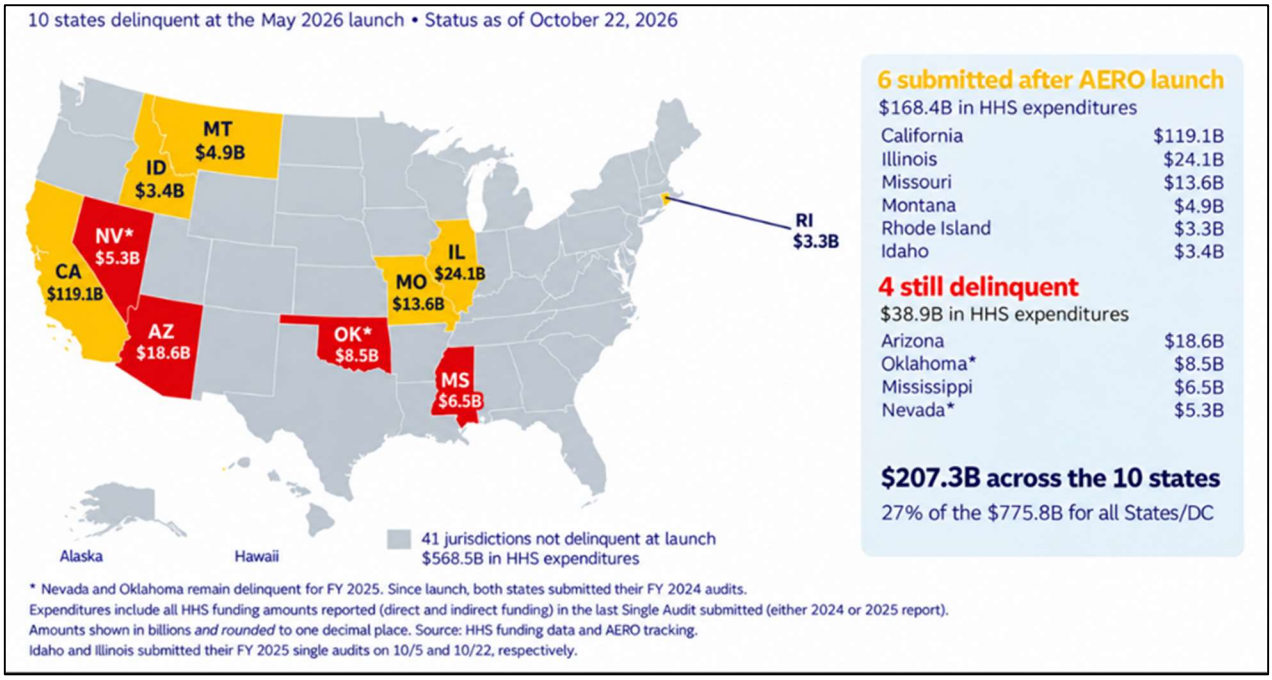
Figure 6: Funding in Single Audit Reports Received during FY 2026 (in billions)



HHS at a Glance: Organization, Financial Condition, and Performance

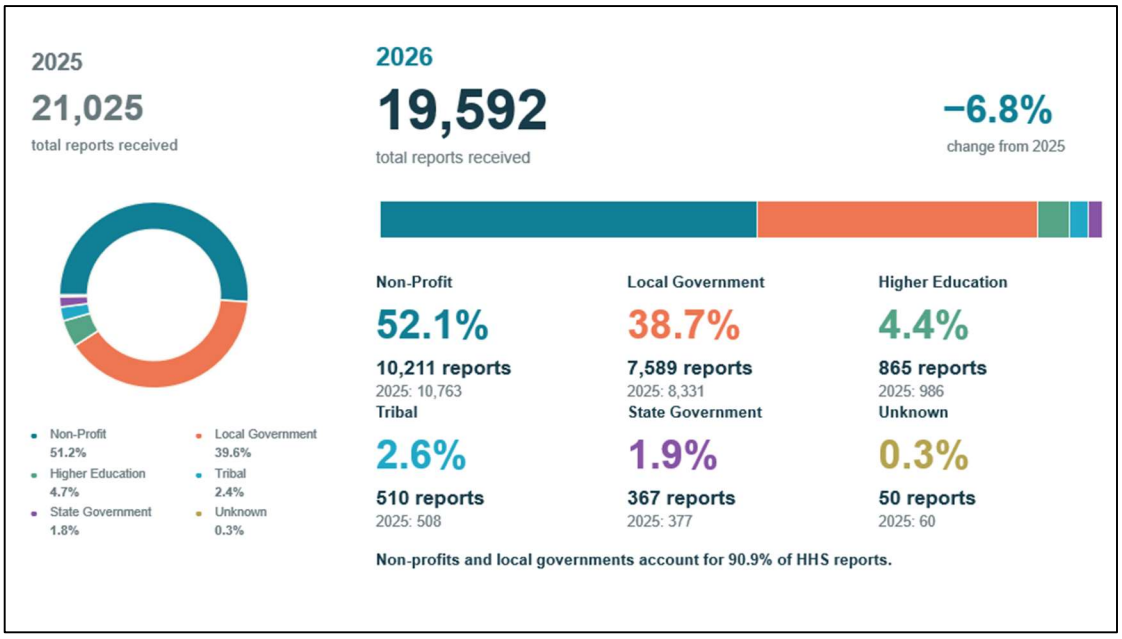
At AERO's launch, ASFR engaged 10 states with overdue FY 2025 Single Audits; Nevada and Oklahoma also had overdue FY 2024 audits. As of the date of this report, six states have since submitted their FY 2025 audits, and Nevada and Oklahoma have submitted their FY 2024 audits. The four states with outstanding FY 2025 audits have established plans to return to compliance. Collectively, the 10 states reported approximately $207B in HHS expenditures in their latest available audits. Figure 7 shows each state's submission status and associated HHS expenditures.

Figure 7: AERO Progress on Delinquent State Single Audits



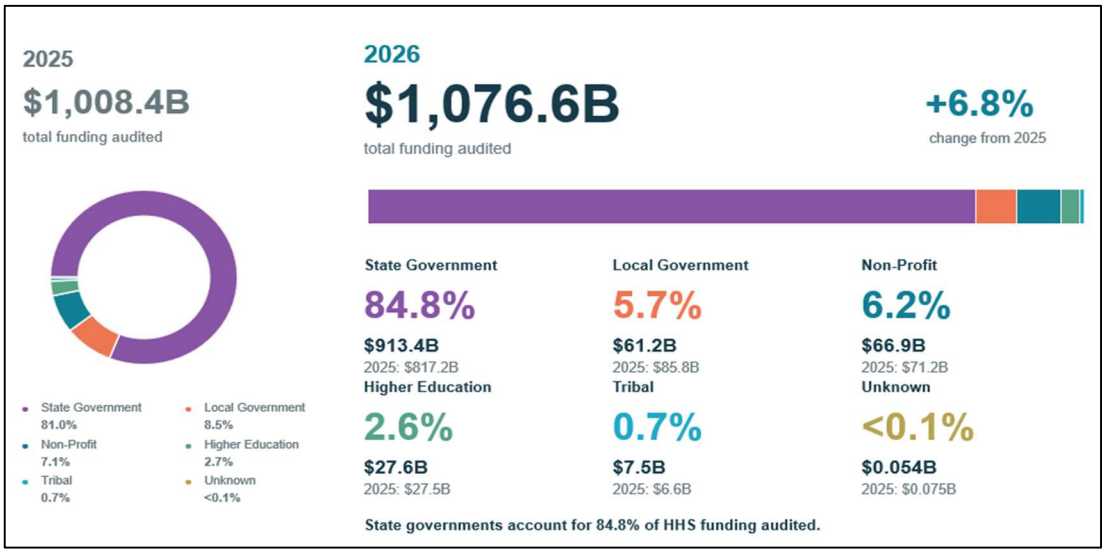
Beyond its initial outreach to states, HHS oversees Single Audits across many recipients and programs. Nearly all reports submitted by HHS recipients (91 percent) came from local governments and nonprofit organizations (see Figure 8).

Figure 8: HHS Single Audit Reports by Entity Type



However, state programs accounted for 85 percent of the $1,076.6B in audited HHS expenditures (see Figure 9).

Figure 9: HHS Funding Audited by Entity Type (in billions)



Of the HHS funded programs represented in single audit reports in FY 2026, 71 percent underwent compliance testing. Auditors select programs based on expenditures, risk, and other factors. Programs tested range from large, state-administered programs such as Medicaid and Temporary Assistance for Needy Families to locally administered programs supporting community health centers and biomedical research.

Compliance testing identifies issues requiring corrective action. Audit findings alert recipients and awarding agencies to internal control or compliance problems that might otherwise go undetected, including questioned costs, services provided to ineligible clients, errors in required financial or performance reports, and other issues.

To promote timely resolution, the Uniform Guidance requires recipients to prepare a corrective action plan for each current-year audit finding. The responsible Federal agency or pass-through entity must issue a management decision within six months after the FAC accepts the audit report. In FY 2026, auditors identified nearly $195 million in questioned costs related to HHS funding, about 30 percent of which HHS confirmed as overpayments (see the Payment Integrity section for recovery details).

By promoting timely audit submissions, resolving findings, and monitoring corrective actions, HHS strengthens accountability, program integrity, and stewardship of taxpayer dollars.

Systems, Legal Compliance, and Internal Control

FINANCIAL MANAGEMENT SYSTEMS OVERVIEW

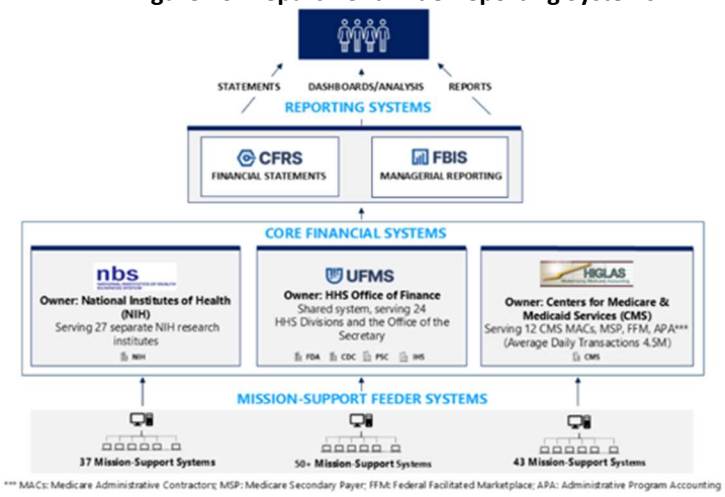
The HHS Financial Management Systems Environment (FMSE) supports the management of approximately $3.4T in FY 2026 budgetary resources. The FMSE consists of two Department-wide reporting systems and a core financial system, as shown in Figure 10. The Consolidated Financial Reporting System (CFRS) and Financial Business Intelligence System (FBIS) support financial statement preparation, managerial reporting, analytics, and data-driven decision-making.

PRIMARY OBJECTIVES

1. Efficient financial transaction processing
2. Complete and accurate financial information
3. Strong internal controls
4. Improved data integrity
5. Federal transparency

The core financial system operates through three instances: the National Institutes of Health Business System (NBS) supports NIH and ARPA-H; the Healthcare Integrated General Ledger Accounting System (HIGLAS) supports CMS; and the Unified Financial Management System (UFMS) provides shared services to the remaining 24 HHS Divisions and OS. Together, these systems integrate with more than 130 mission-support systems across HHS and the federal government. All three operate on the same commercial platform, supporting Department-wide financial data standardization. Collectively, the FMSE provides mission-critical financial capabilities that enable HHS to manage funds, process payments, and efficiently disburse resources for contracts, grants, and other financial assistance that support delivery of the HHS mission. The FMSE operates in accordance with applicable federal financial management laws and regulations. Additional information on relevant requirements is available in the HHS Financial Policy Library.

Figure 10: Department-wide Reporting Systems



FINANCIAL MANAGEMENT SYSTEMS IMPROVEMENT STRATEGY

HHS operates in a rapidly evolving environment shaped by new federal requirements and Executive Orders (EOs), increasing cybersecurity risks, accelerating technology changes, and the continued need to modernize financial systems and improve operational efficiency. The Financial Management Systems Improvement Strategy (see Figure 11) integrates five complementary programs into a comprehensive approach to address these challenges through financial systems modernization, cloud adoption, strengthened cybersecurity and internal controls, advanced analytics, automation, and emerging technologies such as Super Intelligence (SI). Together, these programs strengthen financial management and system resilience, improve the user experience, reduce administrative burden, and enhance the accuracy, timeliness, security, and efficiency of HHS financial operations.



Figure 11: Financial Management Systems Improvement Strategy

Systems, Legal Compliance, and Internal Control

FINANCIAL SYSTEMS IMPROVEMENT PROGRAM

The Financial Systems Improvement Program (FSIP) is a multiyear program to implement state-of-the-art technology and increase HHS's return on system investments. HHS maintained 99.95 percent system availability and 90 percent customer satisfaction across UFMS, FBIS, and CFRS, while advancing initiatives to improve the efficiency and effectiveness of the FMSE.

99.95 percent
System Availability

90 percent
Customer Satisfaction

1 STRENGTHENED PAYMENT INTEGRITY

Strengthened federal payment integrity and advanced implementation of EOs 14247 and 14249 by modernizing HHS payment-file and financial system capabilities, enabling paper-check exception decisions, Do Not Pay validation against Treasury's Death Master File, and advancement of taxpayer and bank-account verification. These improvements strengthened payment accuracy, traceability, and helped prevent improper payments.

83 percent
Reduction in Paper Checks

100 percent
Treasury Do Not Pay Use

2 CONSOLIDATED PROCUREMENT

Implemented financial system changes supporting HHS's transition from decentralized procurement to modernized enterprise shared services under the Office of Mission Acquisition Solutions (OMAS), enabling transitioning of more than 4,000 contract awards representing approximately $2.5B in annual obligations to harness collective buying power and drive Department-wide efficiencies.

3 ADVANCED G-INVOICING COMPLIANCE AND TRANSACTION EFFICIENCY

Advanced G-Invoicing compliance and interagency buy/sell transaction efficiency, supporting remediation of a government-wide material weakness. Automating high-volume Service and Supply Fund processing increased adoption and saved ~6K labor hours in FY 2026.

88 percent
G-Invoicing utilization across eligible transactions

$6.52B
In G-Invoicing transactions

10,887
G-Invoicing orders

~6K
Labor hours saved

4 STRENGTHENED FINANCIAL SYSTEM RESILIENCE

Completed the first comprehensive UFMS Portfolio disaster recovery exercise, simulating a real-world service disruption and validating recovery of critical financial systems and supporting services to strengthen continuity and recovery readiness.

19
Financial applications and security/monitoring tools covered

Validated
Networking routing, external dependencies, connectivity, and end-to-end recovery capabilities

5 ADVANCED ENTERPRISE FINANCIAL MODERNIZATION

Advanced enterprise financial modernization initiatives, including GO.gov Travel, Grants Close-out Business Process Reengineering (CBPR), and Treasury cloud migration, positioning HHS to streamline business processes, reduce manual and fragmented operations, strengthen system integration, and deliver more standardized, automated, and scalable financial services.

Systems, Legal Compliance, and Internal Control

FINANCIAL BUSINESS INTELLIGENCE PROGRAM

The Financial Business Intelligence Program provides approximately 1,500 HHS financial management users with analytics and reporting capabilities through FBIS, helping transform financial data into information for operational and strategic decision-making.

1 EXPANDED FBIS ASSISTANT



Enhanced the FBIS Assistant, an SI-enabled support tool that helps users quickly find reports, training materials, and support resources.

Since its launch in FY 2024, the Assistant has supported:

250K+	954	75 percent
user interactions	frequent users	satisfaction rate

2 SUSTAINED FEDERAL SPENDING TRANSPARENCY & DATA QUALITY

Implemented required Treasury reporting changes ahead of mandated deadlines, enabling timely DATA Act submissions and uninterrupted Department-wide financial reporting while strengthening the accuracy and integrity of HHS spending, award, and procurement data.

99 percent	COMPLIANT WITH
DATA Act match rate	DATA Act reporting requirements

FINANCIAL MANAGEMENT SYSTEMS INNOVATION PROGRAM

HHS is applying automation, cloud technology, and SI to streamline financial processes, strengthen system performance, and reduce manual effort.

1 EXPANDED FINANCIAL MANAGEMENT AUTOMATION



Expanded financial management automation through Robotic Process Automation (RPA), delivering measurable improvements in transaction processing, automation performance, and reduced manual effort.

40K+	95 percent	~9K
Transactions processed	Automation success rate	Staff hours saved

2 MODERNIZED FINANCIAL SYSTEMS INFRASTRUCTURE



Transitioned from vendor-dependent hosting to an HHS-controlled cloud environment, increasing agility, portability, security visibility, and operational control while supporting approximately 5,000 users without disruption.

300+	~80 percent	65 percent
Servers transitioned	Faster incident response	Reduction in vulnerabilities

3 ADVANCED ENTERPRISE SI ADOPTION AND EFFICIENCY



Advanced enterprise SI adoption through a Vertex SI pilot spanning software development, testing, cybersecurity, incident management, and RPA quality assurance, demonstrating opportunities to accelerate delivery and redirect technical resources to higher-value mission priorities.

97 percent	~50 percent ↓	25-30 percent
RPA code-review time	UFMS information-search time	Development and code-review effort

Systems, Legal Compliance, and Internal Control

FINANCIAL SYSTEMS SECURITY AND INTERNAL CONTROLS PROGRAM

The Financial Systems Security and Internal Controls Program provides governance and oversight to strengthen the reliability, availability, security, and internal control of HHS financial systems. The program coordinates risk remediation, control assessments, and audit-readiness activities across the Department.

NO IT MATERIAL WEAKNESS **since FY 2018**

NO IT SIGNIFICANT DEFICIENCY **since FY 2025**

83 percent FY 2025 AUDIT FINDINGS REMEDIATED

1 ACHIEVED A HISTORIC FINANCIAL SYSTEMS CONTROL MILESTONE

Eliminated the Department's remaining IT significant deficiency, while maintaining substantial *Federal Financial Management Improvement Act (FFMIA)* compliance and reducing financial reporting risk across systems supporting nearly one-third of all federal outlays.

2 IMPROVED SECURITY AND CONTROL EFFECTIVENESS

Sustained zero audit findings among grants management systems, UFMS, and CFRS for the fourth consecutive year and completed remediation of all remaining long-standing audit findings. These efforts significantly reduce cybersecurity and internal control risk.

97 percent Reduction in audit findings since FY 2013

87 percent Accelerated time to remediate audit findings

3 STRENGTHENED INTERNAL CONTROLS AND MANAGEMENT ASSURANCE

Standardized A-123 IT control and FFMIA assessments across HHS financial systems, strengthening risk identification, financial reporting reliability, and support for Secretary's Statement of Assurance.

91 percent Effectiveness of assessed controls

All **47** Systems substantially compliant with FFMIA

4 IMPROVED THE QUALITY AND EFFICIENCY OF FINANCIAL SYSTEMS OVERSIGHT

Automated processing of 5.8K control effectiveness data points across assessed systems within Divisions, strengthening assurance while reducing administrative burden. Improved the quality of audit evidence submitted, decreasing overall requests from 1.4K to 1.2K even as the number of controls tested increased.

99 percent Reduction in manual effort (360 → 4 hours)

12 percent Increase in tested controls (600 → 680)

FINANCIAL SYSTEMS MANAGEMENT AND GOVERNANCE

HHS strengthened enterprise financial management governance through the Financial Management Governance Board (FGB) and Enterprise Financial Systems Office (EFSO), improving coordination, stakeholder engagement, decision making, and alignment of Department-wide priorities.

1 INCREASED DEPARTMENT-WIDE COLLABORATION

Strengthened Department-wide financial management governance through the FGB, enabling more coordinated decision-making, alignment of enterprise priorities, and management of cross-cutting risks across more than 15 strategic initiatives, including grants and acquisition modernization, Human Resources IT (HRIT) modernization, and Audit Enforcement and Risk Oversight (AERO).

2 ADVANCED ENTERPRISE COLLABORATION AND INTEGRATION

Advanced enterprise collaboration and integration through the EFSO and Financial Systems Consortium (FSC), improving alignment, risk management, and execution across critical HHS financial systems initiatives. In FY 2026, these groups coordinated HHS-wide implementation for GSA's government-wide GO.gov initiative, engaging ~100 HHS and GSA leaders while addressing enterprise risks, implementation challenges, and technical dependencies.

Legal Compliance

Antideficiency Act

The *Antideficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, obligating before funds are available, and accepting unauthorized voluntary services. ADA reports can be found on U.S. GAO - ADA Resources.

HHS management is proactive in preventing ADA violations. The Administrative Control of Funds policy, as required by U.S. Code, Title 31, Money and Finance, Section 1514, "Administrative Division of Apportionments," states HHS's guidelines for budget execution, specifying basic fund control principles and concepts. HHS is currently reviewing 3 potential issues and remains fully committed to resolving these matters appropriately and complying with all aspects of the law.

Chief Financial Officers Act of 1990, Government Management Reform Act of 1994, Government Performance and Results Act of 1993, and GPRA Modernization Act of 2010

The *Chief Financial Officers Act of 1990* (CFO Act) required select executive branch federal agencies to submit annual financial statements and undergo independent financial audits. To ensure timely and accurate reporting of financial statements, the CFO Act established Chief Financial Officer positions in 24 major federal agencies (i.e., 24 CFO Act agencies) who were also responsible for financial management oversight, effective internal control implementation, and financial system modernization. The CFO Act strengthened federal financial oversight by improving the quality and reliability of financial data, enhanced accountability for the use of taxpayer funds, supported effective decision-making through accurate reporting, and paved the way for government-wide audit reporting.

The *Government Management Reform Act of 1994* (GMRA) required the preparation and submission of audited financial statements to Congress and the public in 24 CFO Act agencies. GMRA also mandated preparation and submission of government-wide consolidated audited financial statements to report on the government's financial performance and position. HHS strives for strong fiscal stewardship and transparency by complying with the CFO Act and GMRA requirements.

The *Government Performance and Results Act of 1993* established requirements for federal agencies to create strategic plans, set measurable goals, and report on performance. The *GPRA Modernization Act of 2010* strengthened these requirements by mandating priority goals, frequent performance reporting, and greater transparency. These enhancements, detailed in the Performance section of the MD&A, demonstrate HHS's commitment to achieving its mission and goals.

Digital Accountability and Transparency Act of 2014

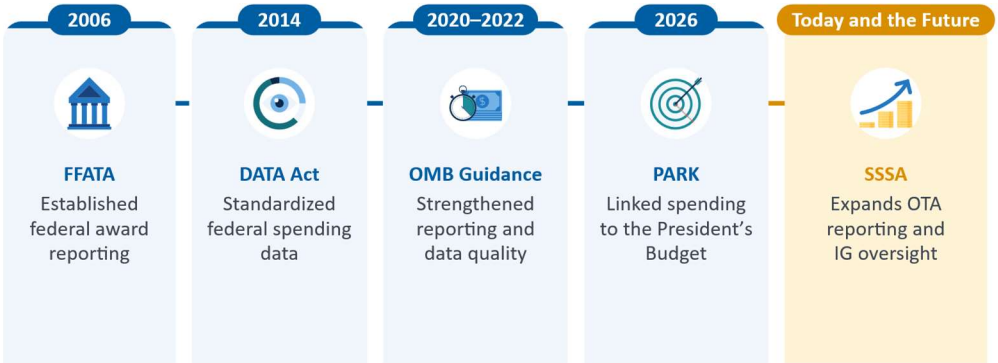
DATA Act: Evolution of Data Quality

Building on the *Federal Funding Accountability and Transparency Act of 2006* (FFATA), the *Digital Accountability and Transparency Act of 2014* (DATA Act) expanded and standardized federal spending reporting to improve the transparency, consistency, and accessibility of data published on USAspending.gov. The U.S. Department of the Treasury (Treasury) established the Governmentwide Spending Data Model (GSDM) as the authoritative framework for defining and structuring the data elements agencies use to report federal spending. Subsequent OMB Memorandums further strengthened these requirements by increasing reporting frequency and emphasizing data quality, cross-file validation, and certification to support accurate and reliable public reporting.

Starting with FY 2026 reporting, the OMB-assigned Program Activity Reporting Key (PARK) became the sole program activity identifier for DATA Act submissions, replacing the legacy program activity code and name fields. HHS implemented PARK in all three core financial system instances in December 2025, creating a more direct link between reported spending and the President's Budget.

On September 11, 2026, the *Stop Secret Spending Act of 2025* (SSSA) was signed into law, amending FFATA to require that other transaction agreements (OTAs), a category of award not previously subject to standard DATA Act reporting, be disclosed on USAspending.gov. Under the SSSA, HHS will incorporate OTA reporting requirements as Treasury and OMB issue implementation guidance and expects to address Inspector General (IG) oversight reporting prior to the FY 2029 reporting deadline. The SSSA also requires agency IGs to periodically report on the agency's spending data quality and use of data standards starting in FY 2027.

Together the DATA Act, GSDM, and OMB guidance have strengthened HHS's ability to deliver transparent data to bolster public trust and enable oversight by increasing accountability, reducing waste, and improving data quality. The SSSA will continue this emphasis on data quality in the years to come.



Systems, Legal Compliance, and Internal Control

Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to assess their internal controls and financial management systems each year. Agency leaders must submit an annual statement confirming whether these controls are working effectively and if their financial systems meet government-wide standards. Section 2 of the FMFIA covers internal control requirements, while Section 4 addresses system compliance. Agencies also need to report any major weaknesses and outline plans to fix them.

In May 2025, GAO released updated internal control standards for the federal government, effective in FY 2026. These standards focus on principles related to operations, reporting, and compliance. In March 2026, the OMB updated Circular A-123, *Management's Responsibility for Internal Control*, which provides streamlined guidance for federal agencies to improve internal control assessment and continuous monitoring. The revision provides agencies with guidance on adopting a comprehensive, preventative, risk-informed approach to internal control. The Department works with its Divisions to meet these requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems with mandated requirements. FFMIA expanded on FMFIA by requiring agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. OMB Circular A-123, Appendix D, *Management of Financial Management Systems – Risk and Compliance*, provides guidance on a risk-based approach for assessing compliance with FFMIA.

HHS has strong internal control and risk management programs. The Department works closely with its Divisions to remediate major weaknesses and non-compliance issues by identifying the root causes and ensuring active oversight of corrective actions. Based on internal reviews and the FY 2025 audit, HHS is confident that its internal controls are operating effectively and its financial systems comply with requirements. For more details, see the "Internal Control" and "Management Assurance" sections below.

Payment Integrity Information Act of 2019

Improper payments occur when a payment is made in an incorrect amount under statutory or other legally applicable requirements. If agencies cannot determine if a payment is proper due to missing or insufficient documentation, it is classified as "unknown." Additionally, payments made to the correct recipient in the correct amount may still be considered "technically improper" if they violate any applicable laws or regulations.

Under the *Payment Integrity Information Act of 2019* (PIIA), agencies are required to assess their programs and activities to identify those that may be susceptible to significant improper payments (known as risk-susceptible programs). These programs must calculate improper payment estimates, establish reduction targets, and implement corrective actions. HHS actively works to prevent, detect, and reduce improper payments by reviewing its programs and activities using risk models, statistical estimates, and internal control reviews.

HHS conducted 84 improper payment risk assessments in FY 2026. No new risk-susceptible programs were identified. HHS maintains a longstanding estimation and reporting process, strengthened by corrective actions across its risk-susceptible programs. HHS reported improper payment estimates and accompanying information for 9 of the 10 risk-susceptible programs in the FY 2026 AFR.

HHS utilizes the Do Not Pay portal to verify both payments and recipients, helping identify potential improper payments or ineligible recipients. In FY 2026, HHS screened approximately $712.9B in Treasury-disbursed payments through the Do Not Pay portal. For a detailed overview of HHS's initiatives to reduce improper payments and combat fraud, please refer to the *Payment Integrity Report* in the *Other Information* section.

PAYMENT INTEGRITY AT A GLANCE

What the Law Requires and Where HHS Stands

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Improper payment estimates are NOT fraud estimates.

WHAT PIIA REQUIRES

- **Assess programs for risk** (all programs over $10 million in outlays, at least every three years)
- **Estimate improper payments**
- **Set reduction targets and implement corrective actions**
- **Report results and recover overpayments**

WHAT COUNTS AS AN IMPROPER PAYMENT

Program Outlays

- **Properly Paid**
- **Improperly Paid**
  - **Monetary Loss**
  - **Non-Monetary Loss**
- **Unknown**

WHAT MAKES A PROGRAM RISK-SUSCEPTIBLE

A program is risk-susceptible when improper and unknown payments exceed 1.5% of outlays and $10 million—or total at least $100 million regardless of percentage.

HHS OVERALL RESULT (FY 2026)

$113.90 billion
estimated improper and unknown payments

6.18%
improper payment rate

9
risk-susceptible programs measured

84
risk assessments in FY 2026, with no new risk-susceptible programs identified

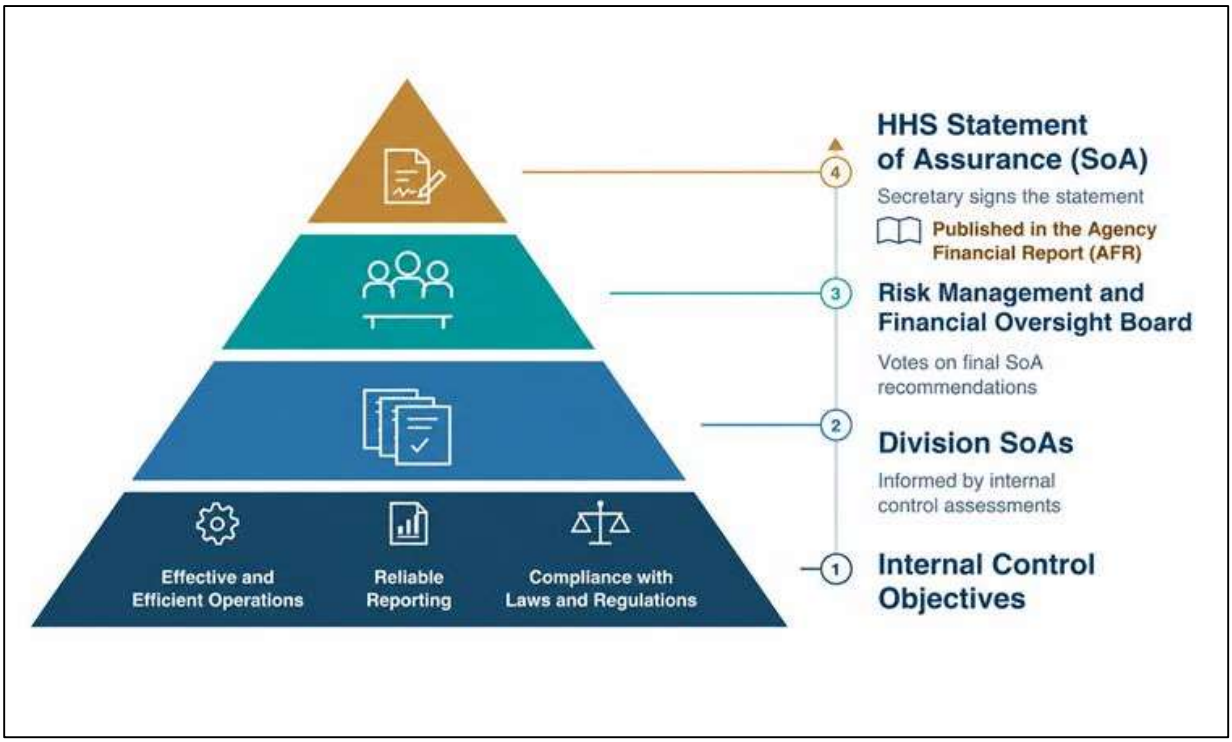
Internal Control

FMFIA requires agency heads to annually assess and report on internal control and financial systems that safeguard federal programs. This ensures efficient operations, reliable reporting, compliance with laws and regulations, and proper stewardship of federal assets. HHS conducts risk-based evaluations of its internal controls in accordance with OMB Circular A-123, *Management's Responsibility for Internal Control*.

OMB Circular A-123 guides agencies in strengthening accountability and program effectiveness by managing risks and routinely assessing internal controls. HHS continues to enhance its internal control process to better identify risks, develop effective responses, and implement timely corrective actions. Ongoing communication with Divisions supports the assessment of internal controls, including disaster-related controls, and helps improve processes to ensure they meet management's objectives.

HHS management is responsible for maintaining effective internal controls. As part of this responsibility, leadership regularly assesses control effectiveness and provides annual assurance statements. The HHS Risk Management and Financial Oversight Board reviews these statements from the Divisions and recommends Department-wide assurance for the Secretary's annual Statement of Assurance, as illustrated in **Figure 12**.

Figure 12: Secretary's Annual Statement of Assurance Process



Management Assurances

Statement of Assurance

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Washington, D.C. 20201

HHS management is responsible for managing risk and maintaining effective internal control under the Federal Managers' Financial Integrity Act of 1982 (FMFIA). These responsibilities support effective and efficient operations, reliable reporting, compliance with laws and regulations, and the safeguarding of assets.

The Department assessed its risks and internal controls in accordance with Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*. Based on this assessment, the Department provides reasonable assurance that HHS internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2026, except for the material noncompliance with the *Payment Integrity Information Act of 2019* described in the summary on the next page.

HHS also evaluated its financial management systems in accordance with OMB Circular A-123 and the *Federal Financial Management Improvement Act of 1996* (FFMIA). FFMIA requires substantial compliance with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger at the transaction level. Based on this evaluation, the Department provides reasonable assurance that the Department's financial management systems substantially comply with FFMIA and conform to FMFIA objectives.

HHS will continue to strengthen its internal controls and financial management systems to protect taxpayer resources and uphold accountability and transparency.

/Robert F. Kennedy, Jr./

Robert F. Kennedy, Jr.
Secretary of Health and Human Services
November 13, 2026

Management Assurances

Summary

Material Noncompliance with PIIA — Temporary Assistance for Needy Families (TANF)

HHS did not report a required improper payment estimate for the TANF program, resulting in material noncompliance with PIIA. Statutory limitations under 42 U.S.C. § 617 prevent HHS from requiring states to participate in TANF improper payment measurement. As reported in prior years, these limitations persist and restrict access to the state-level data needed to develop an estimate.

HHS continues to support the authorized use of TANF funds and strengthen fiscal and program integrity through ongoing data reporting and technical assistance to states. Additional details appear in the "Payment Integrity Report" within the "Other Information" section of this Agency Financial Report.

Financial Section

- Message from the Assistant Secretary for Financial Resources
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Required Supplementary Information

MESSAGE FROM THE ASSISTANT SECRETARY FOR FINANCIAL RESOURCES



As the Assistant Secretary for Financial Resources (ASFR) and Chief Financial Officer (CFO), I am honored to join Secretary Kennedy in presenting the Department of Health and Human Services (HHS) Fiscal Year (FY) 2026 Agency Financial Report (AFR), which reflects steadfast commitment to responsible stewardship of taxpayer dollars and marks HHS's 28th consecutive unmodified audit opinion and the second consecutive year with no significant deficiencies in our information technology control environment. This sustained excellence directly reflects the professionalism of our entire HHS workforce, whose tireless dedication safeguards our financial reporting integrity. HHS manages one of the largest and most complex budgets in the world, encompassing over $2.0T dollars in federal outlays that impacts every community in our great nation. With that extraordinary scale comes an uncompromising duty to the American taxpayer: to ensure every public resource is stewarded with maximum efficiency, absolute integrity and unyielding accountability.

TRANSFORMING FINANCIAL MANAGEMENT

For too long across the federal landscape, financial management has been constrained by fragmented legacy systems and siloed administrative practices that impede timely action on noncompliance and obscure enterprise visibility. We are confronting these longstanding challenges with decisive action.

Over the past fiscal year, HHS has spearheaded pivotal transformation of the Department's financial operations. We are shifting HHS from reactive operations to an integrated, data-driven enterprise that operates as one cohesive Department. By deploying Super Intelligence (SI), dismantling administrative barriers and enforcing rigorous accountability, we are structurally reshaping financial operations to deliver greater transparency, strengthen reporting accuracy, and generate lasting value for the American people.

AUDIT ENFORCEMENT AND RISK OVERSIGHT

A credible financial management framework requires zero tolerance for waste, fraud, and chronic noncompliance. For years, single audits submitted by states, local governments, and recipient organizations routinely uncovered internal control deficiencies, questioned costs, and non-compliance. Yet too often, these findings have remained unresolved and hidden in plain sight.

To confront this systemic vulnerability, I launched the Audit Enforcement and Risk Oversight (AERO) initiative, executing an aggressive, Department-wide program integrity overhaul:

- **SI-Enabled Forensic Oversight:** We deployed advanced SI and automated analytics to systematically scan and cross-reference single audit information across all 50 states. The analysis isolates repeat findings, unresolved internal control deficiencies, and delinquent filings to pinpoint risk at a scale and speed that manual review could never achieve.
- **Statutory Enforcement with Real Consequences:** Exercising our statutory authorities under the Single Audit Act and the Uniform Guidance, we no longer meet noncompliance with passive correspondence. While HHS stands ready to partner with recipients committed to remediation, those who persistently disregard fiduciary obligations face direct financial consequences. Within four months of launch, half of the ten states with delinquent FY 2025 audits had submitted them and the remainder had committed to compliance plans, covering recipients that account for approximately $207.0B in HHS funding.

ENTERPRISE ACQUISITION MODERNIZATION

Alongside accountability efforts, we are instilling equal discipline into how the Department procures resources. Acquisitions represent one of HHS's primary operational engines, delivering mission-critical supplies, world-class scientific equipment, and healthcare resources. While the Department's decentralized Divisions historically purchased goods and services independently, FY 2026 marked a decisive transition towards an integrated enterprise acquisition model. Guided by our Procurement Alignment and Collaboration Taskforce (PACT), the Office of Acquisitions advanced an enterprise approach that

strengthens shared acquisition services, leverages HHS's collective buying power, modernizes acquisition technology, and drives measurable efficiencies Department-wide:

- **Enterprise Acquisition Shared Services and Systems Modernization:** Through the Office of Mission Acquisition Solutions (OMAS), we established HHS's enterprise shared-service model for common information technology and professional services acquisition, transitioning more than 4,000 contracts across 10 Divisions, representing approximately $2.5B in annual obligations and $4.5B in prior-year obligations, under one organization. In parallel, we expanded the HHS Consolidated Acquisition System (HCAS) platform, retiring two legacy systems, reducing contract-writing platforms from six to four and migrating the HCAS application and its acquisition data to a FedRAMP-authorized cloud environment, establishing a modern foundation supporting the HHS acquisition lifecycle.
- **Fiscal Impact:** Building on the $16.3B in validated FY 2025 savings achieved through the HHS Cost Efficiency Initiative (HCEI), our coordinated acquisition strategy projected an additional $5.2B in FY 2026 cost avoidance. Additionally, our targeted Undelivered Order (UDO) cleanup initiative closed out $341.3M in stale obligations across 2,337 contracts.

MODERNIZING FEDERAL FINANCIAL ASSISTANCE

Our modernization efforts also extend to Federal financial assistance, which is foundational to HHS's mission, funding healthcare access, biomedical research, state public health infrastructure, and human services. Yet, the systems administering these hundreds of billions of dollars have historically relied on decades-old legacy tools that increase grantee burden while obscuring enterprise spending trends. Through our Office of Grants, we are executing a comprehensive grants modernization agenda headlined by the Simpler Notices of Funding Opportunity (NOFOs) initiative and a modernized Grants.gov:

- **Enterprise Standardization and Lifecycle Intelligence:** For the first time at HHS, we set HHS-wide standards for writing nearly 2,000 NOFOs and implemented a common content structure across 14 awarding Divisions. We validated more than 650 HHS Financial Assistance Listings, representing approximately $600.0B in federal funding, building the authoritative program data needed to connect appropriations, programs, funding opportunities, award spending, and performance outcomes end to end.
- **Lowering Applicant Burden and Modernizing Grants.gov:** We overhauled Grants.gov to make finding and applying for federal funding intuitive and streamlined, deploying a modern application process across two federal agencies and updating essential reporting forms applicants use most. In the first six months of 2026 alone, the modern platform registered more than 6 million visits and captured 75 percent of total Grants.gov search traffic. Every hour we remove from navigating federal systems is an hour returned to the communities our recipients serve.

DISCIPLINED BUDGET EXECUTION

Underpinning these reforms, our Office of Budget led the development of the FY 2027 President's Budget, proposing $14.0B in discretionary savings that exceeded OMB's targets, while executing the FY 2026 budget through operating plans and apportionments, implementing enacted rescissions promptly across every Division in accordance with federal requirements.

INTEGRATED FINANCIAL MANAGEMENT

Together, AERO enforcement efforts, OMAS acquisition consolidation, enterprise grants modernization, and disciplined budget execution represent far more than isolated technology and workflow upgrades. They form an interdependent financial management architecture that directly reinforces HHS's financial reporting integrity.

STEWARDSHIP AND RESULTS

The operational and structural reforms underway across ASFR prove that the federal government can move with agility and operate with fiscal discipline. As we move forward, we will continue to pioneer modern financial practices, eliminate wasteful redundancies, and enforce strict stewardship across every dollar entrusted to HHS. The American people deserve nothing less.

/Gustav P. Chiarello III/

Gustav P. Chiarello III
Assistant Secretary for Financial Resources
November 16, 2026

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 13, 2026

TO: The Secretary

FROM: /Tamara Lilly/
Acting Deputy Inspector General for Audit Services

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2026*, OAS-26-17-073

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services' (HHS) fiscal year (FY) 2026 financial statements, internal control over financial reporting, 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 (EY) to audit the HHS: (1) consolidated balance sheets as of September 30, 2026 and 2025, and the related consolidated statements of net cost and changes in net position; (2) combined statement of budgetary resources for the years then ended; and (3) sustainability financial statements that comprise the statement of social insurance as of January 1, 2026, 2025, 2024, 2023, and 2022, and the related statement of changes in social insurance amounts for the periods ended January 1, 2026 and 2025. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 24-02, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, EY determined that the FY 2026 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position, and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. However, EY was unable to obtain sufficient appropriate audit evidence for the amounts presented in the statements of social insurance as of January 1, 2026, 2025, 2024, 2023, and 2022, and the related statements of changes in social

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insurance amounts for the periods ended January 1, 2026 and 2025. Therefore, EY issued a disclaimer of opinion on the sustainability financial statements and related notes.

Under the standards established by the American Institute of Certified Public Accountants and the standards applicable to financial audits contained in *Government Auditing Standards*, EY identified a series of issues that resulted in significant deficiencies related to HHS's: (1) Financial Reporting Oversight and (2) Insufficient Internal Controls to Mitigate Financial Reporting Risks. The firm provided associated recommendations. EY did not identify any deficiencies in internal control that it considered a material weakness.

EY also identified that HHS is not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (PIIA, P.L. No. 116-117).

Evaluation and Monitoring of Audit Performance

We reviewed EY'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 that related to the review of internal controls over financial reporting
- Reviewing the auditors' reports
- Reviewing the HHS *FY 2026 Agency Financial Report*

EY 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 HHS's compliance with laws and regulations. However, our review, as limited to the procedures listed above, disclosed no instances in which EY did not comply, in all material respects, with U.S. generally accepted government auditing standards.

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If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 834-5992 or Carla.Lewis@oig.hhs.gov. Please refer to report number OAS-26-17-073.

Attachment



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Report of Independent Auditors

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

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of the U.S. Department of Health and Human Services (HHS), which comprise the consolidated balance sheets as of September 30, 2026 and 2025, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of HHS at September 30, 2026 and 2025, and the results of its net cost of operations, its changes in net position and its budgetary resources for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

We were also engaged to audit the sustainability financial statements of HHS, which comprise the statement of social insurance as of January 1, 2026, 2025, 2024, 2023, and 2022 and the related statement of changes in social insurance amounts for the periods ended January 1, 2026, and 2025, and the related notes (collectively referred to as the "sustainability financial statements").

We do not express an opinion on the accompanying sustainability financial statements of HHS. Because of the significance of the matters described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the sustainability financial statements.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS), in accordance with the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*), and in accordance with the provisions of Office of Management and Budget

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(OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 24-02 are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of HHS and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. 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, 2026 and 2025, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

As discussed in Note 23 to the financial statements, the statement of social insurance presents the actuarial present value of the 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. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statement of social insurance and the related statement of changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA).

With respect to the estimates for the social insurance program presented as of January 1, 2026, 2025, 2024, 2023, and 2022, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections, using

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certain alternative payment provisions, intended to quantify the potential understatement of projected Medicare costs in future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 24, certain features of current law may result in some challenges for the Medicare program. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. As a result of these matters, we were unable to obtain sufficient appropriate audit evidence for the amounts presented in the statement of social insurance as of January 1, 2026, 2025, 2024, 2023, and 2022, and the related statement of changes in social insurance amounts for the years ended January 1, 2026 and 2025, and the related notes.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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 Responsibilities for the Audit of the Financial Statements

Except as described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02 will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such

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procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit 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 HHS's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about HHS's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the required supplementary information, such as Management's Discussion and Analysis on pages 9 to 60, the Combining Statement of Budgetary Resources, and Deferred Maintenance and Repairs from pages 139 to 141, be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the 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 financial statements in an appropriate operational, economic, or historical context. We were unable to apply certain limited procedures to the Required Supplementary Information related to the sustainability financial statements from 141 to 158 in accordance with GAAS because of the significance of the matters described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report. We do not express an opinion or provide any assurance on the Required Supplementary Information related to the sustainability financial statements. We have applied certain limited procedures to the Management's Discussion and Analysis and other required supplementary information in accordance with GAAS, 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 financial statements, and other knowledge we obtained during our audit of the financial statements. We do not

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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 Information

Management is responsible for the other information included in the Agency Financial Report. The other information comprises the Message from the Secretary, About the Agency Financial Report, Message from the Assistant Secretary for Financial Resources, Other Financial Information, Summary of Financial Statement Audit and Management Assurances, Civil Monetary Penalty Adjustment for Inflation, Biennial Review of User Fees, Grants Closeout Reporting, Payment Integrity Report, FY 2026 Top Management and Performance Challenges Identified by the Office of Inspector General, and Section 4: Appendices, as identified on HHS's Agency Financial Report Table of Contents, but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 13, 2026 on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is solely 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 effectiveness of HHS's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 13, 2026

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Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters 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 of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*, the consolidated 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, 2026, 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 (collectively referred to as the "financial statements"), and our report dated November 13, 2026 expressed an unmodified opinion thereon. We also were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2026, and the related statement of changes in social insurance amounts for the period ended January 1, 2026, and the related notes (collectively referred to as the "sustainability financial statements"), and our report dated November 13, 2026 disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors as we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) as a basis for designing 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's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's internal control. We did not consider 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 preparing performance information and ensuring efficient operations.

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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 not identify any deficiencies in internal control that we consider to be material weaknesses. We identified certain deficiencies in internal control described below that we consider to be significant deficiencies.

Significant Deficiencies

Financial Reporting Oversight Significant Deficiency

Our review of internal control identified the following significant deficiency in the current year's audit relating to financial reporting oversight.

Financial Adjustment Policy Implementation

As identified in previous years, HHS recorded a significant number of nonstandard journal vouchers for entries that are unable to be posted through routine systematic processing. These entries consist of non-standard postings to record both the proprietary and budgetary effects of certain financial activities, including closing activities, for which either the financial system is not configured properly to post automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. In response to this finding, HHS issued a Financial Adjustments Policy (the "Policy") which aids in identifying minimum requirements for preparing, reviewing, approving, classifying and posting financial adjustments to standardize the process consistently across HHS, as well as establish oversight and monitoring efforts over entries deemed higher risk. HHS has issued additional guidance to assist Divisions in standardizing and categorizing financial adjustments to comply with the Policy in an effort to risk-assess the large population journal vouchers. In FY 2026, HHS continued to make progress in implementing and evaluating compliance with the Policy across accounting centers, including identifying populations of financial adjustments, analyzing transaction activity, evaluating adjustment classification, and providing timely feedback to the Divisions. While these efforts represent significant advancement in the implementation of the Policy, one milestone

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remains pending for the Divisions to further enhance monitoring procedures. This includes performing comprehensive analysis of non-standard manual journal entry populations, as a whole, that would assist with reducing risks of inaccuracy, untimeliness, and potentially incomplete financial information.

Centers for Medicare & Medicaid Services (CMS) Oversight Processes

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on internal control, dated November 12, 2026. In that report, we outlined details of deficiencies noted and recommended improvements in its financial management controls. Consistent with our findings in the previous year, we concluded the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting. The following areas identified in the CMS current year audit merit continued focus.

Medicaid Entitlement Benefits Due and Payable (EBDP)

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 prior years, CMS completed the implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims, and encounters. As of the end of fiscal year 2026, while data maintained within T-MSIS is utilized for operational purposes, management continues to evaluate the reliability and completeness of the claims-level information maintained within T-MSIS, prior to determining how this could be utilized in the financial accounting and reporting for Medicaid, and specifically Medicaid EBDP. CMS should continue to evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures that may require consideration in determining the Medicaid EBDP liability as of year-end, as required by Statement of Federal Financial Accounting Standards No. 5*, Accounting for Liabilities of the Federal Government*, even if this data ultimately never becomes the basis for the EBDP estimate. Given the claims-level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability calculated during prior periods which could serve to validate the continued use of a similar methodology. Medicaid EBDP is a significant liability on the FY 2026 financial statements and is subject to volatility. The lack of detailed claims data limits the ability to consider the impact of such a change, or other changes such as those related to the claims processing timing, on a timely basis or consider the potential impact of these items on the

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EBDP estimate, presenting a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Status of Budgetary Resources

Components of Medicare are funded, in part, by the federal government through annual appropriations. These amounts are transferred from the Treasury general fund to the SMI trust fund through the Payments to the Healthcare Trust Funds (PTF) account. According to OMB Circular A-11, obligations are recorded when the federal government places an order for an item or a service, awards a contract, receives a service, or enters into similar transactions that will require payments in the same or a future period. Obligations are also recorded when you make an expenditure transfer between a federal government account and a Trust Fund. During its year-end close process, CMS recorded obligations against the PTF account that did not meet the requirements of a valid obligation as defined under OMB Circular A-11. CMS subsequently reclassified these amounts from obligated balances to an unobligated balance for proper presentation on the Statement of Budgetary Resources. However, CMS's budgetary controls associated with this process did not identify the accounting treatment of these obligated amounts was incorrect, representing a risk that similar classification errors could occur and not be detected timely.

Statement of Social Insurance

The Statement of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The 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 models, and, as a result, the reviews of the underlying data are robust, in line with CMS's policies and procedures. As part of this review, the inputs into the spreadsheet models are checked against the original data sources to ensure that no input errors have been made. In addition, output data, including that which is generated from updating and running any macro in the spreadsheet, is checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet models or Excel macro programs to ensure that the projection output from the programs are as expected and reasonable. The Government Accountability Office (GAO)'s *Standards for Internal Control in the Federal Government* indicate that management should design control activities to achieve objectives and respond to risks. However, during our audit procedures of the SOSI, we identified that documentation evidencing the review of inputs/outputs was not sufficiently precise. Additionally, formula errors were identified that were not detected by the organization's monitoring and review function, and, accordingly, the related internal control was not functioning at the level of precision as

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designed. Inadequate review procedures may result in errors within the SOSI models and could lead to misstatements within the SOSI financial statements and related footnotes.

Recommendations

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

- HHS should continue monitoring and oversight activities to ensure Divisions' comprehensive review of financial adjustment classifications align with the Financial Adjustments Policy. Further, the Divisions should develop enhanced procedures to validate and document the completeness of the overall manual journal entry population as well as perform an analysis that asserts the accuracy and reasonableness of the non-standard journal entry population. Lastly, HHS should continue to identify root causes of non-standard journal entries and assess potential process enhancements to reduce their occurrence.

- We recommend that CMS continue to develop, refine, and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. This would include having CMS:

    - Continue to evaluate how the Medicaid claims-level data can be refined to analyze trends at a claims-level to enable the performance of robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the financial accounting and reporting of the Medicaid program.

    - 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 this liability.

    - Ensure controls are designed to properly record obligations for PTF transactions that meet the requirements of a valid obligation in accordance with OMB Circular A-11. For unique situations where Congress intends for funds to remain available beyond the period of availability, CMS should work with legal counsel, OMB and Treasury to determine the proper accounting treatment.

    - Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision to ensure the completeness and accuracy of the models and the related financial statements. When changes are made to the SOSI models, such as changes to the

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methodology or key assumptions, management should require an enhanced review specific to these changes.

Insufficient Internal Controls to Mitigate Financial Reporting Risks Significant Deficiency

The GAO's Standards for Internal Control in the Federal Government (Green Book) indicates that internal control is a process effected by an entity's oversight body, management and other personnel designed to provide reasonable assurance that the objectives of an entity will be achieved. As part of our procedures, we noted instances where documentation to support the design or operation of controls addressing financial reporting risks were lacking, not sufficient, or were outdated.

Insufficient controls within the Commissioned Corps Pension Liability

As part of our audit procedures, we noted various controls within the Commissioned Corps Liability (CCL) process were ineffectively designed or lacked evidence to support performance of control activities. Specifically, we identified instances where controls were not sufficiently designed to address risks around the completeness and accuracy of the participant data utilized for the liability calculation and reasonableness of changes in the liability amount year over year. Further, we were unable to obtain sufficient documentation to evidence control activities performed over the review and approval of participant data entry into the system of records.

These findings resulted from insufficient process analysis and documentation of reporting risks and responsive controls compounded by personnel turnover. Specifically, cycle memorandums and standard operating procedures were not sufficiently developed to define the required steps for identifying and assessing relevant financial reporting risks, designing and executing responsive controls, and documenting the performance and review of control activities. Personnel turnover further contributed to gaps in institutional knowledge and consistency in the execution and documentation of these processes.

The findings outlined above resulted in a misstatement of the Commissioned Corps Liability and further impacted management's ability to perform adequate monitoring and evaluation procedures to ensure controls are designed, implemented and operating effectively, as required by the GAO Green Book.

OMB Circular A-123 Program

To support federal agencies' required assertions under FMFIA, OMB issued Circular A-123, *Management's Responsibility for Internal Control,* which requires agencies to annually assess risks that impact their ability to achieve operational and financial reporting objectives. It also prescribes a governance structure for (1) implementing the requirement to integrate risk management and internal control functions, (2) assessing the effectiveness of the environment and (3) reporting the level of

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reasonable assurance in an annual Statement of Assurance (SOA) included in the respective Agency Financial Report.

As part of its process, HHS worked with its 13 Divisions to communicate their responsibilities for OMB Circular A-123. Divisions' responsibilities included: performing risk assessments; identifying, testing, and documenting key controls in end-to-end business processes; developing corrective action plans for identified control deficiencies; reporting findings to the departmental level; and supporting the development of their Division level assurance statements which are used in the development of the HHS-wide statement.

As part of our testing procedures, we identified instances where risk assessments were not sufficient in identifying actionable risks, concluding on the risk approach, or identifying sufficient controls responsive to risks. Further, documentation provided to support the testing of controls responsive to risks was insufficient or unavailable. Lastly, while significant progress was made to understand and evaluate long-standing deficiencies as part of a Corrective Action Plan (CAP), milestones are still in progress, and we continued to identify instances of un-remediated internal control deficiencies dating back over 10 years. The absence of sufficient risk assessment and monitoring procedures over controls responsive to identified risks may result in inaccurate internal control oversight and reporting.

Recommendations

We recommend that HHS and its Divisions:

- Establish policies and procedures to routinely update process-level documentation to ensure it reflects current control design activities and system environment and is at the appropriate level of detail to allow management to effectively monitor the control activities and address financial reporting risks. Enhance policies and procedures to formally retain evidence of control activities, including subjective decisions made during control execution, to ensure adequate documentation is available to support internal control evaluations and monitoring.

- Perform a full process analysis to identify areas of risk and ensure control procedures are designed to mitigate the identified risk, including evaluating the precision and sensitivity of the control, especially in areas that are subjective and judgmental. Enhance procedures and documentation over risk assessment and control monitoring processes to ensure risks are identified, evaluated for approach, and responded to with effective mitigating controls.

- Define and develop contingency plans for key roles to help address unexpected personnel changes that may impact internal controls over financial reporting and continue to evaluate and resolve long-standing internal control deficiencies.

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Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA), noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02, which are described below, and disclosed no instances of noncompliance in which HHS's financial management systems did not substantially comply with the Section 803(a) requirements of FFMIA.

The *Payment Integrity Information Act of 2019* (PIIA) requires federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. Given the large number of unique programs administered by HHS, the nature and volume of its expenditures present a substantial challenge to HHS in the quantification, evaluation and remediation of improper payments. Additionally, for the CMS, health insurance claims, payments to private health plans under the Medicare Advantage program, and payments to states for Medicaid represent the vast majority of the CMS payments. These payments involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates.

To address the challenges noted above, HHS has developed a series of processes throughout the agency to monitor, investigate, estimate and report on improper payments. These processes include (1) identifying risk-susceptible programs through an annual risk assessment process, (2) estimating and reporting improper payment rates for those programs that are deemed risk-susceptible, (3) developing corrective actions to remediate causes that result in improper payments and (4) executing recovery activities to recoup improper payments. While the Department continues to make progress, HHS is not in full compliance with the requirements of the PIIA. For example:

- During FY 2026, HHS updated its program inventory to align with the Federal Program Inventory and identified 281 programs and activities subject to the 3-year assessment cycle as their annual outlays exceeding $10 million. Of these 281 programs, HHS completed approximately 85% within the past three years including 84 risk assessments in FY 2026. We acknowledge that HHS reported that it continued to implement process enhancement to achieve full coverage of all qualifying programs by FY 2028. The PIIA and Section VI of Appendix C of OMB A-123 requires each agency to perform a risk assessment not less frequently than once

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every three fiscal years for each program and activity that exceeds $10 million of all reported program or activity payments made during that fiscal year. As HHS did not complete full assessment of all 281 programs within a 3-year cycle, HHS is not in compliance with PIIA.

- HHS has developed, executed and reported improper payments for 9 of its 10 risk-susceptible programs. For the remaining risk-susceptible program, the Temporary Assistance for Needy Families (TANF) program, HHS indicated that it is working to address various challenges to enable it to develop and report an improper payment estimate.

- Although HHS has calculated and reported an improper payment estimate for the federally facilitated exchange of the advance premium tax credit program, it has not calculated and reported an improper payment estimate for the state-based exchanges.

- From FY 2020 to FY 2023, we reported that ACF had not calculated or published error rates for its Foster Care program. This was due to a suspension of onsite Title IV-E Foster Care Eligibility Reviews in response to the COVID-19 pandemic. The Title IV-E Review protocol is not conducted specifically for improper payment estimation but is instead governed by regulations authorizing federal monitoring of child welfare programs. HHS uses certain testing results from these reviews to calculate the Foster Care improper payment error rates. Generally, the process to capture all states' results takes three years with one-third being visited annually. Each year the error rate is updated to include new data for the states visited that year. ACF resumed conducting Title IV-E Review in FY 2024 and conducted reviews of forty-two states from FY 2024 to FY 2026. Of those states, sixteen were newly added in FY 2026. HHS represented to us that there is a delay in completion timeline and anticipate completing the review of all fifty states, the District of Columbia, and Puerto Rico by FY 2028.

- HHS is not in full compliance with the PIIA, as recovery activities of the identified improper payments for the Medicare Part C program are delayed. HHS remains committed to achieving reductions in all improper payment rates through various corrective actions. While management continues to implement corrective actions to reduce the improper payment rates for all programs, the rates for some programs, such as the Medicare FFS, Medicaid, and CHIP programs increased from the prior year.

HHS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on HHS's response to the findings identified in our audit and described in the accompanying letter dated November 13, 2026. HHS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and accordingly, we express no opinion on the response.

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Purpose of This Report

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

Ernst & Young LLP

November 13, 2026

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Department's Response to the Report of the Independent Auditors

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary for Financial Resources
Washington, D.C. 20201

To: T. March Bell, Inspector General

From: Gustav Chiarello, Assistant Secretary for Financial Resources

Subject: Fiscal Year 2026 Independent Auditors' Financial Statement Audit Reports

The Department of Health and Human Services (HHS) appreciates the work of the Office of Inspector General and its independent auditors, Ernst and Young (EY), in completing the Fiscal Year (FY) 2026 financial statement audit. The independent review provides important insight into the strength of our financial reporting and internal controls and identifies areas where additional work is needed.

HHS received an *unmodified ("clean")* opinion on its principal financial statements, continuing the Department's longstanding record of sound financial management. The auditors also issued a disclaimer of opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts and reported significant deficiencies and compliance findings.

We take these findings seriously, including the longstanding disclaimer on the social insurance statements. HHS continues to work with responsible program and operational leadership to address the underlying issues, strengthen internal controls, and improve financial reporting and compliance. This work will continue into FY 2027 as we build on progress made and address areas where additional improvement is needed. Being clear about both our progress and the work that remains is an important part of accountability.

We continue to hold ourselves accountable for the appropriate use of taxpayer funds, modeling the same standards we ask of our financial assistance partners through Single Audit resolution. Through efforts such as the Audit Enforcement and Risk Oversight initiative, HHS is placing greater focus on addressing unresolved audit findings, following through on corrective actions, and holding recipients of HHS funds accountable for resolving identified issues.

We appreciate the many individuals across HHS whose work supports the integrity of our financial reporting. We also appreciate the independent auditors and the Office of Inspector General for identifying opportunities to improve. We will continue using their findings and recommendations to strengthen financial management and accountability across HHS.

/Gustav P. Chiarello III/

Gustav P. Chiarello III
Assistant Secretary for Financial Resources
November 13, 2026

Principal Financial Statements

U.S. Department of Health and Human Services

Consolidated Balance Sheets

As of September 30, 2026 and 2025

(in Millions)

	2026	2025
Assets (Note 2)		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 3)	$ 831,741	$ 659,351
Investments, Net (Note 4)	452,654	414,323
Accounts Receivable, Net (Note 5)	717	763
Advances and Prepayments (Note 8)	1,983	1,966
Total Intragovernmental Assets	**1,287,095**	**1,076,403**
Other than Intragovernmental Assets:		
Accounts Receivable, Net (Note 5)	49,106	49,212
Inventory and Related Property, Net (Note 6)	18,517	19,183
Property, Plant and Equipment, Net (Note 7)	9,305	9,391
Advances and Prepayments (Note 8)	173	118
Other Assets:		
Loans Receivable, Net	378	377
Other	1	9
Total Other than Intragovernmental Assets	**77,480**	**78,290**
Total Assets	**$ 1,364,575**	**$ 1,154,693**
Stewardship Land (Note 20)		
Liabilities (Note 9)		
Intragovernmental Liabilities:		
Accounts Payable	$ 1,306	$ 1,099
Advances from Others and Deferred Revenue	722	500
Other Liabilities:		
Accrued Liabilities (Note 12)	95	-
Other Liabilities (Note 13)	2,882	2,172
Total Intragovernmental Liabilities	**5,005**	**3,771**
Other than Intragovernmental Liabilities:		
Accounts Payable	1,872	1,443
Entitlement Benefits Due and Payable (Note 10)	181,701	163,952
Federal Employee Salary, Leave, and Benefits Payable (Note 11)	1,311	1,374
Pensions and Post-Employment Benefits Payable (Note 11)	22,422	22,567
Advances from Others and Deferred Revenue	3,844	4,365
Other Liabilities:		
Accrued Liabilities (Note 12)	18,318	18,042
Contingencies and Commitments (Note 14)	22,752	17,785
Other Liabilities (Note 13)	6,316	1,655
Total Other than Intragovernmental Liabilities	**258,536**	**231,183**
Total Liabilities	**263,541**	**234,954**
Net Position		
Unexpended Appropriations – Funds from Dedicated Collections (Note 19)	345,280	236,903
Unexpended Appropriations – Funds from Other than Dedicated Collections	337,706	297,983
Total Unexpended Appropriations	**682,986**	**534,886**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 19)	411,876	373,853
Cumulative Results of Operations – Funds from Other than Dedicated Collections	6,172	11,000
Total Cumulative Results of Operations	**418,048**	**384,853**
Total Net Position	**1,101,034**	**919,739**
Total Liabilities and Net Position	**$ 1,364,575**	**$ 1,154,693**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Consolidated Statements of Net Cost

For the Fiscal Years Ended September 30, 2026 and 2025

(in Millions)

	2026	2025
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 2,035,138	$ 1,867,923
Earned Revenue	(197,953)	(176,901)
CMS Net Cost of Operations	1,837,185	1,691,022
Other Segments:		
Administration for Children and Families (ACF)	71,835	76,120
Administration for Community Living (ACL)	2,527	3,057
Agency for Healthcare Research and Quality (AHRQ)	251	351
Administration for Strategic Preparedness and Response (ASPR)	1,961	1,073
Centers for Disease Control and Prevention (CDC)	15,857	17,900
Food and Drug Administration (FDA)	6,223	6,945
Health Resources and Services Administration (HRSA)	14,231	14,912
Indian Health Service (IHS)	14,847	10,924
National Institutes of Health (NIH)	46,415	48,930
Office of the Secretary (OS)	8,334	12,544
Program Support Center (PSC)	2,128	2,837
Substance Abuse and Mental Health Services Administration (SAMHSA)	7,578	8,316
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	192,187	203,909
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes (Note 11)	(64)	496
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	192,123	204,405
Earned Revenue	(8,314)	(8,221)
Other Segments Net Cost of Operations	183,809	196,184
Net Cost of Operations (Note 21)	**$ 2,020,994**	**$ 1,887,206**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position

For the Fiscal Year Ended September 30, 2026

(in Millions)

	Funds from Dedicated Collections (Note 19)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations				
Beginning Balance	$ 236,903	$ 297,983	$ -	$ 534,886
Appropriations Received	838,292	1,033,102	-	1,871,394
Appropriations Transferred in/out	-	(1,834)	-	(1,834)
Other Adjustments	(38,251)	(59,572)	-	(97,823)
Appropriations Used	(691,664)	(931,973)	-	(1,623,637)
Net Change in Unexpended Appropriations	108,377	39,723	-	148,100
Total Unexpended Appropriations	**$ 345,280**	**$ 337,706**	**$ -**	**$ 682,986**
Cumulative Results of Operations				
Beginning Balance	$ 373,853	$ 11,000	$ -	$ 384,853
Adjustments (+/-)				
Change in Accounting Principles (+/-)	-	(55)	-	(55)
Beginning Balances, as Adjusted	373,853	10,945	-	384,798
Other Adjustments	(158)	-	-	(158)
Appropriations Used	691,664	931,973	-	1,623,637
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	411,467	-	-	411,467
Nonexchange Revenue – Investment Revenue	15,647	885	-	16,532
Nonexchange Revenue – Other	3,539	360	-	3,899
Donations and Forfeitures of Cash and Cash Equivalents	54	-	-	54
Transfers in/out without Reimbursement	(6,086)	4,926	-	(1,160)
Donations and Forfeitures of Property	-	11	-	11
Imputed Financing	670	1,684	(490)	1,864
Other	1	(1,903)	-	(1,902)
Net Cost of Operations	1,078,775	942,709	(490)	2,020,994
Net Change in Cumulative Results of Operations	38,023	(4,773)	-	33,250
Total Cumulative Results of Operations	**$ 411,876**	**$ 6,172**	**$ -**	**$ 418,048**
Net Position	**$ 757,156**	**$ 343,878**	**$ -**	**$ 1,101,034**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position

For the Fiscal Year Ended September 30, 2025

(in Millions)

	Funds from Dedicated Collections (Note 19)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations				
Beginning Balance	$ 263,916	$ 319,995	$ -	$ 583,911
Appropriations Received	657,934	932,858	-	1,590,792
Appropriations Transferred in/out	-	(1,472)	-	(1,472)
Other Adjustments	(75,243)	(66,743)	-	(141,986)
Appropriations Used	(609,704)	(886,655)	-	(1,496,359)
Net Change in Unexpended Appropriations	(27,013)	(22,012)	-	(49,025)
Total Unexpended Appropriations	**$ 236,903**	**$ 297,983**	**$ -**	**$ 534,886**
Cumulative Results of Operations				
Beginning Balance	$ 348,049	$ 10,738	$ -	$ 358,787
Appropriations Used	609,704	886,655	-	1,496,359
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	400,622	-	-	400,622
Nonexchange Revenue – Investment Revenue	12,521	1,056	-	13,577
Nonexchange Revenue – Other	3,224	131	-	3,355
Donations and Forfeitures of Cash and Cash Equivalents	43	-	-	43
Transfers in/out without Reimbursement	(5,824)	4,265	-	(1,559)
Donations and Forfeitures of Property	-	11	-	11
Imputed Financing	1,318	1,618	(440)	2,496
Other	15	(1,647)	-	(1,632)
Net Cost of Operations	995,819	891,827	(440)	1,887,206
Net Change in Cumulative Results of Operations	25,804	262	-	26,066
Total Cumulative Results of Operations	**$ 373,853**	**$ 11,000**	**$ -**	**$ 384,853**
Net Position	**$ 610,756**	**$ 308,983**	**$ -**	**$ 919,739**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Combined Statements of Budgetary Resources
For the Fiscal Years Ended September 30, 2026 and 2025
(in Millions)

	2026	2025
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory) (Note 15)	$ 360,924	$ 387,756
Appropriations (Discretionary and Mandatory)	3,128,370	2,695,918
Borrowing Authority (Discretionary and Mandatory)	9	-
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	35,082	46,071
Total Budgetary Resources	**$ 3,524,385**	**$ 3,129,745**
Status of Budgetary Resources		
New Obligations and Upward Adjustments	$ 3,072,674	$ 2,794,363
Unobligated Balance, End of Year		
Apportioned, Unexpired Accounts	179,859	67,232
Exempt from Apportionment, Unexpired Accounts	1,833	1,234
Unapportioned, Unexpired Accounts	59,371	18,397
Unexpired Unobligated Balance, End of Year	241,063	86,863
Expired Unobligated Balance, End of Year	210,648	248,519
Unobligated Balance, End of Year	451,711	335,382
Total Budgetary Resources	**$ 3,524,385**	**$ 3,129,745**
Outlays, Net and Disbursements, Net		
Outlays, Net (Discretionary and Mandatory)	$ 2,906,482	$ 2,671,374
Distributed Offsetting Receipts	(902,410)	(786,930)
Agency Outlays, Net (Discretionary and Mandatory) (Note 21)	**$ 2,004,072**	**$ 1,884,444**
Disbursements, Net	**$ (36)**	**$ (134)**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Statement of Social Insurance (Unaudited)

75-Year Projection as of January 1, 2026 and Prior Base Years
(in Billions)

	2026	Estimates from Prior Years 2025	2024	2023	2022
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 16,265	$ 16,554	$ 16,189	$ 15,360	$ 14,767
SMI Part B	47,557	47,167	40,323	39,008	39,039
SMI Part D	10,122	6,910	7,097	6,865	7,372
Have attained eligibility age (age 65 or over)					
HI	960	1,042	953	862	793
SMI Part B	9,871	9,517	8,181	7,683	7,447
SMI Part D	2,196	1,592	1,517	1,315	1,164
Those expected to become participants					
HI	15,465	15,537	15,360	15,046	14,603
SMI Part B	11,720	11,845	10,161	9,934	10,131
SMI Part D	3,408	2,231	2,393	2,372	3,094
All current and future participants					
HI	$ 32,691	$ 33,133	$ 32,502	$ 31,268	$ 30,163
SMI Part B	69,148	68,530	58,665	56,625	56,618
SMI Part D	15,726	10,733	11,008	10,551	11,630
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 24,201	$ 23,964	$ 22,970	$ 23,622	$ 23,211
SMI Part B	47,145	46,832	39,853	38,539	38,605
SMI Part D	10,122	6,910	7,097	6,865	7,372
Have attained eligibility age (age 65 and over)					
HI	8,473	8,045	7,357	7,215	7,010
SMI Part B	10,293	9,980	8,508	8,038	7,825
SMI Part D	2,196	1,592	1,517	1,315	1,164
Those expected to become participants					
HI	4,463	4,426	4,794	5,061	5,036
SMI Part B	11,711	11,717	10,304	10,048	10,188
SMI Part D	3,408	2,231	2,393	2,372	3,094
All current and future participants:					
HI	$ 37,136	$ 36,435	$ 35,120	$ 35,897	$ 35,257
SMI Part B	69,148	68,530	58,665	56,625	56,618
SMI Part D	15,726	10,733	11,008	10,551	11,630
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 23 and 24)					
HI	$ (4,446)	$ (3,301)	$ (2,618)	$ (4,630)	$ (5,094)
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 23 and 24)					
HI	$ (4,446)	$ (3,301)	$ (2,618)	$ (4,630)	$ (5,094)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	256	237	209	198	177
SMI Part B	148	152	172	194	163
SMI Part D	21	19	16	18	20
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 23 and 24)					
HI	$ (4,190)	$ (3,064)	$ (2,410)	$ (4,432)	$ (4,917)
SMI Part B	148	152	172	194	163
SMI Part D	21	19	16	18	20

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.

Principal Financial Statements

U.S. Department of Health and Human Services
Statement of Social Insurance (Continued) (Unaudited)

75-Year Projection as of January 1, 2026 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	2026	2025	2024	2023	2022
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 13,028	$ 12,152	$ 10,651	$ 9,860	$ 9,404
Expenditures	20,962	19,617	17,383	16,567	15,998
Income less expenditures	(7,934)	(7,465)	(6,731)	(6,707)	(6,595)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	73,944	70,631	63,609	61,232	61,178
Expenditures	81,468	77,706	69,920	69,026	69,188
Income less expenditures	(7,524)	(7,075)	(6,310)	(7,794)	(8,010)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(15,458)	(14,540)	(13,042)	(14,501)	(14,605)
Combined Medicare Trust Fund assets at start of period	424	408	397	410	360
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (15,034)	$ (14,132)	$ (12,645)	$ (14,091)	$ (14,244)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$ 30,593	$ 29,613	$ 27,914	$ 27,352	$ 27,828
Expenditures	19,581	18,374	17,491	17,480	18,318
Income less expenditures	11,012	11,239	10,423	9,871	9,510
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,446)	(3,301)	(2,618)	(4,630)	(5,094)
Combined Medicare Trust Fund assets at start of period	424	408	397	410	360
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (4,022)	$ (2,893)	$ (2,222)	$ (4,220)	$ (4,734)

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.

Principal Financial Statements

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Unaudited)

January 1, 2025 to January 1, 2026

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				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	Combined HI and SMI trust fund account assets	
Total Medicare (Note 25)					
As of January 1, 2025	$ 112,396	$ 115,697	$ (3,301)	$ 408	$ (2,893)
Reasons for change					
Change in the valuation period	4,115	4,239	(124)	13	(111)
Change in projection base	1,236	701	535	3	538
Changes in the demographic assumptions	(2,236)	(1,229)	(1,007)	-	(1,007)
Changes in economic and health care assumptions	2,653	2,574	79	-	79
Changes in law	(598)	29	(628)	-	(628)
Net changes	5,169	6,314	(1,144)	16	(1,128)
As of January 1, 2026	$ 117,565	$ 122,011	$ (4,446)	$ 424	$ (4,022)
HI - Part A (Note 25)					
As of January 1, 2025	$ 33,133	$ 36,435	$ (3,301)	$ 237	$ (3,064)
Reasons for change					
Change in the valuation period	1,089	1,212	(124)	8	(116)
Change in projection base	41	(494)	535	11	546
Changes in the demographic assumptions	(1,430)	(422)	(1,007)	-	(1,007)
Changes in economic and health care assumptions	488	409	79	-	79
Changes in law	(631)	(3)	(628)	-	(628)
Net changes	(443)	701	(1,144)	18	(1,126)
As of January 1, 2026	$ 32,691	$ 37,136	$ (4,446)	$ 256	$ (4,190)
SMI - Part B (Note 25)					
As of January 1, 2025	$ 68,530	$ 68,530	$ -	$ 152	$ 152
Reasons for change					
Change in the valuation period	2,681	2,681	-	7	7
Change in projection base	(84)	(84)	-	(10)	(10)
Changes in the demographic assumptions	(752)	(752)	-	-	-
Changes in economic and health care assumptions	(1,236)	(1,236)	-	-	-
Changes in law	9	9	-	-	-
Net changes	619	619	-	(4)	(4)
As of January 1, 2026	$ 69,148	$ 69,148	$ -	$ 148	$ 148
SMI - Part D (Note 25)					
As of January 1, 2025	$ 10,733	$ 10,733	$ -	$ 19	$ 19
Reasons for change					
Change in the valuation period	345	345	-	(1)	(1)
Change in projection base	1,279	1,279	-	3	3
Changes in the demographic assumptions	(55)	(55)	-	-	-
Changes in economic and health care assumptions	3,400	3,400	-	-	-
Changes in law	23	23	-	-	-
Net changes	4,994	4,994	-	2	2
As of January 1, 2026	$ 15,726	$ 15,726	$ -	$ 21	$ 21

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.

Principal Financial Statements

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Continued) (Unaudited)

January 1, 2024 to January 1, 2025

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 25)					
As of January 1, 2024	$ 102,175	$ 104,793	$ (2,618)	$ 397	$ (2,222)
Reasons for change					
Change in the valuation period	3,319	3,416	(97)	22	(75)
Change in projection base	1,737	2,364	(627)	(11)	(638)
Changes in the demographic assumptions	(1,361)	(1,637)	275	-	275
Changes in economic and health care assumptions	6,487	6,723	(236)	-	(236)
Changes in law	39	37	2	-	2
Net changes	10,221	10,904	(683)	11	(672)
As of January 1, 2025	$ 112,396	$ 115,697	$ (3,301)	$ 408	$ (2,893)
HI - Part A (Note 25)					
As of January 1, 2024	$ 32,502	$ 35,120	$ (2,618)	$ 209	$ (2,410)
Reasons for change					
Change in the valuation period	962	1,059	(97)	24	(73)
Change in projection base	62	689	(627)	5	(622)
Changes in the demographic assumptions	(304)	(579)	275	-	275
Changes in economic and health care assumptions	(89)	147	(236)	-	(236)
Changes in law	-	(2)	2	-	2
Net changes	632	1,315	(683)	29	(654)
As of January 1, 2025	$ 33,133	$ 36,435	$ (3,301)	$ 237	$ (3,064)
SMI - Part B (Note 25)					
As of January 1, 2024	$ 58,665	$ 58,665	$ -	$ 172	$ 172
Reasons for change					
Change in the valuation period	2,025	2,025	-	(3)	(3)
Change in projection base	1,614	1,614	-	(18)	(18)
Changes in the demographic assumptions	(675)	(675)	-	-	-
Changes in economic and health care assumptions	6,861	6,861	-	-	-
Changes in law	40	40	-	-	-
Net changes	9,864	9,864	-	(21)	(21)
As of January 1, 2025	$ 68,530	$ 68,530	$ -	$ 152	$ 152
SMI - Part D (Note 25)					
As of January 1, 2024	$ 11,008	$ 11,008	$ -	$ 16	$ 16
Reasons for change					
Change in the valuation period	333	333	-	-	-
Change in projection base	61	61	-	3	3
Changes in the demographic assumptions	(383)	(383)	-	-	-
Changes in economic and health care assumptions	(285)	(285)	-	-	-
Changes in law	-	-	-	-	-
Net changes	(275)	(275)	-	3	3
As of January 1, 2025	$ 10,733	$ 10,733	$ -	$ 19	$ 19

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

Notes to the Principal Financial Statements

Note 1. Reporting Entity and Summary of Significant Accounting Policies

A. Reporting Entity

The United States (U.S.) Department of Health and Human Services (HHS or the Department) is a Cabinet-level agency within 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. The law established a new federal entity, the Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for enhancing the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

The accompanying financial statements include activities and operations of HHS. In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, HHS has included all consolidation entities it is accountable for in this general purpose federal financial report. The Office of the Secretary (OS) and 12 Divisions listed below are consolidated in the HHS financial statements. HHS conducted a systematic and thorough review of all organizations and determined HHS does not have any disclosure entities.

Organization and Structure of HHS

Each HHS Division is 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) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS Divisions. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC), and Advanced Research Projects Agency for Health (ARPA-H) is combined with the National Institutes of Health (NIH) for financial reporting purposes. Responsibility segment management 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 13 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Administration for Strategic Preparedness and Response (ASPR)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS)
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

CMS, the largest HHS Division, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other health-related programs. CMS is also a separate reporting entity. The CMS annual financial report can be found at CMS.gov (unaudited).

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 Officers Act of 1990* (CFO Act), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These financial statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the 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 as federal GAAP. Therefore, these statements are 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 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 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 223 appropriation accounts. These accounts are used for general government functions, collection of receipts, and suspense. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position. The Statement of Budgetary Resources is represented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from that statement. Supplemental information is accumulated from the Divisions, 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.

Accounting standards require all reporting entities to disclose that accounting standards allow certain presentations and disclosures to be modified, if needed, to prevent the disclosure of classified information.

C. Budgetary Terms

The purpose of federal budgetary accounting is to control, monitor, and report on funds made available to federal agencies by law and help ensure compliance with the law. The following budget terms are commonly used.

Appropriations

Appropriations are a provision of law, not necessarily in an appropriations act, authorizing the expenditure of funds for a given purpose. Usually, but not always, an appropriation provides budget authority.

Budgetary Resources

Budgetary resources consist of new budget authority and unobligated balances from prior year budget authority and are available for obligation in a given year.

Offsetting Collections

Offsetting collections are payments to the Government, which by law are credited to expenditure accounts and deducted from gross budget authority and outlays of the expenditure account, rather than added to receipts. Offsetting collections are to be spent for the purposes of the account, usually without further action by Congress. They result from business-like transactions with the public (i.e., payments from the public in exchange for goods and services, reimbursements for damages, and gifts or donations of money to the Government) and from intragovernmental transactions.

Offsetting Receipts

Offsetting receipts are payments to the Government, which are credited to offsetting receipt accounts and deducted from gross budget authority and outlays, rather than added to receipts. Offsetting receipts are not authorized to be credited directly to expenditure accounts, since the legislation that authorizes the offsetting receipts may designate them for a specific purpose or appropriate them for expenditure for that purpose or require them to be appropriated in annual appropriations acts before they can be spent. Similar to offsetting collections, offsetting receipts usually result from business-like transactions with the public and from intragovernmental transactions with other Government accounts.

Obligations

An obligation is an action that creates a legal liability to disburse funds, immediately or in the future. Budgetary resources must be available before obligating actions can be taken legally. In entitlement programs, obligations may arise under operation of law.

Outlays

Outlays are payments to liquidate an obligation. Outlays generally are equal to cash disbursements. Outlays are the measure of Government spending. Net outlays are gross outlays reduced by offsetting collections.

D. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with GAAP are based on a 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.

E. *Patient Protection and Affordable Care Act*

In fiscal year (FY) 2010, the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* were signed and are collectively referred to as the PPACA. The PPACA contains the most significant changes to health care coverage since the *Social Security Act*.

Health Insurance Exchange Risk Adjustment Program

The Risk Adjustment program is a permanent program. The Risk Adjustment program applies to non-grandfathered individual and small group plans inside and outside the Exchanges. The Risk Adjustment program provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a Risk Adjustment program. States operating a Risk Adjustment program may have an entity other than the Exchange perform this function. CMS operates a Risk Adjustment program for each state that does not operate its own Risk Adjustment program.

F. 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 has allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

Under the PPACA, HHS has established a child relationship with the Internal Revenue Service (IRS) of the U.S. Department of the Treasury (Treasury) for the payment of the advance premium tax credits to insurance providers. No financial activity is included in HHS's financial statements.

HHS also received allocation transfers, as the child, from Environmental Protection Agency and the Departments of Justice, State, Treasury, and U.S. Agency for International Development. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Office of Personnel Management (OPM), Social Security Administration (SSA), and Departments of Commerce, War, Labor (DOL), and Treasury.

G. Changes, Reclassifications and Adjustments

Effective FY 2026, the principal statements and footnotes have been updated to a comparative presentation format in accordance with OMB Circular A-136. Accordingly, the accompanying financial statements and related disclosures present both FY 2026 and FY 2025 financial information, unless otherwise noted.

H. Funds from Dedicated Collections

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

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

HHS's major funds from dedicated collections are described in the sections below.

Federal Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Federal Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this trust fund. The financial statements include HI trust fund activities administered by Treasury. The HI trust fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contribution Act* (FICA) and the *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with

no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from the SSA records of wages established and maintained by SSA in accordance with wage information reports.

Federal Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Federal Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this trust fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching 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 outlines the ratio for the match 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.

Federal Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003*, established the Medicare Prescription Drug Benefit – Part D. Medicare also helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. In addition, the Low-Income Subsidy helps those with limited income and resources.

The PPACA provided that beneficiary cost sharing in the Part D coverage gap be reduced for brand-name and generic drugs to a 25 percent coinsurance. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program at Section 1893 of the *Social Security Act*. HIPAA Section 201 also established the Health Care Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program. The Medicare Integrity Program is funded by congressionally appropriated federal funds.

Separately, the Medicaid Integrity Program was established by the *Deficit Reduction Act of 2005* (DRA) and codified at Section 1936 of the *Social Security Act*. The Medicaid Integrity Program represents the federal government's first national strategy to detect and prevent Medicaid fraud and abuse. The Medicaid Integrity Program is funded by congressionally appropriated federal funds.

I. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriations 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; 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.

Earned Revenue

Earned 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 full cost recovery with 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 services. Certain fees charged by HHS are based on amounts 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 Reporting 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 Fund or HHS designated Special Funds. Amounts not retained for use by HHS are reported as Transfers in/out without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally enforceable claim to resources arises, but only to the extent that collection is probable, and the amount is reasonably estimable.

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

Imputed Financing Sources

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the OPM, and certain legal judgments against HHS are paid from the Judgment Fund maintained by Bureau of Fiscal Service (Fiscal Service), Treasury. When costs are identifiable to HHS, directly attributable to HHS's operations, and 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.

J. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions other than intragovernmental 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 earned revenue is classified as other than intragovernmental, 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 SSA and Treasury. SSA determines eligibility for Medicare programs and deducts Medicare Part B premiums from Social Security benefit payments for 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. 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, as well as beneficiary premiums and payments from states.

K. 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 entity obligations.

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

L. Fund Balance with Treasury

Fund Balance with Treasury is the aggregate amount of funds in the Department's accounts with Treasury. Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Treasury processes cash receipts and disbursements for the Department's operations. HHS reconciles Fund Balance with Treasury accounts with Treasury on a regular basis.

M. Custodial Activity

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

ACF receives funding from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. FDA custodial activity involves collections of Civil Monetary Penalties that are assessed by the Department of Justice on behalf of the FDA. FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. CDC's custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

N. 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 funds in the HI and SMI trust funds not needed 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 Fiscal Service to the HI and SMI trust funds as evidence of their receipt and are reported as an asset of 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 Fiscal Service 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 the Fiscal Service. Interest income is compounded semi-annually (i.e., June and December) by the Fiscal Service, and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30.

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 Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

The NIH gift funds are invested in Non-Marketable, Market-Based Securities issued by the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS's intent to hold investments to maturity.

O. 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 accounts. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties, criminal restitution, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, Medicare Secondary Payer accounts receivable, and Marketplace activities.

Accounts Receivable, Net from the public is net of an allowance for uncollectible accounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable is comprised mostly of amounts due to HHS related to collections for Marketplace activities.

P. Advances and Prepayments and Accrued Liabilities

Formula grants and block grants are funded when grantees provide services or payments to individuals and local agencies from a fixed amount of money. These grants are funded based on allocations determined by budgets and agreements approved by the sponsoring Division. The expenses are recorded as the grantees draw funds, no year-end accrual is required.

HHS recognizes grant expenses at the time of payment to the grant recipients. The accrual includes the incurred but not reported (IBNR) amount. Other Accrued Liabilities include expenses accrued for the Risk Adjustment and Transitional Reinsurance programs that are administered by CMS under the *Affordable Care Act*. These amounts represent estimates of payments due to those participating in the Marketplace activities.

Q. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of Stockpile Materials Held for Emergency or Contingency and Inventory Held for Sale or Use.

Stockpile Materials Held for Emergency or Contingency are held to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Biomedical Advanced Research and Development Authority (BARDA) established Vendor Managed Inventories and Vaccines for Children (VFC). These stockpiles contain millions of units of vaccines, antibiotics, antitoxins, antivirals, chemical antidotes and other lifesaving medical material or devices stored and maintained in both finished forms and bulk drug substance for deployment and use as needed.

HHS has increased the preparedness of the nation by procuring medical countermeasures including anthrax vaccine and antitoxins, botulin antitoxins, vaccines and antivirals for smallpox and Ebola virus, treatments for exposure to nerve agents and other chemical threats, and treatments for injuries that would arise from radiological and nuclear events. These actions are possible through BARDA investment of Project BioShield funding and through SNS procurement, management and deployment of commercial and non-commercial medical countermeasures for identified Chemical, Biological, Radiological, Nuclear and Explosive threats, and other pandemic and emerging infectious diseases. All stockpiles are valued at historical cost, using various cost flow assumptions, including the first-in/first-out (FIFO) for SNS and specific identification for VFC.

Inventory Held for Sale or Use includes Inventories Held for Sale and Operating Material and Supplies. Inventories Held for Sale consist of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. These inventories are valued at historical cost using the weighted average valuation method for the PSC's SSF inventories and using the moving average valuation method for the NIH's SSF 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 FIFO cost flow assumption.

R. Property, Plant and Equipment, Net

Property, Plant and Equipment (PP&E), Net consists of buildings, structures, and facilities used for general operations, land acquired for general operating purposes, equipment, assets that transfer ownership, leasehold improvements, construction-in-progress, and internal-use software. The basis for recording purchased PP&E is full cost, including all costs incurred to bring the PP&E to a form and location suitable for its intended use and is presented net of accumulated depreciation.

When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of PP&E transferred from other federal entities is the transferring entity's net book value. Except for internal-use software, HHS capitalizes all PP&E with an initial acquisition cost of $100,000 or more and an estimated useful life of two years or more.

HHS is required to report a right-to-use lease asset and a lease liability for non-intragovernmental, non-short-term contracts or agreements, when the entity has the right to obtain and control access to economic benefits or services from an underlying property, plant, or equipment asset for a period of time in exchange for consideration under the terms of the contract or agreement. HHS is required to report a right-to-use lease asset and a lease liability where HHS is a lessee, and a lease receivable and deferred revenue liability where HHS is the lessor.

An embedded lease is a contract or agreement that contains a lease and non-lease component, and the primary purpose is attributed to the non-lease component. In accordance with SFFAS 62, *Transitional Amendment to SFFAS 54*, HHS has elected to use the Transitional Accommodation for embedded leases through September 30, 2026, which allows for the embedded lease to be accounted for as non-lease through the accommodation period.

PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

In accordance with SFFAS 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal-use software costs for appropriated fund accounts is $1M, and the threshold for revolving fund accounts is $500,000. Costs below the threshold levels are expensed. Software is amortized using the straight-line method over a period of 5 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

S. 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. HHS's liabilities are classified as covered by budgetary resources, not covered by budgetary resources, or not requiring 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 DOL for disability payments. The actuarial *Federal Employee Compensation Act* (FECA) liability determined by the DOL but not yet billed is also included in this category.

Liabilities Not Requiring Budgetary Resources

Clearing accounts, non-fiduciary deposit funds, custodial collections, and unearned revenue and liabilities that have not in the past required and will not in the future require use of budgetary resources.

T. Federal Employee Salary, Leave and Benefits Payable

Federal Employee Salary, Leave and Benefits Payable consist 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 consist primarily of HHS's current FECA liability to DOL.

U. Pensions and Post-Employment Benefits Payable

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 on the Consolidated Balance Sheet. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statement of Net Cost.

Pensions and Post-Employment Benefits Payable also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are 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 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. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

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. The FERS plan has three parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes one percent of each employee's pay to the Thrift Savings Plan and matches the first three percent of employee contributions dollar for dollar. Each additional dollar of the employee's next two percent of basic pay is matched at 50 cents on the dollar.

OPM 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, or other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. However, HHS does 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.

V. Contingencies and Commitments

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 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS 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.

Treaties and other international agreements are written agreements between the U.S. and other sovereign states, or between the U.S. and international organizations, governed by international law. The Department of State developed and continues to manage the Circular 175 procedures, which outlines the approval process for the negotiation and conclusion of international agreements which HHS will become a party. For reporting purposes HHS has no present or contingency obligation related to treaties and international agreements when entered into force.

HHS has no material obligations related to cancelled appropriations for which there is a contractual commitment for payment or for contractual arrangements which may require future financial obligations.

W. Statement of Social Insurance (unaudited)

The financial statements are based on the selection of accounting policies and the application of significant accounting estimates, some of which 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 in understanding the effect of changes in assumptions to the related information.

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

	2026	2025
Non-Entity Intragovernmental Assets	$ 10	$ 22
Non-Entity Other than Intragovernmental Assets	87	72
Total Non-Entity Assets	97	94
Total Entity Assets	1,364,478	1,154,599
Total Assets	**$ 1,364,575**	**$ 1,154,693**

HHS reported an increase of $209.9B in Total Entity Assets primarily due to changes in Fund Balance with Treasury and Investments. Refer to the respective notes below for additional information.

Note 3. Fund Balance with Treasury (in Millions)

	2026	2025
Status of Fund Balance with Treasury		
Unobligated Balance	$ 451,711	$ 335,382
Obligated Balance not yet Disbursed	460,351	398,658
Non-Budgetary Fund Balance with Treasury	(80,321)	(74,689)
Total Fund Balance with Treasury	**$ 831,741**	**$ 659,351**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $60.6B as of September 30, 2026 ($54.8B as of September 30, 2025). The restricted amount is primarily for CHIP, CMS Program Management, Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations.

The Non-Budgetary Fund Balance with Treasury mostly represents amounts that have not yet been withdrawn from the Trust Funds.

Note 4. Investments, Net (in Millions)

	2026				
	Cost	Amortized (Premium) Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 444,004	$ -	$ 3,734	$ 447,738	$ 447,738
Non-Marketable: Market-Based	4,886	2	28	4,916	4,916
Total Intragovernmental	**$ 448,890**	**$ 2**	**$ 3,762**	**$ 452,654**	**$ 452,654**

	2025				
	Cost	Amortized (Premium) Discount	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 406,751	$ -	$ 2,987	$ 409,738	$ 409,738
Non-Marketable: Market-Based	4,511	53	21	4,585	4,585
Total Intragovernmental	**$ 411,262**	**$ 53**	**$ 3,008**	**$ 414,323**	**$ 414,323**

HHS investments consist primarily of Medicare Trust Fund investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2028 through June 30, 2040 with interest rates ranging from 1.500 percent to 4.625 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2027 with an interest rate of 4.875 percent.

Securities held by the Vaccine Injury Compensation trust fund will mature in FY 2026 through FY 2028. The Market-Based Notes paid rates ranging from 2.250 percent to 4.125 percent during October 1, 2025 to September 30, 2026. The Market-Based Bonds pay 5.375 percent through FY 2031.

The Non-Marketable Market-Based Securities held in the NIH gift funds yielded rates ranging from 3.537 percent to 3.869 percent from October 1, 2025 through September 30, 2026 depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

	2026				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 717	$ -	$ 717	$ -	$ 717
Total Intragovernmental	**$ 717**	**$ -**	**$ 717**	**$ -**	**$ 717**
Other than Intragovernmental					
Entity					
Medicare	$ 41,133	$ -	$ 41,133	$ (7,987)	$ 33,146
Medicaid	7,569	-	7,569	(1,032)	6,537
Other	11,079	567	11,646	(2,310)	9,336
Non-Entity	15	200	215	(128)	87
Total Other than Intragovernmental	**$ 59,796**	**$ 767**	**$ 60,563**	**$ (11,457)**	**$ 49,106**

	2025				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 763	$ -	$ 763	$ -	$ 763
Total Intragovernmental	**$ 763**	**$ -**	**$ 763**	**$ -**	**$ 763**
Other than Intragovernmental					
Entity					
Medicare	$ 37,445	$ -	$ 37,445	$ (5,689)	$ 31,756
Medicaid	7,917	-	7,917	(847)	7,070
Other	12,064	508	12,572	(2,258)	10,314
Non-Entity	17	169	186	(114)	72
Total Other than Intragovernmental	**$ 57,443**	**$ 677**	**$ 58,120**	**$ (8,908)**	**$ 49,212**

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

	2026	2025
Inventory Held for Sale or Use	$ 2,035	$ 2,540
Stockpile Materials Held for Emergency or Contingency	16,482	16,643
Total Inventory and Related Property, Net	**$ 18,517**	**$ 19,183**

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

	Depreciation Method	Estimated Useful Lives	2026 Acquisition Cost	2026 Accumulated Depreciation	2026 Net Book Value
Land Improvements & Temporary Land Rights	Straight-Line	1-10 Yrs	$ 18	$ (10)	$ 8
Construction in Progress	N/A	N/A	3,570	-	3,570
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	7,928	(4,906)	3,022
Equipment	Straight-Line	3-20 Yrs	2,088	(1,140)	948
Internal Use Software	Straight-Line	5-10 Yrs	6,121	(4,908)	1,213
Assets Under Capital Lease	Straight-Line	1-30 Yrs	28	(21)	7
Leasehold Improvements	Straight-Line	*Life of Lease	43	(18)	25
Right-to-Use Lease	Straight-Line	*Life of Lease	600	(88)	512
Total			**$ 20,396**	**$ (11,091)**	**$ 9,305**

	Depreciation Method	Estimated Useful Lives	2025 Acquisition Cost	2025 Accumulated Depreciation	2025 Net Book Value
Land & Land Rights	N/A	N/A	$ 71	$ (8)	$ 63
Construction in Progress	N/A	N/A	3,114	-	3,114
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	7,739	(4,652)	3,087
Equipment	Straight-Line	3-20 Yrs	2,021	(1,079)	942
Internal Use Software	Straight-Line	5-10 Yrs	6,559	(4,911)	1,648
Assets Under Capital Lease	Straight-Line	1-30 Yrs	46	(37)	9
Leasehold Improvements	Straight-Line	*Life of Lease	52	(25)	27
Right-to-Use Lease	Straight-Line	*Life of Lease	556	(55)	501
Total			**$ 20,158**	**$ (10,767)**	**$ 9,391**

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

	2026 PP&E, Net	2025 PP&E, Net
Balance Beginning of Year, Unadjusted	$ 9,391	$ 9,267
Effects of Implementation of SFFAS 59	(55)	-
Balance Beginning of Year, Adjusted	9,336	9,267
Capitalized Acquisitions	936	1,282
Right-to-Use Lease Assets	10	(264)
Dispositions	(35)	77
Revaluations other than for impairment (+/-)	(3)	-
Depreciation Expense	(965)	(971)
Other	26	-
Balance End of Year	**$ 9,305**	**$ 9,391**

As of September 30, 2026, HHS has recorded $0.5B in right-to-use lease assets primarily attributable to laboratory space and clinics. Additionally, HHS has right-to-use lease agreements based on delegated authority under the *Indian Health Care Improvement Act* (Public Law 94-437). The costs of these leases are nominal (typically no cost or one dollar), as they are leases between HHS and a Tribal Organization where the Tribe provides the building and HHS provides the health care services.

Note 8. Advances and Prepayments (in Millions)

	2026	2025
Intragovernmental		
Advances to Other Federal Entities	$ 1,983	$ 1,966
Total Intragovernmental	**$ 1,983**	**$ 1,966**
Other than Intragovernmental		
Grant Advances	$ 21	$ 22
Other	152	96
Total Other than Intragovernmental	**$ 173**	**$ 118**

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

	2026	2025
Intragovernmental		
Legal Liabilities (Note 13)	$ 1,912	$ 1,224
Custodial Liabilities (Note 13)	376	330
Other	184	175
Total Intragovernmental	**$ 2,472**	**$ 1,729**
Other than Intragovernmental		
Federal Employee Salary, Leave and Benefits Payable	$ 871	$ 919
Pensions and Post-Employment Benefits Payable	22,422	22,565
Contingencies and Commitments (Note 14)	22,752	17,785
Accrued Liabilities	9,142	9,809
Unfunded Lease Liability	563	535
Other	503	238
Total Other than Intragovernmental	**$ 56,253**	**$ 51,851**
Total Liabilities Not Covered by Budgetary Resources	$ 58,725	$ 53,580
Total Liabilities Covered by Budgetary Resources	200,447	176,145
Total Liabilities Not Requiring Budgetary Resources	4,369	5,229
Total Liabilities	**$ 263,541**	**$ 234,954**

Liabilities Not Covered by Budgetary Resources had an increase of $5.1B, mostly due to increases in Contingencies of $5.0B.

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

	2026	2025
Medicare Fee-For-Service	$ 65,137	$ 64,352
Medicare Advantage/Prescription Drug Program	50,184	40,343
Medicaid	64,782	57,979
CHIP	1,598	1,278
Total Entitlement Benefits Due and Payable	**$ 181,701**	**$ 163,952**

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

The Medicare fee-for-service liability is primarily an actuarial liability which represents: (1) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (2) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (4) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year; and (5) an estimate of retroactive settlements of cost reports. The September 30, 2026, and 2025 estimates also include amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals, as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of the calendar year 2026. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2026.

The Medicaid and CHIP liabilities represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded as of September 30, 2026 and September 30, 2025.

Note 11. Federal Employee Benefits Payable (in Millions)

	2026	2025
Federal Employee Salary, Leave and Benefits Payable		
Unfunded Leave	$ 871	$ 919
Accrued Funded Leave and Payroll	436	451
Other	4	4
Total Federal Employee Salary, Leave and Benefits Payable	**$ 1,311**	**$ 1,374**
Pensions and Post-Employment Benefits Payable		
PHS Commissioned Corps Pension Liability	$ 21,019	$ 21,316
PHS Commissioned Corps Post-Retirement Health Benefits	1,207	1,028
Workers' Compensation Benefits (Actuarial FECA Liability)	196	221
Other	-	2
Total Pensions and Post-Employment Benefits Payable	**$ 22,422**	**$ 22,567**

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 4,997 active-duty officers, 67 individual ready reserve members, and 8,543 retiree annuitants and survivors. As of September 30, 2026, the actuarial accrued liability for the retirement benefit plan was $21.0B and $1.2B for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commissioned Corps Retirement System and the Post-Retirement Medical Plan are not funded. Therefore, in accordance with SFFAS 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 discount rate is based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates are matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flow, as long as 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, 2026 and September 30, 2025, were:

	2026	2025
Discount Rate	3.23 percent	3.20 percent
Annual Basic Pay Scale Increase	2.70 percent	2.54 percent
Annual Inflation	2.60 percent	2.64 percent

The table shows key valuation results as of September 30, 2026 and 2025, in conformance with the actuarial reporting standards set forth in SFFAS 5 and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of September 30, 2026, and actuarial assumptions. The September 30, 2026 valuation includes a decrease in liabilities of $0.1B resulting from changes in the assumed annual inflation rates, discount rate, and salary scale. These changes in combination with the actual plan experience over the past year (based upon new census data), resulted in an overall net decrease in the actuarial accrued liability as compared to the prior valuation. The annual expense for the Retirement Benefit Plan for FY 2026 has decreased relative to the prior year expense.

	2026	2025
Beginning Liability Balance	$ 22,344	$ 20,882
Expense:		
Normal Cost	576	554
Interest on the Liability Balance	701	655
Actuarial (Gain)/Loss		
From Experience	(510)	536
From Assumption Changes		
Change in Inflation/Salary Increase Assumption	(117)	251
Change in Experience Study Assumption	-	114
Change in New Medical Trends Assumption	64	90
Change in Others	(11)	41
Total From Assumption Changes	$ (64)	$ 496
Net Actuarial (Gain)/Loss	(574)	1,032
Total Expense	$ 703	$ 2,241
Less Amounts Paid	(821)	(779)
Ending Liability Balance	**$ 22,226**	**$ 22,344**

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 IBNR claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. For FYs 2026 and 2025, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues for the current and prior four years.

Interest Rate Assumptions Utilized for Discounting		
	2026	2025
Wage Benefits	3.857% in Year 1 and years thereafter	3.221% in Year 1 and years thereafter
Medical Benefits	3.578% in Year 1 and years thereafter	2.944% in Year 1 and years thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (i.e., cost of living adjustments [COLA]) and medical inflation factors (i.e., consumer price index-medical [CPI-M]) are applied to the calculations of projected future benefits. The actual rates for these factors are also used to adjust the methodology's historical payments to current year constant dollars. The compensation COLAs and CPI-Ms used in the projections are:

	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036
COLA	N/A	4.23%	3.31%	2.71%	2.52%	2.41%	2.31%	2.21%	2.20%	2.20%	2.20%
CPI-M	N/A	2.78%	2.92%	3.52%	3.71%	3.88%	3.86%	3.86%	3.86%	3.86%	3.86%

Note 12. Accrued Liabilities (in Millions)

	2026	2025
Intragovernmental		
Other Accrued Liabilities	$ 95	$ -
Total Intragovernmental	**$ 95**	**$ -**
Other than Intragovernmental		
Grant Liability	$ 3,827	$ 4,340
Other Accrued Liabilities	14,491	13,702
Total Other than Intragovernmental	**$ 18,318**	**$ 18,042**

Note 13. Other Liabilities (in Millions)

	2026	2025
Intragovernmental		
Legal Liabilities	$ 1,912	$ 1,224
Benefit Program Contribution Payable	144	138
Custodial Liabilities	376	330
Debt	387	452
Other	63	28
Total Intragovernmental	**$ 2,882**	**$ 2,172**
Other than Intragovernmental		
Custodial Liabilities	$ 11	$ 11
Lessee Lease Liability	563	536
Environmental and Disposal Liabilities	203	229
Other	5,539	879
Total Other than Intragovernmental	**$ 6,316**	**$ 1,655**

The Lessee Lease Liability represents lessee funded and unfunded lease liability for right-to-use lease assets. The net present value of future payments over the term of the lease is recognized and amortized over the term of the arrangements.

The increase in Other than Intragovernmental, Other Liabilities is due to an increase of $5.0B for the Medicare Shared Savings Program – Accountable Care Organization accrual.

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. The liabilities are primarily related to the Medicaid audit and program disallowances. 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. HHS does not record an accrual for a contingent liability if it is not estimable and probable, but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances and Legal Contingencies

The amount of $12.5B as of September 30, 2026 ($8.2B as of September 30, 2025) consists of $11.5B for Medicaid audit and program disallowances, reimbursement of state plan amendments and $1.1B for legal contingent liabilities. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or HHS can decrease the state's authority. 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.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v Ramah Navajo Chapter*, dated June 18, 2012, and subsequent cases related to contract support costs have resulted in increased claims against IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid, and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. The estimated amount recorded for contract support costs is $6.7B as of September 30, 2026 ($6.7B as of September 30, 2025).

Other contingent liabilities against HHS have been accrued in the financial statements for ASPR, the Vaccine Injury Compensation Program, and the Health Center Program malpractice claims through the *Federal Tort Claims Act*.

Note 15. Net Adjustments to Unobligated Balance, Brought Forward, October 1 (in Millions)

	2026	2025
Unobligated Balance, End of Year (from Prior Year)	$ 335,382	$ 345,826
Adjustments to Unobligated Balance Brought Forward:		
Recoveries of Prior Year Unpaid Obligations	51,324	69,589
Recoveries of Prior Year Paid Obligations	18,409	22,823
Appropriation Withdrawn	(552)	(4,277)
Appropriation Temporarily Precluded from Obligation - Prior Year	(9)	(11)
Cancelled Authority	(44,764)	(46,049)
Prior Year Adjustments	(11)	120
Other	1,145	(265)
Total Unobligated Balance Brought Forward, October 1	**$ 360,924**	**$ 387,756**

Net adjustments to Unobligated Balance, Brought Forward, October 1 primarily includes activity related to recoveries of prior year unpaid and paid obligations, appropriation withdrawn, appropriations which were temporarily precluded from obligation in the prior year, cancelled authority, and prior year adjustments.

Cancelled Authority of $44.8B is primarily due to the return of the cancelled year authority to Treasury, which included $38.2B for Payments to the Health Care Trust Funds and $5.7B for CHIP.

Note 16. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, cooperative research and development agreement 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; therefore, it 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 $335.8B as of September 30, 2026 ($305.5B as of September 30, 2025) are included in Investments on the Consolidated Balance Sheets.

Note 17. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

	2025			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 3,129,745	$ 2,794,363	$ 786,930	$ 2,671,374
Expired Accounts	(250,442)	-	-	-
Other	-	4	302	1
Budget of the U.S. Government	**$ 2,879,303**	**$ 2,794,367**	**$ 787,232**	**$ 2,671,375**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2026, has not been published; therefore, no comparisons can be made between FY 2026 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2028 President's Budget* is expected to be released in February 2027 and may be obtained from OMB (unaudited) or from the Government Publishing Office (unaudited).

HHS reconciled the amounts of the FY 2025 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2025 from the Appendix in the *FY 2027 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays.

The *President's Budget* includes budgetary resources available for obligation. Budgetary resources that were not available are a reconciling item between the Combined Statement of Budgetary Resources and the *President's Budget*. The Expired Accounts line in the above table includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

Note 18. Undelivered Orders (in Millions)

	2026			2025		
	Federal	Non-Federal	Total	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 1,447	$ 1,634	$ 3,081	$ 1,307	$ 1,275	$ 2,582
Undelivered Orders, Unpaid	10,771	256,939	267,710	11,244	215,713	226,957
Total Undelivered Orders	**$ 12,218**	**$ 258,573**	**$ 270,791**	**$ 12,551**	**$ 216,988**	**$ 229,539**

Undelivered Orders include obligations that have been prepaid or advanced but not yet received, as well as goods and services ordered that have not been received. HHS reported $270.8B of budgetary resources obligated for undelivered orders as of September 30, 2026 ($229.5B as of September 30, 2025).

The Undelivered Orders, Unpaid increase of $40.8B is primarily due to the increase in the obligation amount for PTF related to SMI and Part D benefit payments of $44.5B offset by a decrease in PHSSEF of $4.3B.

Note 19. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the table. The Medicare program includes the HI trust fund; the SMI trust fund, which includes both Part B medical insurance, and the Medicare Prescription Drug Benefit – Part D; and the Medicare and Medicaid Integrity Programs. Other significant funds from dedicated collections programs include the Vaccine Injury Compensation trust fund, the Risk Adjustment Program, Program Management, and the Quality Improvement Organizations program.

Notes to the Principal Financial Statements

Balance Sheet	2026 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 382,445	$ 24,727	$ 407,172	$ -	$ 407,172
Investments, Net	447,738	3,970	451,708	-	451,708
Accounts Receivable, Net	120,658	6,625	127,283	(126,650)	633
Advances and Prepayments	2	187	189	(70)	119
Total Intragovernmental Assets	**950,843**	**35,509**	**986,352**	**(126,720)**	**859,632**
Accounts Receivable, Net	33,146	8,518	41,664	-	41,664
Property, Plant and Equipment, Net	165	762	927	-	927
Advances and Prepayments	1	1	2	-	2
Total Other than Intragovernmental Assets	**33,312**	**9,281**	**42,593**	**-**	**42,593**
Total Assets	**$ 984,155**	**$ 44,790**	**$ 1,028,945**	**$ (126,720)**	**$ 902,225**
Accounts Payable	$ 131,640	$ 64	$ 131,704	$ (126,650)	$ 5,054
Advances from Others and Deferred Revenue	-	-	-	(70)	(70)
Other Liabilities	70	22	92	-	92
Total Intragovernmental Liabilities	**131,710**	**86**	**131,796**	**(126,720)**	**5,076**
Accounts Payable	106	239	345	-	345
Entitlement Benefits Due and Payable	115,321	-	115,321	-	115,321
Federal Employee Salary, Leave & Benefits Payable	10	142	152	-	152
Pensions and Post-Employment Benefits Payable	-	12	12	-	12
Advances from Others and Deferred Revenue	2,052	1,548	3,600	-	3,600
Other Liabilities	6,060	14,503	20,563	-	20,563
Total Other than Intragovernmental Liabilities	**123,549**	**16,444**	**139,993**	**-**	**139,993**
Total Liabilities	**255,259**	**16,530**	**271,789**	**(126,720)**	**145,069**
Unexpended Appropriations	341,379	3,901	345,280	-	345,280
Cumulative Results of Operations	387,517	24,359	411,876	-	411,876
Total Liabilities and Net Position	**$ 984,155**	**$ 44,790**	**$ 1,028,945**	**$ (126,720)**	**$ 902,225**
Statement of Net Cost					
Gross Program Costs	$ 1,257,645	$ 23,088	$ 1,280,733	$ (40)	$ 1,280,693
Less: Earned Revenues	(183,134)	(18,824)	(201,958)	12	(201,946)
Net Cost of Operations	**$ 1,074,511**	**$ 4,264**	**$ 1,078,775**	**$ (28)**	**$ 1,078,747**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 233,517	$ 3,386	$ 236,903	$ -	$ 236,903
Appropriations Received	837,498	794	838,292	-	838,292
Appropriation Used	(691,395)	(269)	(691,664)	-	(691,664)
Other	(38,241)	(10)	(38,251)	-	(38,251)
Total Unexpended Appropriations	**341,379**	**3,901**	**345,280**	**-**	**345,280**
Cumulative Results of Operations:					
Beginning Balance	350,512	23,341	373,853	-	373,853
Other Adjustments	(38)	(120)	(158)	-	(158)
Appropriations Used	691,395	269	691,664	-	691,664
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	6,334	(1)	6,333	-	6,333
Intragovernmental Nonexchange Revenue	424,319	1	424,320	-	424,320
Donations and Forfeitures of Cash and Cash Equivalents	-	54	54	-	54
Transfers in/out without Reimbursement	(10,507)	4,421	(6,086)	-	(6,086)
Imputed Financing	13	657	670	(28)	642
Other	-	1	1	-	1
Net Cost of Operations	1,074,511	4,264	1,078,775	(28)	1,078,747
Net Change and Cumulative Results of Operations	37,005	1,018	38,023	-	38,023
Total Cumulative Results of Operations	**387,517**	**24,359**	**411,876**	**-**	**411,876**
Net Position, End of Period	**$ 728,896**	**$ 28,260**	**$ 757,156**	**$ -**	**$ 757,156**

Notes to the Principal Financial Statements

Balance Sheet	2025 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 262,493	$ 21,359	$ 283,852	$ -	$ 283,852
Investments, Net	409,738	3,950	413,688	-	413,688
Accounts Receivable, Net	109,703	6,804	116,507	(115,860)	647
Advances and Prepayments	1	113	114	(76)	38
Total Intragovernmental Assets	**781,935**	**32,226**	**814,161**	**(115,936)**	**698,225**
Accounts Receivable, Net	31,756	9,267	41,023	-	41,023
Property, Plant and Equipment, Net	196	1,068	1,264	-	1,264
Advances and Prepayments	1	-	1	-	1
Other Assets	-	9	9	-	9
Total Other than Intragovernmental Assets	**31,953**	**10,344**	**42,297**	**-**	**42,297**
Total Assets	**$ 813,888**	**$ 42,570**	**$ 856,458**	**$ (115,936)**	**$ 740,522**
Accounts Payable	$ 120,066	$ 61	$ 120,127	$ (115,860)	$ 4,267
Advances from Others and Deferred Revenue	-	-	-	(76)	(76)
Other Liabilities	95	19	114	-	114
Total Intragovernmental Liabilities	**120,161**	**80**	**120,241**	**(115,936)**	**4,305**
Accounts Payable	143	300	443	-	443
Entitlement Benefits Due and Payable	104,695	-	104,695	-	104,695
Federal Employee Salary, Leave & Benefits Payable	12	147	159	-	159
Pension, Post-Employment, & Veterans Benefits Payable	-	13	13	-	13
Advances from Others and Deferred Revenue	2,596	1,577	4,173	-	4,173
Other Liabilities	2,252	13,726	15,978	-	15,978
Total Other than Intragovernmental Liabilities	**109,698**	**15,763**	**125,461**	**-**	**125,461**
Total Liabilities	**$ 229,859**	**$ 15,843**	**$ 245,702**	**$ (115,936)**	**$ 129,766**
Unexpended Appropriations	233,517	3,386	236,903	-	236,903
Cumulative Results of Operations	350,512	23,341	373,853	-	373,853
Total Liabilities and Net Position	**$ 813,888**	**$ 42,570**	**$ 856,458**	**$ (115,936)**	**$ 740,522**
Statement of Net Cost					
Gross Program Costs	$ 1,151,455	$ 25,786	$ 1,177,241	$ 23	$ 1,177,264
Less: Earned Revenues	(160,942)	(20,480)	(181,422)	(41)	(181,463)
Net Cost of Operations	**$ 990,513**	**$ 5,306**	**$ 995,819**	**$ (18)**	**$ 995,801**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 260,565	$ 3,351	$ 263,916	$ -	$ 263,916
Appropriations Received	657,683	251	657,934	-	657,934
Appropriation Used	(609,496)	(208)	(609,704)	-	(609,704)
Other	(75,235)	(8)	(75,243)	-	(75,243)
Total Unexpended Appropriations	**233,517**	**3,386**	**236,903**	**-**	**236,903**
Cumulative Results of Operations:					
Beginning Balance	326,649	21,400	348,049	-	348,049
Appropriations Used	609,496	208	609,704	-	609,704
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	429	-	429	-	429
Intragovernmental Nonexchange Revenue	415,938	-	415,938	-	415,938
Donations and Forfeitures of Cash and Cash Equivalents	-	43	43	-	43
Transfers in/out without Reimbursement	(11,497)	5,673	(5,824)	-	(5,824)
Imputed Financing	10	1,308	1,318	(18)	1,300
Other	-	15	15	-	15
Net Cost of Operations	990,513	5,306	995,819	(18)	995,801
Net Change and Cumulative Results of Operations	23,863	1,941	25,804	-	25,804
Total Cumulative Results of Operations	**350,512**	**23,341**	**373,853**	**-**	**373,853**
Net Position, End of Period	**$ 584,029**	**$ 26,727**	**$ 610,756**	**$ -**	**$ 610,756**

Note 20. Stewardship Land

HHS Stewardship Land (i.e., land not acquired for or in connection with PP&E) is Indian Trust land used to support the IHS day-to-day operations of providing health care to American Indians and Alaska Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS 29*, Heritage Assets and Stewardship Land,* HHS does not report a related amount on the Consolidated Balance Sheet.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to American Indians and Alaska Natives. Health services are provided on tribal/reservation trust land that DOI assigned to IHS for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

Indian Trust Land by Locations and Number of Sites

IHS Area	2026	2025
Albuquerque	6	6
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	36
Oklahoma City	1	1
Phoenix	10	10
Portland	3	3
Tucson	5	5
Total	**79**	**79**

Note 21. Reconciliation of Net Cost to Net Outlays (in Millions)

The Reconciliation of Net Cost of Operations to Net Outlays reconciles proprietary basis of accounting Net Cost of Operations to budgetary basis of accounting Outlays, Net. Reconciling items include activity impacting Net Cost of Operations but are not included in Outlays, Net and activity impacting Outlays, Net but are not included in Net Cost of Operations. The miscellaneous items account for activities to be added or removed based on HHS activities that are not reflected in the reconciliation crosswalk.

Notes to the Principal Financial Statements

	2026			2025		
	Intragovernmental	Other than Intragovernmental	Total	Intragovernmental	Other than Intragovernmental	Total
Net Cost of Operations	**$ 9,649**	**$ 2,011,345**	**$ 2,020,994**	**$ 10,354**	**$ 1,876,852**	**$ 1,887,206**
Components of Net Cost Not Part of the Outlays:						
Property, Plant, and Equipment Depreciation Expense	-	(965)	(965)	-	(971)	(971)
Lessee Lease Amortization	-	(34)	(34)	-	(29)	(29)
Cost of Goods Sold	-	(3)	(3)	-	(21)	(21)
Applied Overhead/Cost Capitalization Offset	-	435	435	-	547	547
Gains/Losses on All Other Investments	-	(5)	(5)	-	16	16
	-	**(572)**	**(572)**	**-**	**(458)**	**(458)**
Increase/(Decrease) in Assets:						
Accounts Receivable	(46)	(171)	(217)	(20)	10,649	10,629
Securities and Investments	702	-	702	442	-	442
Advances and Prepayments	17	55	72	(864)	72	(792)
Other Assets	-	(7)	(7)	-	(34)	(34)
	673	**(123)**	**550**	**(442)**	**10,687**	**10,245**
(Increase)/Decrease in Liabilities:						
Accounts Payable	(207)	(422)	(629)	440	189	629
Lessee Lease Liability	-	(28)	(28)	-	253	253
Entitlement Benefits Due and Payable	-	(17,749)	(17,749)	-	(22,355)	(22,355)
Federal Employee Salary, Leave, and Benefits Payable	-	63	63	-	138	138
Pensions and Other Post-Employment Benefits Payable	-	145	145	-	(1,438)	(1,438)
Accrued Liabilities	(95)	(276)	(371)	-	(871)	(871)
Contingencies and Commitments	-	(4,967)	(4,967)	-	(2,798)	(2,798)
Other Liabilities	(871)	(4,428)	(5,299)	79	3,359	3,438
	(1,173)	**(27,662)**	**(28,835)**	**519**	**(23,523)**	**(23,004)**
Other Financing Sources:						
Imputed Financing	(1,864)	-	(1,864)	(2,496)	-	(2,496)
Total Components of Net Cost Not Part of the Outlays	**(2,364)**	**(28,357)**	**(30,721)**	**(2,419)**	**(13,294)**	**(15,713)**
Components of Outlays Not Part of Net Cost:						
Acquisition of Capital Assets	9	927	936	5	1,277	1,282
Acquisition of Inventory	1	1,300	1,301	1	2,818	2,819
Other Financing Sources:						
Donated Revenue	-	(54)	(54)	-	(42)	(42)
Transfers (in)/out without Reimbursement	1,160	-	1,160	1,559	-	1,559
Total Components of Outlays Not Part of Net Cost	**1,170**	**2,173**	**3,343**	**1,565**	**4,053**	**5,618**
Miscellaneous Items:						
Custodial/Non-Exchange Revenue	16,153	(934)	15,219	13,185	(526)	12,659
Non-entity activity	1,851	-	1,851	1,619	-	1,619
Other Temporary Timing Differences	-	55	55	-	-	-
Appropriated Receipts for Trust/Special Funds	-	12,762	12,762	-	11,780	11,780
Reconciling Items:						
Custodial/Non-Exchange Revenue	(16,153)	934	(15,219)	(13,185)	526	(12,659)
Debt	(41)	-	(41)	129	-	129
Miscellaneous Receipts	(838)	-	(838)	(879)	-	(879)
Investment Interest Receivable	(702)	-	(702)	(442)	-	(442)
Unfunded Lease Liability	-	27	27	-	(228)	(228)
Other Expenses Not Requiring Budgetary Resources	-	(971)	(971)	-	(3,249)	(3,249)
Federal Share of Child Support Collections	(379)	-	(379)	(392)	-	(392)
Total Miscellaneous Items	**(109)**	**11,873**	**11,764**	**(223)**	**8,303**	**8,080**
Net Outlays	**$ 8,346**	**$ 1,997,034**	**$ 2,005,380**	**$ 9,277**	**$ 1,875,914**	**$ 1,885,191**
Other Reconciling Items			(1,308)			(747)
Agency Outlays, Net			**$ 2,004,072**			**$ 1,884,444**

Note 22. Reclassification of Financial Statement Line Items for Financial Report Compilation Process

Reclassification of Statement of Net Cost to Line Items Used for Government-wide Statement of Net Cost For the Year Ended September 30, 2026 (in Millions)						
FY 2026 HHS Statement of Net Cost		**Line Items Used to Prepare FY 2026 Government-wide Statement of Net Cost**				
Financial Statement Line	**Amounts**	**Dedicated Collections Combined**	**Dedicated Collections Eliminations**	**All Other Amounts (with Eliminations)**	**Total**	**Reclassified Financial Statement Line**
		$ 1,278,063	**$ -**	**$ 938,885**	**$ 2,216,948**	***Non-Federal Costs***
						Intragovernmental Costs
		464	-	2,040	2,504	*Benefit Program Costs*
		670	(28)	1,222	1,864	*Imputed Costs*
		1,399	(12)	3,866	5,253	*Buy/Sell Costs*
		-	-	10	10	*Purchase of Assets*
		-	-	8	8	*Borrowing and Other Interest Expense*
		139	-	611	750	*Other Expenses (w/o Reciprocals)*
		$ 2,672	**$ (40)**	**$ 7,757**	**$ 10,388**	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 2,035,138					
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	192,187					
Total Gross Costs	**$ 2,227,325**	**$ 1,280,735**	**$ (40)**	**$ 946,642**	**$ 2,227,336**	***Total Reclassified Gross Costs***
		$ (201,895)	**$ -**	**$ (3,598)**	**$ (205,493)**	**Non-Federal Earned Revenue**
						Intragovernmental Earned Revenue
		(18)	12	(722)	(727)	*Buy/Sell Revenue*
		-	-	(10)	(10)	*Borrowing and Other Interest Revenue*
		-	-	-	-	*Purchase of Assets Offset*
		$ (18)	**$ 12**	**$ (732)**	**$ (738)**	**Total Intragovernmental Earned Revenue**
CMS: Earned Revenue	$ (197,953)					
Other Segments: Earned Revenue	(8,314)					
Total Earned Revenue	**$ (206,267)**	**$ (201,913)**	**$ 12**	**$ (4,330)**	**$ (206,231)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes	(64)	-	-	(64)	(64)	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost of Operations	**$ 2,020,994**	**$ 1,078,821**	**$ (28)**	**$ 942,248**	**$ 2,021,041**	**Net Cost of Operations**

*Subtotals and totals may not equal due to rounding.

Notes to the Principal Financial Statements

Reclassification of Statement of Changes in Net Position to Line Items Used for Government-wide Statement of Operations and Changes in Net Position For the Year Ending September 30, 2026 (in Millions)			
FY 2026 HHS Statement of Change in Net Position		Line Items Used to Prepare FY 2026 Government-wide Statement of Changes in Net Position	
Financial Statement Line	Amounts	Total	Reclassified Financial Statement Line
UNEXPENDED APPROPRIATIONS			
Unexpended Appropriations, Beginning Balance	$ 534,886	$ 534,888	Unexpended Appropriations, Beginning Balance
Appropriations Received	1,871,394	1,871,394	Appropriations Received (RC 41)
Appropriations Transferred In/Out	(1,834)	(1,834)	Appropriations Transferred In/Out (RC 08)
Appropriations Used	(1,623,637)	(1,623,637)	Appropriations Used (RC 39)
Other Adjustments	(97,823)	(97,823)	Other Adjustments
Total Unexpended Appropriations	**$ 682,986**	**$ 682,986**	**Total Unexpended Appropriations**
CUMULATIVE RESULTS OF OPERATIONS			
Cumulative Results, Beginning Balance	$ 384,853	$ 384,851	Cumulative Results, Beginning Balance
Changes in Accounting Principles	(55)	(55)	Changes in Accounting Principles
Appropriations Used	1,623,637	1,623,637	Appropriations Expended (RC 38)
Other Adjustments	(158)	(158)	Revenue and Other Financing Sources - Cancellations (RC 36)
Nonexchange Revenue – Tax Revenue	411,467	411,467	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	16,532	16,532	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange) (RC 03)
		2,061	*Collections Transferred into a TAS Other Than the General Fund of the U.S. Government (RC 15)*
		3,156	*Other Taxes and Receipts (RC 45)*
		(1,316)	*Other Taxes and Receipts*
Nonexchange Revenue – Other	3,899	3,901	Total Other Taxes and Receipts
Donations and Forfeitures of Cash and Cash Equivalents	54	54	Other Taxes and Receipts
		985	*Expenditure Transfers in of Financing Sources (RC 09)*
		(3,972)	*Expenditure Transfers out of Financing Sources (RC 09)*
		1,826	*Non-expenditure Transfers in/out of Unexpended Appropriations and Financing Sources (RC 08)*
Transfers in/out Without Reimbursement – Budgetary	(1,160)	(1,161)	Total Transfers in/out without reimbursement
Donations and Forfeitures of Property	11	11	Donations and Forfeitures of Property
Imputed Financing	1,864	1,864	Imputed Financing Sources (RC 25)
		(3,302)	*Non-Entity Collections transferred to the General Fund (RC 44)*
		(87)	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund (RC 48)*
		1,535	*Other*
Other	(1,902)	(1,854)	Total Other
Total Financing Sources	**2,054,189**	**2,054,238**	**Total Financing Sources**
Net Cost of Operations	**2,020,994**	**2,021,041**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 418,048**	**$ 418,048**	**Total Cumulative Results of Operations**
Total Net Position	**$ 1,101,034**	**$ 1,101,036**	**Total Net Position**

*Subtotals and totals may not equal due to rounding.

To prepare the *Financial Report of the U.S. Government* (FR), Treasury requires agencies to submit an adjusted trial balance, which is a listing of amounts by USSGL account that appears in the financial statements. Treasury uses the trial balance information reported in Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) to develop a Reclassified Statement of Net Cost, and a Reclassified Statement of Changes in Net Position for each agency, which are accessed using GTAS. Treasury eliminates all intragovernmental balances from the reclassified statements and aggregates lines with the same title to develop the FR statements. This note shows the HHS financial statements and the HHS reclassified statements prior to elimination of intragovernmental balances and prior to aggregation of repeated FR line items. A copy of the 2025 FR can be found at Fiscal Service's website (unaudited) and the 2026 FR will be posted to the site as soon as it is released.

The Statement of Net Cost and Statement of Changes in Net Position have immaterial differences primarily due to the presentations between HHS's financial statements and the reclassified financial statements. There is $47M due to custodial activities and the remainder of the differences are due to rounding.

Note 23. Statement of Social Insurance (Unaudited)

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

Actuarial present values are computed under the intermediate set of assumptions specified in the *2026 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

With two exceptions, the projections are based on the *Social Security Act's* current law provisions as of the date of release of the Medicare Trustees Report. The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Medicare Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date. However, implementation was initially delayed until January 1, 2023. Since then, legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The COVID-19 pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized, and the Trustees rely more on recent experience when developing the cost projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and 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,

premiums paid by, or on behalf of, aged uninsured beneficiaries, 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. Fees related to brand-name prescription drugs 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.

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 expected to participate 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 estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits 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 consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

The estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care costs, wages, and the CPI; fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75 year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2026 SOSI actuarial projections are drawn from the Medicare Trustees Reports for 2026. Specific assumptions are made for each of the different types of service

provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website (unaudited).[8]

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2026

				Annual percentage change in:							
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real wage[4]	Nominal wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[12]
2026	1.59	130,000	769.7	1.82	4.49	2.62	2.1	6.3	5.9[9,10]	18.3[10,11]	1.7
2030	1.61	978,000	749.0	2.08	4.53	2.40	1.8	5.0	7.2	1.9	1.7
2040	1.72	1,227,000	691.4	1.21	3.64	2.40	1.8	4.1	5.9	3.3	2.1
2050	1.75	1,196,000	637.7	1.12	3.55	2.40	1.7	3.3	3.7	4.0	2.3
2060	1.75	1,178,000	590.0	1.10	3.53	2.40	1.7	3.3	3.8	4.0	2.3
2070	1.75	1,166,000	547.7	1.13	3.56	2.40	1.6	3.4	3.6	3.8	2.3
2080	1.75	1,157,000	510.1	1.13	3.56	2.40	1.6	3.3	3.6	3.8	2.3
2090	1.75	1,151,000	476.6	1.14	3.57	2.40	1.7	3.6	3.8	3.9	2.3
2100	1.75	1,148,000	446.7	1.13	3.55	2.40	1.7	3.3	3.7	3.9	2.3

[1]Average number of children per woman.

[2]Includes lawful permanent resident immigration, net of emigration, as well as temporary or unlawfully present immigration.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated total population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4]Annual percentage change in average wages adjusted for the average percentage change in the CPI.

[5]Average annual wage in covered employment.

[6]The CPI 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 pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

[9]Reflects impacts of policy changes for skin substitutes.

[10]Reflects *Inflation Reduction Act of 2022*.

[11]Reflects increases in the utilization of GLP-1 and expensive specialty drugs in 2025 and impacts of higher projected cost trends and lower projected direct and indirect remuneration (DIR).

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

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

[8]The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation and is likewise not subject to audit by independent auditors.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance
FY 2026-2022

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real wage[4]	Nominal wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2026	1.75	1,148,000	446.7	1.13	3.55	2.40	1.7	3.3	3.7	3.9	2.3
2025	1.9	1,235,000	438.5	1.12	3.55	2.40	1.9	3.6	3.8	4.0	2.3
2024	1.9	1,214,000	438.9	1.12	3.54	2.40	1.9	3.5	3.7	3.9	2.3
2023	2.0	1,214,000	440.6	1.12	3.55	2.40	2.0	3.5	3.7	4.0	2.3
2022	2.0	1,215,000	440.6	1.15	3.55	2.40	2.0	3.5	3.7	4.2	2.3

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2050.

[2]Includes lawful permanent resident (LPR) immigration, net of emigration, as well as temporary or unlawfully present immigration. The ultimate level of net LPR immigration is 788,000 persons per year, and the assumption for annual net temporary or unlawfully present immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2100.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated total population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2100.

[4]Beginning with the 2023 Trustees Report, for consistency with other growth rate measures, the real-wage growth is defined as the annual percentage change in average wages adjusted for the average percentage change in the CPI. In the 2022 and earlier Trustees Reports it is presented as the difference between percentage increases in wages and the CPI and referred to as real-wage differential. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2100.

[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 2100.

[6]The CPI 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. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2100.

[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 pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented for FY 2026 is the value assumed in the year 2100. However, since the assumption for 2100 is not available for the FY 2022 through FY 2025 projection, the assumption presented is the value assumed for 2090.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

Note 24. Alternative Statement of Social Insurance Projections (Unaudited)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

Certain features of current law may result in some challenges for the Medicare program. There remains continued uncertainty regarding adherence to current-law payment updates, particularly in the long range. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician Medicare provider categories are reduced by the growth in economy-wide private nonfarm

business total factor productivity[1] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in the Medicare Trustees Report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028–2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period.[2] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

Table 3 contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

[1]The term economy-wide private nonfarm business total factor productivity will now be referred to as economy-wide productivity. Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term multifactor productivity with the term total factor productivity, a change in name only as the underlying methods and data were unchanged.

[2]The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the enactment of the *Medicare Access and CHIP Reauthorization Act* (MACRA) in 2015 replaced the sustainable growth rate (SGR) system with specified physician updates.

Table 3: Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	$ 32,691	$ 32,781
Part B	69,148	77,781
Part D	15,726	15,724
Expenditures		
Part A	37,136	43,679
Part B	69,148	77,781
Part D	15,726	15,724
Income less expenditures		
Part A	(4,446)	(10,898)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2026 Trustees Report.

[2]A set of illustrative alternative Medicare projections has been prepared under a hypothetical modification to current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly 36 percent of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans and the physician updates transitioned to the Medicare Economic Index, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 18 percent and Part B expenditures would be higher than the current-law projections by roughly 12 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 12 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very small difference is the result of a slight change in the discount rates that are used to calculate the present values.

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

Note 25. 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 estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2025 to the period beginning on January 1, 2026, and the reconciliation from the period beginning on January 1, 2024 to the period beginning on January 1, 2025. The reconciliation identifies several significant components of the change and provides reasons for the change.

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

The five changes considered in the SCSIA are, in order, as follows:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the SCSIA represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions represent the additional effect these assumptions have once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the SCSIA are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Medicare Trustees Reports for those years. Table 1 of Note 23 summarizes these assumptions for the current year.

Period beginning on January 1, 2025 and ending January 1, 2026

Present values as of January 1, 2025 are calculated using interest rates from the intermediate assumptions of the 2025 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2026. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2025 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2026 Trustees Report.

Period beginning on January 1, 2024 and ending January 1, 2025

Present values as of January 1, 2024 are calculated using interest rates from the intermediate assumptions of the 2024 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2025. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2024 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2025 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2025 to the period beginning on January 1, 2026

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2025-2099) to the current valuation period (2026-2100) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2025, replaces it with a much larger negative net cash flow for 2100, and measures the present values as of January 1, 2026, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2025-2099 to 2026-2100. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2025 are realized. The change in valuation period resulted in a small increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $111B.

From the period beginning on January 1, 2024 to the period beginning on January 1, 2025

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2024-98) to the current valuation period (2025-99) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2024, replaces it with a much larger negative net cash flow for 2099, and measures the present values as of January 1, 2025, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2024-98 to 2025-99. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2024 are realized. The change in valuation period resulted in a small increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $75B.

Change in Projection Base

From the period beginning on January 1, 2025 to the period beginning on January 1, 2026

Actual income and expenditures in 2025 were different from what was anticipated when the 2025 Trustees Report projections were prepared. Based on actual experience: (i) Part A income was higher and expenditures were lower than estimated; (ii) Part B income and expenditures were both lower than anticipated; and (iii) Part D income and expenditures were both higher than estimated. The net impact of the Part A, B, and D projection base changes is an

increase of $538B in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2025 and January 1, 2026 is incorporated in the current valuation and is less than projected in the prior valuation.

From the period beginning on January 1, 2024 to the period beginning on January 1, 2025

Actual income and expenditures in 2024 were different from what was anticipated when the 2024 Trustees Report projections were prepared. For Part A, B, and D income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is a decrease of $638B in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2024 and January 1, 2025 is incorporated in the current valuation and is less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2025 to the period beginning on January 1, 2026

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 Actuarial Services Office at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2026) there were two changes to the ultimate demographic assumptions.

- The ultimate total fertility rate (TFR) was lowered from 1.9 children per woman to 1.75 children per woman.
- The assumed ultimate level of temporary or unlawfully present immigrant entrants for the last 65 years of the projection period was lowered from 1.35M to 1.20M.

In addition to these changes to the ultimate demographic assumptions, the starting demographic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- Final birth rate data for calendar year 2024 and preliminary data for 2025 indicated somewhat lower birth rates than were assumed in the prior valuation, leading to slightly lower assumed birth rates during the period of transition to the ultimate level.
- Various mortality data updates led to higher death rates in all future years relative to the prior valuation.
- Estimated levels of temporary or unlawfully present immigrant entrants in the period 2022-2025 are lower than under the prior valuation.
- Assumed emigration rates from the unlawfully present population in the period 2025-2030 are higher than under the prior valuation.

There were no notable changes in demographic methodology.

These changes resulted in a decrease in the estimated future net cash flow. For Part A, Part B and Part D, the present value of estimated expenditures and income are lower. Overall, these changes decreased the present value of the estimated future net cash flow by $1,007B.

From the period beginning on January 1, 2024 to the period beginning on January 1, 2025

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

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2025) 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. The most significant changes are identified below.

- The ultimate TFR of 1.9 children per woman is reached in 2050, which is 10 years later than assumed in the prior valuation.
- Final birth rate data for calendar year 2023 and preliminary data for 2024 indicated slightly lower birth rates than were assumed in the prior valuation, leading to slightly lower assumed birth rates during the period of transition to the ultimate level.
- Assumed levels of temporary or unlawfully present immigrant entrants in the period 2022–25 are higher than under the prior valuation.
- Mortality data, historical population data, immigration data, marriage data, and divorce data were updated since the prior valuation.

There were two notable changes in demographic methodology.

- The method used for projecting death rates now incorporates Medicare data for deaths at ages 95 through 99, rather than using data only for ages up to 94 as in the prior valuation.
- The method used for projecting temporary or unlawfully present immigration was improved to better reflect recent data on the composition of the entrant population by age.

These changes resulted in an increase in the estimated future net cash flow. For Part A, Part B and Part D, the present value of estimated expenditures and income are lower. Overall, these changes increased the present value of the estimated future net cash flow by $275B.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2025 to the period beginning on January 1, 2026

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

The ultimate economic assumptions for the current valuation (beginning on January 1, 2026) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed. The one significant change to the starting values and transition assumptions was an improved outlook for labor productivity and average earnings growth over the first ten years of the projection period.

There was one notable change in economic methodology, related to the approach used to model labor force participation of workers age 75 and older. The parameters used in the modeling were updated based on more recent data, resulting in lower projected labor force participation and employment rates of the oldest workers.

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

- Higher Part A projected spending growth through 2055 and then lower for the remainder of the long-range projection period, as the impact of the change in demographic assumptions, most notably lower fertility rate assumptions, results in lower GDP projections.

- Lower Part B projected spending growth in the short range mainly because of the assumed impact of policy changes for skin substitutes, which are categorized as physician-administered drugs. Faster projected growth for other Part B drugs and changes in demographic assumptions, most notably the lower fertility rate assumptions, partially offset this lower growth through around 2048. Throughout the remainder of the long-range period the growth is very similar to last year's projection.
- Significantly higher Part D projected spending growth due to increases in the utilization of GLP-1 and expensive specialty drugs in 2025. Additionally, projected growth is higher than in last year's report because of higher cost trends and lower projected DIR through the short-range period. In the long-range period, this difference grows due to the changes in demographic assumptions, most notably the lower fertility rate assumptions, that result in lower GDP projections.

The net impact of these changes was an increase in the estimated future net cash flow for total Medicare. For Part A, these changes increased the present value of estimated future income and expenditures. For Part B, these changes resulted in a decrease in the present value of estimated expenditures (and income) and for Part D they resulted in an increase in the present value of estimated expenditures (and income). Overall, these changes increased the present value of the estimated future net cash flow by $79B.

For the period beginning on January 1, 2024 to the period beginning on January 1, 2025

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

For the current valuation (beginning on January 1, 2025), there was one change to the ultimate economic assumptions. The ratio of total labor compensation to GDP is assumed to increase gradually to 61.2 percent in 2034, and to remain approximately constant thereafter. In the prior valuation, this ratio was assumed to be about 62.8 percent for 2033 and later. This assumption change, considered by itself, implies somewhat slower average earnings growth over the first ten projection years and a level shift in average earnings in the longer term.

In addition to this change to the ultimate economic assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The one significant change is that historical OASDI covered employment for 2022 was slightly higher and its age distribution was different than assumed under the prior valuation.

Additionally, there were several notable changes in economic methodology.

- The model to project the civilian noninstitutional (CNI) population was updated to make the CNI projections more consistent with the projections of the Social Security area population.
- The method used for projecting average weeks worked during a calendar year, a key component of projections of OASDI covered employment, was updated. The updated approach uses historical data through 2021 and a more directly relevant data source.
- The process used to calculate and apply adjustments that smooth the age profile of labor force participation rates was improved, resulting in a decrease in projected labor force participation rates of workers age 75 and older relative to the prior valuation.

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

- Higher Part A projected spending growth because of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

- Higher Part B projected spending growth due to higher projected spending for outpatient hospital and physician-administered drugs.
- Lower Part D projected spending growth because of lower Part D enrollment which is disproportionately lower for those eligible for low-income subsidies.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes decreased the present value of estimated future income and increased the present value of expenditures. For Part B, these changes resulted in an increase in the present value of estimated expenditures (and income) and for Part D they resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $236B.

Changes in Law

For the period beginning on January 1, 2025 to the period beginning on January 1, 2026

The following provisions had a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (Public Law 119-21, enacted on July 4, 2025), which is colloquially referred to as the "*One Big Beautiful Bill Act*" (OBBBA), included provisions that affect the HI and SMI programs.

- The lower ordinary income tax rates and adjusted tax brackets originally enacted under the *2017 Tax Cuts and Jobs Act* are made permanent, and the larger standard deduction provided by the 2017 Act is increased and made permanent as well. Furthermore, a temporary additional standard deduction for taxpayers over age 65 is also added. As a result of these changes, taxable income for many Social Security beneficiaries is reduced. Therefore, less income tax will be paid on Social Security benefits, and the HI trust fund will receive lower levels of revenue in the future from income taxation of Social Security benefits.
- The exclusion for orphan drugs from the Medicare drug price negotiation program is modified in two ways. First, a drug or biologic approved to treat one or more rare diseases or conditions is now exempted from the negotiation program (whereas previously, only those drugs or biologics approved to treat a single rare disease or condition were exempted). Second, if a drug or biologic loses its orphan drug status, the price negotiation eligibility period begins on the first day after the date of non-orphan approval (for drugs) or non-orphan licensure (for biologics), rather than on the original approval or licensure date. These changes apply to initial price applicability years beginning on or after January 1, 2028.
- In the formula for determining payment rates for services under the physician fee schedule, the updates to the conversion factors are temporarily increased, for 2026 only, by 2.5 percent. (That is, for 2026, the 0.75 percent update for physicians who are qualified participants in advanced alternative payment models and the 0.25 percent update for all other physicians are each multiplicatively combined with 2.5 percent.)

The Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Public Law 119-37, enacted on November 12, 2025) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through February 28, 2033. (In other words, the benefit payment reductions for the month of February 2033 are changed from 0 percent to 2 percent.) (Subsequent legislation further extended this provision; see Public Law 119-75, below.)

- Funding in the amount of $1,403M is provided to the Medicare Improvement Fund, from the HI and SMI trust funds in such proportion as is deemed appropriate by the Secretary of HHS, for services provided during and after fiscal year 2027. (Subsequent legislation changed the amount provided; see Public Law 119-75, below.)
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through January 30, 2026 (from September 30, 2025). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. (Subsequent legislation further extended this provision; see Public Law 119-75, below.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2025, is extended through January 30, 2026. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.) (Subsequent legislation further extended this provision; see Public Law 119-75, below.)
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through January 30, 2026 (from September 30, 2025). (Subsequent legislation further extended this provision; see Public Law 119-75, below.)
- Changes are made to the phase-in period for the market-based system intended to update the Medicare clinical laboratory fee schedule. (This fee schedule is used for determining payments for clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests.) First, laboratories are exempted for one month from the requirement that they report private payer rates; that is, the next data-reporting period is now the 3-month period from February 1, 2026, through April 30, 2026 (instead of January 1, 2026, through March 31, 2026). Next, payment reductions are delayed a month, such that tests furnished during January 2026 (like those furnished during 2021–2025) are to be paid at the same rates as under the 2020 fee schedule. Payments for tests provided during February 1, 2026, through December 31, 2028 (rather than January 1, 2026, through December 31, 2028, as provided for under the previous statute) may not be reduced by more than 15 percent per year. (Subsequent legislation further extended these delays; see Public Law 119-75, below.)
- Certain ground ambulance add-on payments that had been extended through September 30, 2025 (under Public Law 119-4) are now extended through January 30, 2026. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities. (Subsequent legislation further extended this provision; see Public Law 119-75, below.)

The Consolidated Appropriations Act, 2026 (Public Law 119-75, enacted on February 3, 2026) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended through August 31, 2033. (In other words, the benefit payment reductions for the months of March 2033 through August 2033 are changed from 0 percent to 2 percent.)
- The funding amount of $1,403M that was previously provided to the Medicare Improvement Fund for services furnished during and after fiscal year 2027, as discussed under Public Law 119-37, is increased to $2,062M.
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through December 31, 2026 (from January 30, 2026). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most

recent sliding scale used to determine the add-on percentages is also extended. After December 31, 2026, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after January 30, 2026, is extended through December 31, 2026. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- For the hospice aggregate cap, the change made by previous legislation—whereby a hospice payment update percentage is used for the annual updates for fiscal years 2017–2033 rather than the Consumer Price Index for All Urban Consumers—is extended through fiscal year 2035.
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through December 31, 2026 (from January 30, 2026).
- For physicians who are qualified participants in advanced alternative payment models, incentive payment availability is reinstated for payment year 2028 (for performance year 2026). These incentive payments are to equal 3.1 percent of fee schedule payments (as compared with 5 percent for payment years 2019–2024; 3.5 percent for payment year 2025; 1.88 percent for payment year 2026; and 0 percent for payment year 2027). In addition, the lower participation thresholds that had been in place prior to payment year 2027, in order to qualify for the incentive payments, will apply in payment year 2028 (for performance year 2026); specifically, physicians must receive at least 50 percent of their Part B payments through the model (as opposed to at least 75 percent) or at least 35 percent of the patients they see must be through the model (as opposed to at least 50 percent). The more stringent thresholds will begin applying in payment year 2029.
- Changes are made to the phase-in period for the market-based system intended to update the Medicare clinical laboratory fee schedule. (This fee schedule is used for determining payments for clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests.) First, laboratories are exempted for three months from the requirement that they report private payer rates; that is, the next data-reporting period is now May 1, 2026, through July 31, 2026 (instead of February 1, 2026, through April 30, 2026). The data collection period is revised as well, to January–June 2025 (from January–June 2019). Next, payment reductions are delayed, such that tests furnished during the last 11 months of 2026 (like those furnished during 2021–2025 and the first month of 2026) are to be paid at the same rates as under the 2020 fee schedule. Payments for tests provided during 2027 through 2029 (rather than February 1, 2026, through December 31, 2028, as provided for under the previous statute) may not be reduced by more than 15 percent per year.
- Certain ground ambulance add-on payments that had been extended through January 30, 2026, under Public Law 119-37, are now extended through December 31, 2027. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.
- Digital health companies can participate in the Medicare diabetes prevention program (MDPP) as virtual suppliers through 2029. (Such participation had been approved under temporary authority during the COVID-19 pandemic and had been subsequently extended through 2027). Also, beneficiaries are now allowed to participate in the program multiple times. (The MDPP is a one-year health behavior change educational program that has demonstrated effectiveness in delaying or preventing the onset of type 2 diabetes among people with prediabetes.)

- For low-income enrollees eligible for cost-sharing subsidies, the existing Part D copayment caps of $1 for a generic or preferred multiple source drug and $3 for a brand-name drug are maintained through 2027. In addition, beginning in 2028, the $1 amount for generic drugs decreases to $0, while the $1 and $3 amounts for preferred multiple source drugs and brand-name drugs, respectively, will each be adjusted annually for inflation.

These changes resulted in a decrease in the Part A present values of estimated future income and a slight decrease in the present value of expenditures. For Part B and Part D, there were small increases in the present values of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $628B for total Medicare.

For the period beginning on January 1, 2024 to the period beginning on January 1, 2025

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions had a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The Consolidated Appropriations Act, 2024 (Public Law 118-42, enacted on March 9, 2024) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through November 30, 2032. (In other words, the benefit payment reductions for the month of November 2032 are changed from 0 percent to 2 percent.)
- The funding amount of $2,197,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-35 in last year's report, is reduced to $0. (This fund is intended to be available for improvements to the original fee-for-service program under Parts A and B, and funding is provided from the HI and SMI trust funds in such proportions as deemed appropriate by the Secretary of Health and Human Services.)
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through December 31, 2024 (from September 30, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After December 31, 2024, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2024, is extended through December 31, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through December 31, 2024 (from March 8, 2024).
- In the formula used for determining payment rates under the physician fee schedule, the physician payment update is changed for services furnished March 9, 2024, through December 31, 2024. As a result, the update of −1.22 percent, which was to be in effect throughout 2024, is now to apply only through March 8, and an update of 0.42 percent (as compared with the 2023 payment level) is to apply for the remainder of the year.
- For physicians participating in advanced alternative payment models, incentive payment availability is extended 1 year, through performance year 2024. However, for payment year 2026 (which applies to

performance year 2024), the incentive payments are to equal 1.88 percent of fee schedule payments (as compared with 5 percent for 2019–2024 and 3.5 percent for 2025). In addition, the current freeze on the participation thresholds that must be met to qualify for the incentive payments is extended for the same additional year. (The more stringent thresholds will now first apply in 2027.)

The Continuing Appropriations and Extensions Act, 2025 (Public Law 118-83, enacted on September 26, 2024) included provisions that affect the HI and SMI programs.

- The funding amount of $0 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-42, is increased to $3,197M for services furnished during and after FY 2026.
- For clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests, changes are made to the market-based system used to update the Medicare clinical laboratory fee schedule. First, laboratories are exempted for another year from the requirement that they report private payer rates; that is, the next data-reporting period is now the first quarter of 2026 (instead of the first quarter of 2025). Next, for the caps in place to limit reductions in fee schedule payments during the phase-in period, the timing is changed. Specifically, tests furnished during 2021–2025 (rather than 2021–2024) are to be paid at the same rates as under the 2020 fee schedule, and payments for tests provided during 2026–2028 (rather than 2025–2027) may not be reduced by more than 15 percent per year.

The American Relief Act, 2025 (Public Law 118-158, enacted on December 21, 2024) included provisions that affect the HI and SMI programs.

- The funding amount of $3,197M that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2026, as discussed under Public Law 118-83, is decreased to $1,251M.
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through March 31, 2025 (from December 31, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After March 31, 2025, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 31, 2024, is extended through March 31, 2025. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through March 31, 2025 (from December 31, 2024).
- Certain ground ambulance add-on payments that had been extended through December 31, 2024, under previous legislation are now extended through March 31, 2025. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.

The Full-Year Continuing Appropriations and Extensions Act, 2025 (Public Law 119-4, enacted on March 15, 2025) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 2 months, through January 31, 2033. (In other words, the benefit payment reductions for the months of December 2032 and January 2033 are changed from 0 percent to 2 percent.)
- The funding amount of $1,251M that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2026, as discussed under Public Law 118-158, is increased to $1,804M.
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through September 30, 2025 (from March 31, 2025). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After September 30, 2025, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after March 31, 2025, is extended through September 30, 2025. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through September 30, 2025 (from March 31, 2025).
- Certain ground ambulance add-on payments that had been extended through March 31, 2025, under Public Law 118-158 are now extended through September 30, 2025. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.

These changes resulted in a slight decrease in the Part A present values of estimated expenditures and a small increase in the Part B present value of estimated expenditures (and income). For Part D, there was no change in the present values of estimated expenditures (and income). Overall, these changes increased the present value of the estimated future net cash flow by $2B for total Medicare.

Required Supplementary Information

Combining Statement of Budgetary Resources

For the Fiscal Year Ended September 30, 2026
(in Millions)

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Accounts	Agency Combined Totals
Budgetary Resources						
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 591	$ 927	$ 183,860	$ 51,665	$ 123,881	$ 360,924
Appropriations (Discretionary and Mandatory)	469,745	624,754	837,474	763,510	432,887	3,128,370
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	9	9
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	2,090	32,992	35,082
Total Budgetary Resources	**$ 470,336**	**$ 625,681**	**$ 1,021,334**	**$ 817,265**	**$ 589,769**	**$ 3,524,385**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 470,336	$ 625,681	$ 731,593	$ 774,776	$ 470,288	$ 3,072,674
Unobligated Balance, End of Year						
Apportioned, Unexpired Accounts	-	-	105,881	3	73,975	179,859
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	1,833	1,833
Unapportioned, Unexpired Accounts	-	-	-	42,486	16,885	59,371
Unexpired Unobligated Balance, End of Year	-	-	105,881	42,489	92,693	241,063
Expired Unobligated Balance, End of Year	-	-	183,860	-	26,788	210,648
Unobligated Balance, End of Year	-	-	289,741	42,489	119,481	451,711
Total Budgetary Resources	**$ 470,336**	**$ 625,681**	**$ 1,021,334**	**$ 817,265**	**$ 589,769**	**$ 3,524,385**
Outlays, Net and Disbursements, Net						
Outlays, Net (Discretionary and Mandatory)	$ 468,277	$ 618,178	$ 685,574	$ 717,033	$ 417,420	$ 2,906,482
Distributed Offsetting Receipts	(65,073)	(835,211)	-	-	(2,126)	(902,410)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 403,204**	**$ (217,033)**	**$ 685,574**	**$ 717,033**	**$ 415,294**	**$ 2,004,072**
Disbursements, Net	**$ -**	**$ -**	**$ -**	**$ -**	**$ (36)**	**$ (36)**

The Summary of Other Agency Accounts table on the next page provides a breakout of the Budgetary Resources and Net Agency Outlays for HHS Divisions and the CMS programs not identified in the table above.

Required Supplementary Information

Summary of Other Agency Accounts

(in Millions)

	Budgetary Resources	Agency Outlays, Net
ACF	$ 87,705	$ 71,508
ACL	2,903	2,309
AHRQ	460	285
ASPR	4,569	2,580
CDC	23,407	15,853
CMS	339,998	236,345
FDA	10,116	2,551
HRSA	16,484	14,649
IHS	19,989	10,089
NIH	60,473	45,366
OS	12,029	5,355
PSC	3,220	700
SAMHSA	8,416	7,704
Totals	**$ 589,769**	**$ 415,294**

Deferred Maintenance and Repairs

The FASAB issued SFFAS 42, *Deferred Maintenance and Repairs*: *Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32,* effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices and improve reporting on Deferred Maintenance and Repairs (DM&R). DM&R are maintenance and repair activities not performed when they should have been or were scheduled to be and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital 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. Other factors under consideration are whether the asset meets applicable building codes 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 when incurred. HHS DM&R relates solely to capitalized Property, Plant, and Equipment (PP&E). HHS tracks replacement value, repair needs data elements, and backlogs of maintenance and repair for owned buildings and structures in the Automated Real Property Inventory Reporting System (ARIS) database.

HHS land holding Divisions prioritize maintenance and repair activities by employing capital planning processes consistent with OMB Circular No. A-11, prioritizing assets based on the Division's strategic goals. Annually, Divisions update their Division Real Property Capital Plans and include a detailed narrative of planning procedures for acquisition, maintenance, operations, and disposal projects for the budget year and five years forward.

HHS uses industry standard criterion, Condition Index (CI) Formula [CI = 1 – (DM&R/Plant Replacement Value (PRV))], to determine acceptable condition standards. A CI of 90 or above is considered good, while a CI below 90 is considered progressively poor condition. Inflation in labor and material costs for DM&R are estimated in accordance with HHS Budget Justification Guidance, where the most current inflation rate specified by OMB is used to project escalations.

In ARIS, mission-critical facilities are marked as 3-High. The minimum maintenance and repair amount needed to ensure mission critical facilities remain mission capable is $0.8B. The increase of $0.5B from FY 2025 to FY 2026 is primarily due to highly mission-critical buildings on the NIH Bethesda Campus, where aging infrastructure has been identified for repair and replacement.

Estimated Cost to Return to Acceptable Condition
(in Millions)

Category of Asset	2026	2025
PP&E		
Buildings	$ 5,766	$ 5,291
Other Structures	22	36
Total	**$ 5,788**	**$ 5,327**

Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for more than six decades. A brief description of the provisions of Medicare's Federal Hospital Insurance (HI, or Part A) trust fund and Federal Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

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

RSI material is generally drawn from the *2026 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.

With two exceptions, the projections are based on the *Social Security Act*'s current-law provisions. The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date. However, implementation was initially delayed until January 1, 2023. Since then, legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The COVID-19 pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized and the Trustees rely more on recent experience when developing the cost

projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

Certain features of current law may result in some challenges for the Medicare program. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician Medicare provider categories are reduced by the growth in economy-wide private nonfarm business total factor productivity.[9] However, these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws:

- *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013);
- *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013);
- Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014;
- *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014);
- *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015);
- *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018);
- *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019);
- *Coronavirus Aid, Relief, and Economic Security Act* (Public Law 116-136, enacted on March 27, 2020);
- *Consolidated Appropriations Act, 2021* (Public Law 116-260, enacted on December 27, 2020);
- *Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes* (Public Law 117-7, enacted on April 14, 2021);
- *Infrastructure Investment and Jobs Act* (Public Law 117-58, enacted on November 15, 2021);
- *Protecting Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021);
- *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022);
- *National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023);
- *Consolidated Appropriations Act, 2024* (Public Law 118-42, enacted on March 9, 2024);
- *Full-Year Continuing Appropriations and Extensions Act, 2025* (Public Law 119-4, enacted on March 15, 2025);
- *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37, enacted on November 12, 2025); and
- *Consolidated Appropriations Act, 2026* (Public Law 119-75, enacted on February 3, 2026).

[9]The term economy-wide private nonfarm business total factor productivity will now be referred to as economy-wide productivity. Beginning with the November 18, 2021, release of the productivity data, the Bureau of Labor Statistics replaced the term multifactor productivity with the term total factor productivity, a change in name only, as the underlying methods and data were unchanged.

Required Supplementary Information

The sequestration reduces benefit payments by the following percentages: 2 percent from April 1, 2013, through April 30, 2020; 1 percent from April 1, 2022, through June 30, 2022; and 2 percent from July 1, 2022, through August 31, 2033.

Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013, through August 31, 2033, excluding May 1, 2020, through March 31, 2022, when it was suspended.

The financial projections for the Medicare program reflect current-law payment updates. These payment updates would probably not be viable indefinitely for most health care provider categories without fundamental changes in the current delivery system. It is conceivable that 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.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting health care cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law.

In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes the following:

- There would be a transition from current-law[10] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; and
- The average physician payment updates would transition from current law[11] to payment updates that reflect the Medicare Economic Index.

The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the Trustees Report if the cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 24 in these consolidated financial statements, in Section V.C of this year's Trustees Report, and in a memorandum prepared by the CMS Office of the Actuary.

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 the CMS website (unaudited).[12]

[10]Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth in economy-wide productivity (1.0 percent over the long range).

[11]The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models or the merit-based incentive payment system, respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.

[12]The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the consolidated financial statement presentation and is likewise not subject to audit by independent auditors.

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[13] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[14]

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

Medicare payment rates for most non-physician provider categories are updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for five categories of health care provider services:

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

HI services are inpatient hospital, skilled nursing facility, home health agency, and hospice. The primary Part B services affected are outpatient hospital, home health agency, and dialysis.

Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.6 percent in 2050, or GDP plus 0.0 percent, declining gradually to 3.4 percent in 2100, or GDP minus 0.3 percent.

(ii) *Physician services.*

Payment rate updates are 0.75 percent per year for qualified physicians assumed to be participating in advanced alternative payment models and 0.25 percent for those assumed to be participating in the merit-

[13]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the sex composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

[14]The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010–2011 Medicare Technical Review Panel (final report available here (unaudited)) and with Finding 3-2 of the 2016–2017 Medicare Technical Review Panel (final report available here(unaudited)).

based incentive payment system. The year-by-year cost growth rates for physician payments are assumed to decline from 3.1 percent in 2050, or GDP minus 0.5 percent, to 2.8 percent in 2100, or GDP minus 0.9 percent.

(iii) *Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity.*

Such services include durable medical equipment that is not subject to competitive bidding,[15] care at ambulatory surgical centers, ambulance services, and medical supplies.

The year-by-year cost growth rates for these services are assumed to decline from 2.8 percent in 2050, or GDP minus 0.8 percent, to 2.6 percent in 2100, or GDP minus 1.1 percent.

(iv) *The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.*

Payments for these Part B services are established through market processes and are not affected by the productivity adjustments. For physician-administered Part B drugs, the *Inflation Reduction Act*'s key inflation provisions are not anticipated to affect such payments over the long range.

The long-range cost growth rates for these services are assumed to equal the growth rates as determined from the "factors contributing to growth" model. The corresponding year-by-year cost growth rates decline from 4.3 percent in 2050, or GDP plus 0.7 percent, to 4.1 percent by 2100, or GDP plus 0.4 percent.

(v) *Prescription drugs provided through Part D.*

Medicare payments to Part D plans are based on a competitive-bidding process, and prior to the *Inflation Reduction Act* these payments were assumed to grow at the same rate as the overall health sector as determined from the factors model. While the negotiation provisions of this law are not anticipated to affect the long-range growth rates for Part D drugs, the inflation provisions would likely lower these trends relative to previous expectations. Analysis of Part D pricing trends over recent years has consistently shown price growth in excess of the CPI, with a portion of these trends offset by increasing rebate percentages, and it was assumed, prior to this legislation, that such trends would continue over the long range.

The *Inflation Reduction Act* is expected to change this dynamic because it requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. The inflation provisions would likely lower price trends, though it is anticipated that they would outpace the CPI because of certain manufacturer adaptations to the new law that may mitigate some of the pricing constraints, including new approaches regarding the development and release of new drugs. As a result, they are assumed to grow slightly more slowly over the long range than would be the case if they were determined strictly through market processes.

The corresponding year-by-year cost growth rates decline from 4.1 percent in 2050, or GDP plus 0.5 percent, to 3.9 percent by 2100, or GDP plus 0.2 percent.

These long-range cost growth rates must be modified to account for demographic impacts. Beginning with the 2020 Trustees Report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death adjustment. This adjustment reflects the fact that the closer an individual is to death, the higher his or her health care spending is. Thus, as mortality rates

[15]The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see Section IV.B of the 2026 Trustees Report.

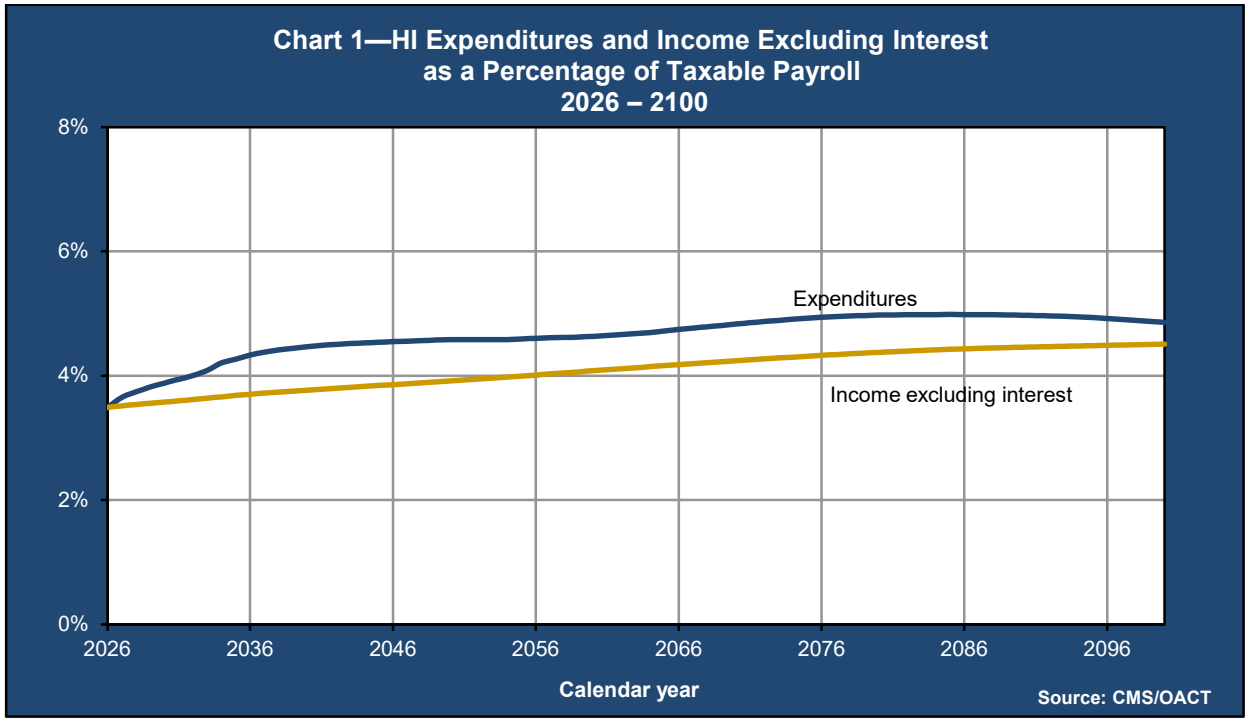
improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on health care is offset somewhat.[16] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing facility, and home health agency services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, the incorporation of the time-to-death adjustment has a smaller effect.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.8 percent in 2050,[17] or GDP plus 0.2 percent, remaining at 3.8 percent by 2100, or GDP plus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2050, declining to 3.7 percent, or GDP plus 0.0 percent by 2100.

HI Cash Flow 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 HI cost rates are mostly consistent with last year's projection through 2050 and then higher through 2100. The cost rate projections are ultimately higher than last year due to changes in demographic assumptions, most notably the lower fertility rate assumptions, that result in lower taxable payroll projections.



[16]More information on the time-to-death adjustment is available on the CMS website (unaudited).

[17]In 2050, the shares of Part B spending are 27 percent for services updated by input price indexes, 15 percent for physician services, 6 percent for services updated by the CPI, and 52 percent for the remaining Part B services.

Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. High-income workers also 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).

Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher 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; this outcome will occur because the income thresholds determining taxable benefits are not indexed for price inflation and the income tax brackets are indexed to the chained CPI, which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the chained CPI as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as taxable payroll.[18] Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

After remaining steady in 2023, 2024, and increasing slightly in 2025, as indicated in Chart 1, the cost rate is projected to rise in 2026 and beyond primarily as a result of an acceleration of health services cost growth. This cost rate increase is moderated by the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.9 percent through 2035 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 4.9 percent in 2050 and 7.4 percent in 2100.

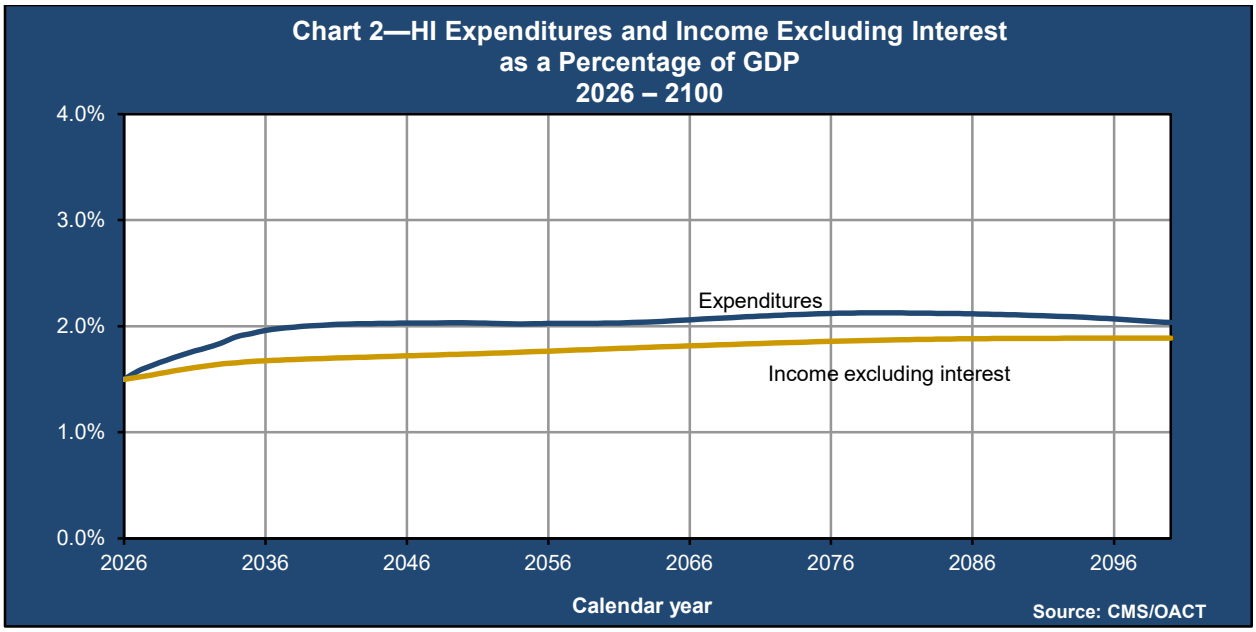
HI and SMI Cash Flow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared with 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 2025, the expenditures were $444.2B, which was 1.4 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2044 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.1 percent in 2100.

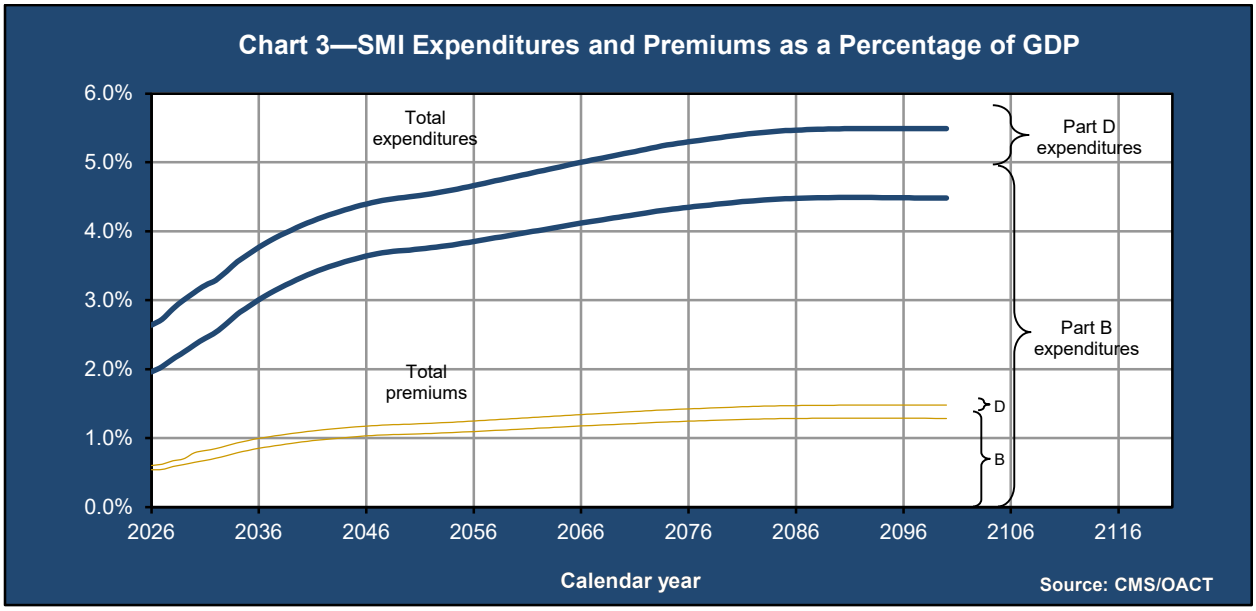
[18]For more detailed information on the projection of income from taxation of Social Security benefits, see Section V.C7 of the *2026 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*.



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 government contributions, which are transfers from the general fund of the Treasury.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.



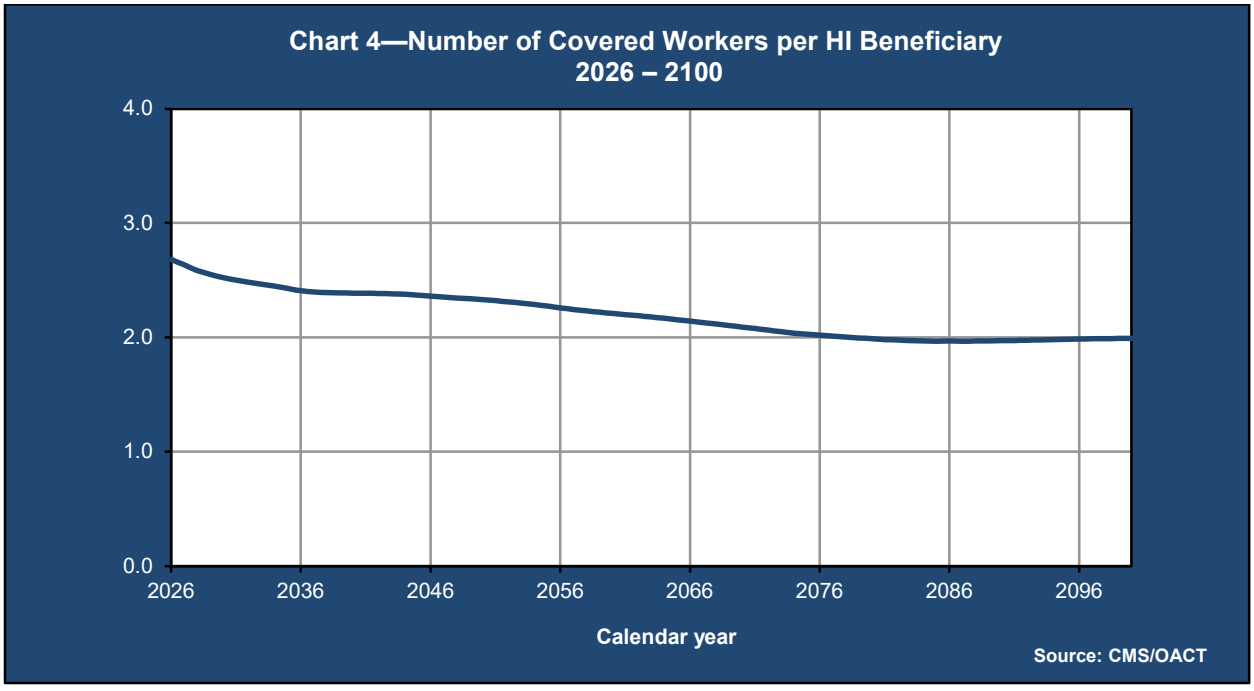
In 2025, SMI expenditures were $765.8B, or about 2.5 percent of GDP. Under current law, they would grow to about 4.5 percent of GDP within 25 years and to 5.5 percent by the end of the projection period, as demonstrated in Chart 3. Under the illustrative alternative, total SMI expenditures in 2100 would be 6.7 percent of GDP.

To match the faster growth rates for SMI expenditures, government contributions and beneficiary premiums would increase more rapidly than GDP over time but at a slower rate compared with the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2025 by about 4.3 percent annually. The associated beneficiary premiums—and general fund 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. State payments have increased faster than GDP for most years since 2015 and are projected to do so for most of the long-range period.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation.



In 2025, every beneficiary had about 2.7 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in Chart 4. The projected ratio continues to decline until there are only 2.0 workers per beneficiary by 2100.

Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under current law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, resulting from either changed conditions or updated information, estimates sometimes change substantially compared with 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.[19] The assumptions varied are the health care cost factors, real-wage growth, CPI, real-interest rate, fertility rate, and net immigration.[20]

For this analysis, the intermediate economic and demographic assumptions in the 2026 Trustees Report were used as the reference point. Each selected assumption was varied individually to produce three scenarios. All present values were calculated as of January 1, 2026, 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 cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 15 to 20 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow 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 cash flow 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 assumed for the intermediate projections.

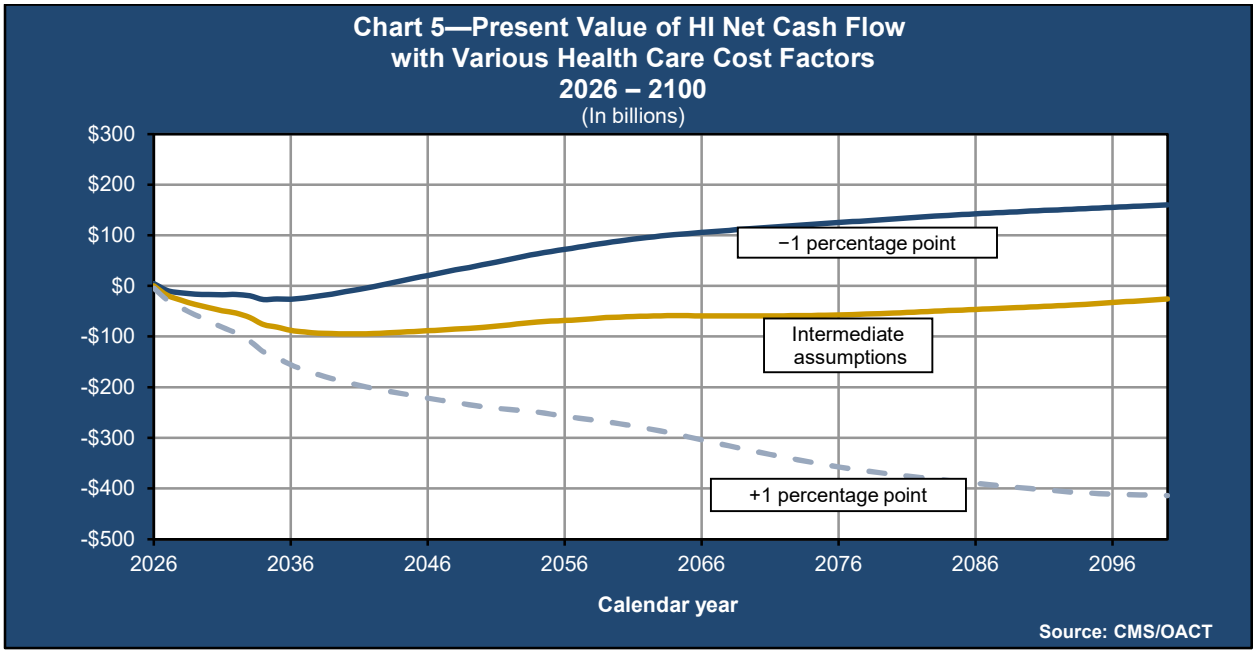
[19]Sensitivity analysis is not done for Parts B or D of the SMI trust fund because of the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

[20]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—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions			
Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$5,867	−$4,446	−$20,882

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $10,313B. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $16,436B.

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



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus because of the improved financial outlook for the HI trust fund as a result of the cost-reduction provisions required under current law. 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 Growth

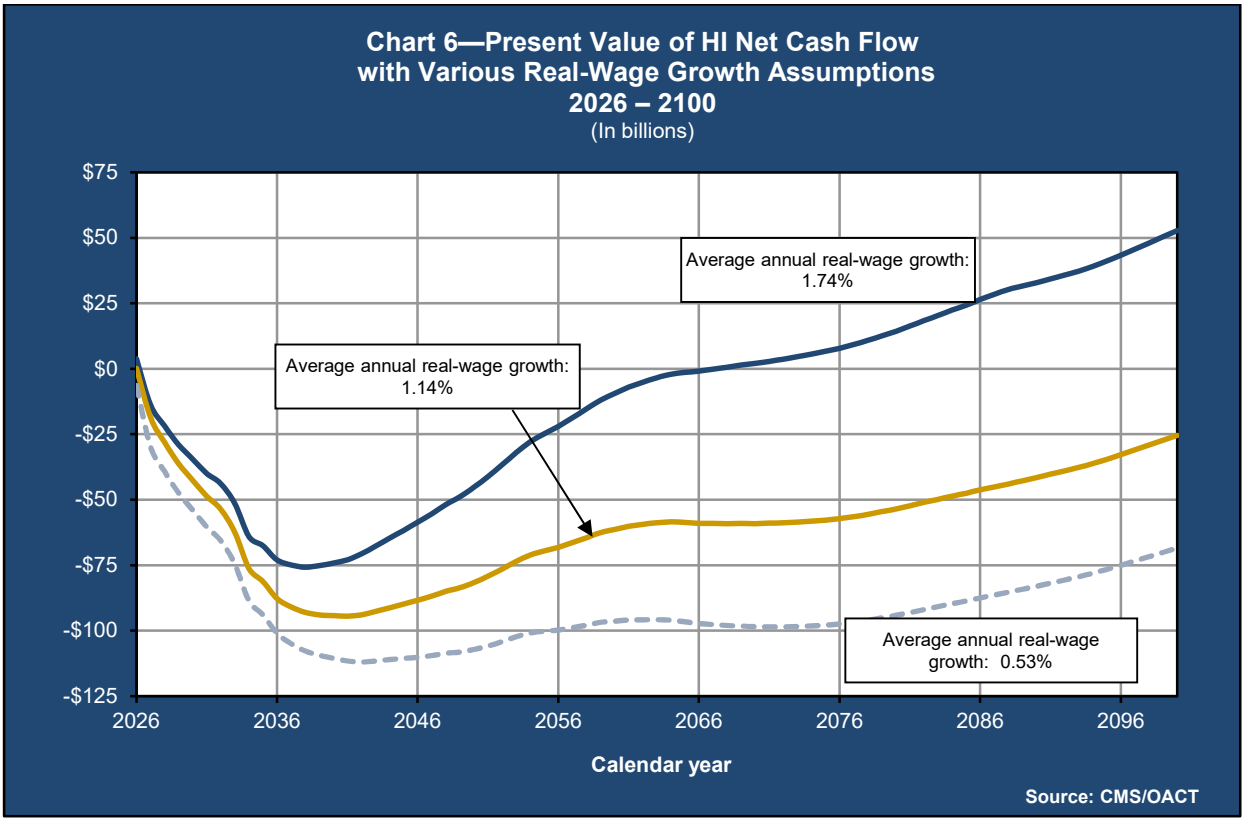
Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage growth assumptions: 0.53, 1.14, and 1.74 percentage points.[21] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent.

[21]Real-wage growth is the annual percentage change in average covered wages adjusted for the average percentage change in the CPI.

Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Growth Assumptions			
Ultimate percentage increase in real-wage growth	0.53	1.14	1.74
Income minus expenditures (in billions)	−$6,769	−$4,446	-$827

As indicated in Table 2, for each 0.6-percentage-point increase in the ultimate real-wage growth assumption, the deficit—expressed in present-value dollars—decreases, on average, by about $2,971B.

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



When expressed in present-value dollars, faster real-wage growth results in smaller HI cash flow deficits, as demonstrated in Chart 6. Higher real-wage growth 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 cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers.

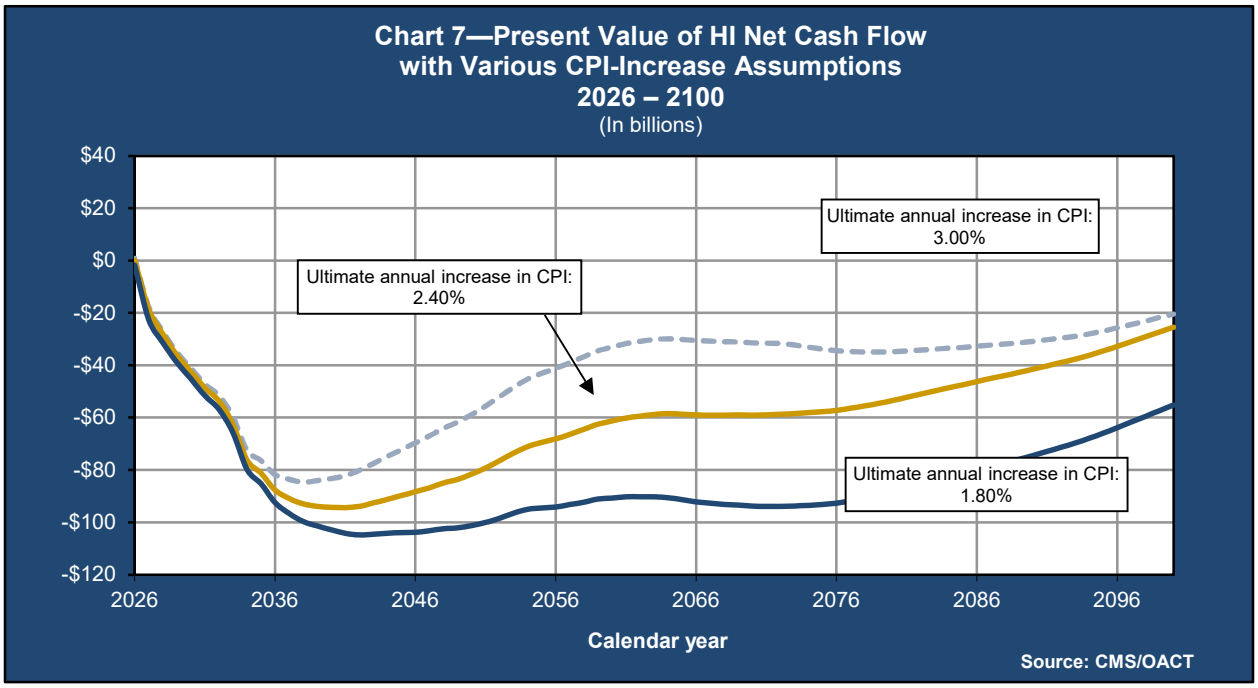
Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the ultimate real-wage growth assumption is 1.14 percent.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions			
Ultimate percentage increase in CPI	3.00	2.40	1.80
Income minus expenditures (in billions)	−$3,211	−$4,446	−$6,245

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,235B. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,799B.

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



This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required 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

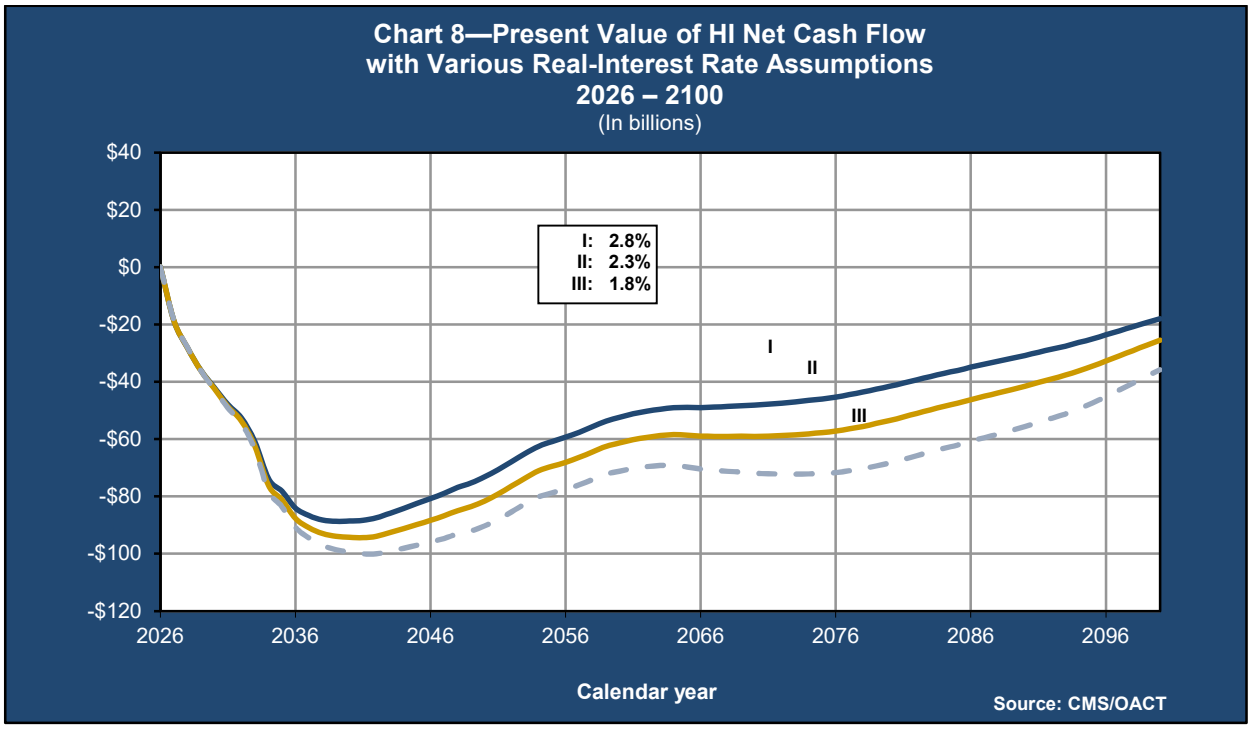
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 4.2, 4.8, and 5.3 percent, respectively.

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

Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	−$5,164	−$4,446	−$3,831

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $135B.

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



The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in Chart 8. 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 2033. 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 cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.40, 1.75, and 2.10 children per woman.

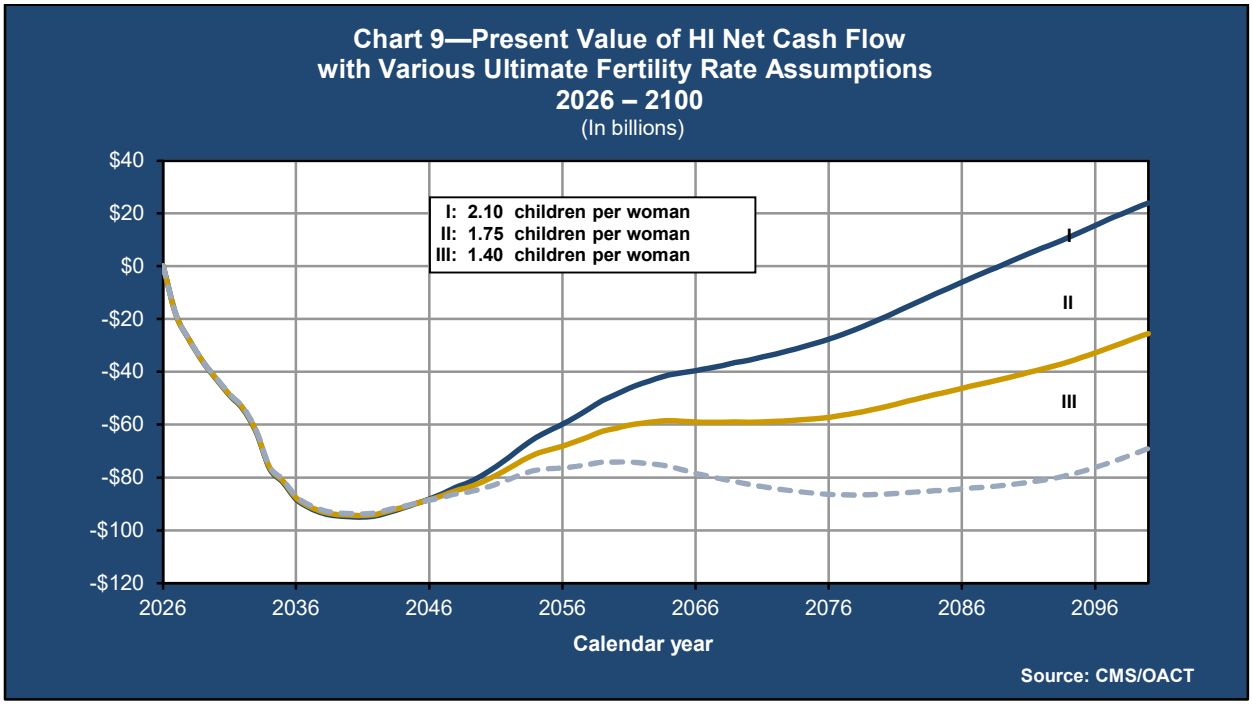
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.40	1.75	2.10
Income minus expenditures (in billions)	−$5,804	−$4,446	−$3,017

[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 every increase of 0.1 percentage point in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $400B.

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



The fertility rate assumption has a substantial impact on projected HI cash flows, as Chart 9 indicates. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, 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.

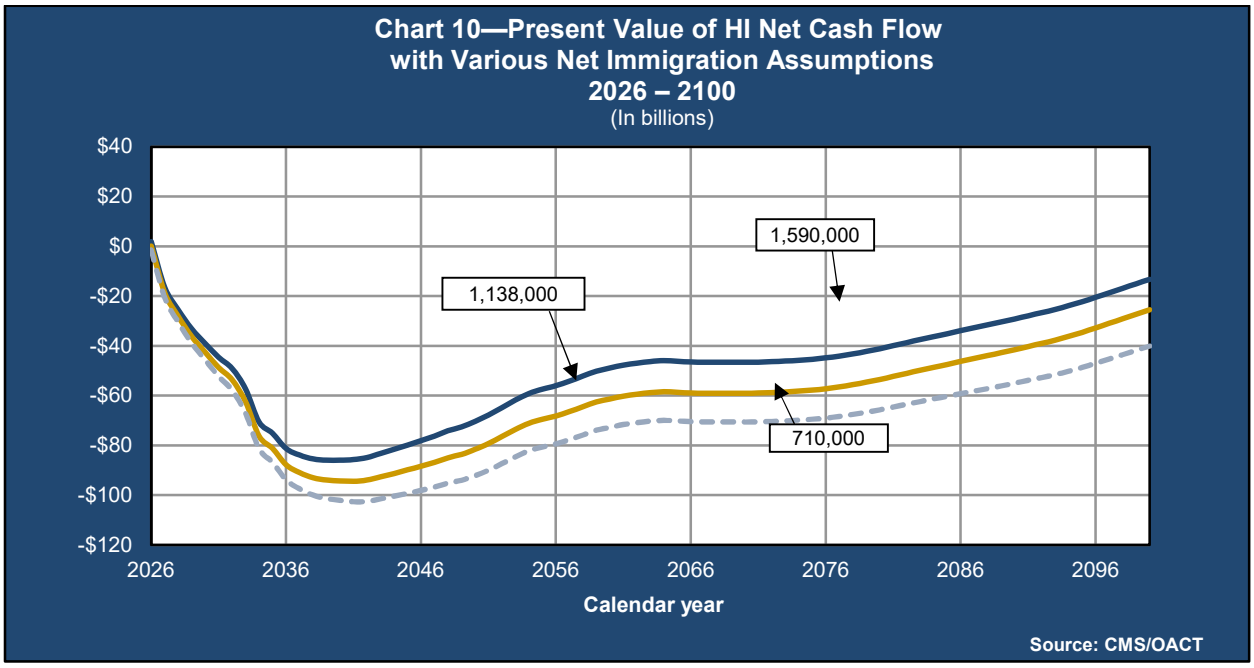
Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 710,000 persons, 1,138,000 persons, and 1,590,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions			
Average annual net immigration	710,000	1,138,000	1,590,000
Income minus expenditures (in billions)	−$5,224	−$4,446	−$3,654

As indicated in Table 6, if the average annual net immigration assumption is 710,000 persons, the deficit—expressed in present-value dollars—increases by approximately $779B. Conversely, if the assumption is 1,590,000 persons, the deficit decreases by $792B.

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



Higher net immigration results in smaller HI cash flow deficits, as demonstrated in Chart 10. Since immigration tends to occur most often among people 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

This year's short-range financial outlook for the HI trust fund is slightly less favorable than last year's Medicare Trustees Report projections. The projected depletion date for the HI trust fund is in the second quarter of 2033, one quarter earlier than estimated in last year's Trustees Report. HI income is projected to be lower throughout the

projection period due to lower taxation of Social Security benefits resulting from the *One Big Beautiful Bill Act*. HI expenditures are projected to be relatively close to last year's projections through the short-range period.

HI expenditures exceeded income each year from 2008 through 2015. However, in 2016 and 2017, there were fund surpluses amounting to $5.4B and $2.8B, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6B, $5.8B, and $60.4B, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5B as these payments began to be repaid to the trust fund, and this continued repayment resulted in a larger surplus in 2022 of $53.9B. In 2023, 2024, and 2025 there were surpluses of $12.2B, $28.7B, and $18.2B, respectively.

After a small projected surplus in 2026, the Trustees project that deficits will return in 2027 and continue until the trust fund becomes depleted in 2033. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services could be rapidly reduced. To date, Congress has never allowed the HI trust fund to become depleted.

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. Policymakers should determine effective solutions to ensure the long-term financial integrity of HI and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this imbalance.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general fund transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. However, this financing would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program expenditures and dedicated financing sources[22] will exceed 45 percent of total Medicare expenditures within the next 7 fiscal years (2026–2032). For the 2026 Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2026, which is the first year of the projection. The Trustees are therefore issuing a determination.[23]

[22]Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State payments 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.

[23]Section V.B of the 2026 Trustees Report contains additional details on these tests.

Because this determination was made last year as well, this year's determination results in a Medicare funding warning, which requires the following:

- The President to submit to Congress proposed legislation to respond to the warning within 15 days after the Fiscal Year 2028 Budget submission; and
- Congress to consider the legislation on an expedited basis.

Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 through 2025 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the HI trust fund's projected depletion, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2026 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together to quickly address these challenges."

Other Information

- Other Financial Information
- Summary of Financial Statement Audit and Management Assurances
- Civil Monetary Penalty for Inflation
- Grants Closeout Reporting
- Payment Integrity Report
- FY 2026 Top Management and Performance Challenges Identified by the Office of Inspector General

Other Financial Information

Consolidating Balance Sheet by Budget Function

As of September 30, 2026

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 17,222	$ 388,510	$ 382,445	$ 43,564	$ 831,741	$ -	$ 831,741
Investments, Net (Note 4)	-	4,916	447,738	-	452,654	-	452,654
Accounts Receivable, Net (Note 5)	348	10,516	120,658	1	131,523	(130,806)	717
Advances and Prepayments (Note 8)	102	2,103	2	243	2,450	(467)	1,983
Total Intragovernmental Assets	**17,672**	**406,045**	**950,843**	**43,808**	**1,418,368**	**(131,273)**	**1,287,095**
Other than Intragovernmental Assets							
Accounts Receivable, Net (Note 5)	-	15,942	33,146	18	49,106	-	49,106
Inventory and Related Property, Net (Note 6)	-	18,517	-	-	18,517	-	18,517
Property, Plant and Equipment, Net (Note 7)	2	9,138	165	-	9,305	-	9,305
Advances and Prepayments (Note 8)	-	154	1	18	173	-	173
Other Assets	-	379	-	-	379	-	379
Total Other than Intragovernmental Assets	**2**	**44,130**	**33,312**	**36**	**77,480**	**-**	**77,480**
Total Assets	**$ 17,674**	**$ 450,175**	**$ 984,155**	**$ 43,844**	**$ 1,495,848**	**$ (131,273)**	**$ 1,364,575**
Stewardship Land (Note 20)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 1	$ 383	$ 131,640	$ -	$ 132,024	$ (130,718)	$ 1,306
Advances from Others and Deferred Revenue	103	1,085	-	1	1,189	(467)	722
Other Liabilities:							
Accrued Liabilities (Note 12)	3	118	-	-	121	(26)	95
Other Liabilities (Note 13)	2	2,861	70	11	2,944	(62)	2,882
Total Intragovernmental Liabilities	**109**	**4,447**	**131,710**	**12**	**136,278**	**(131,273)**	**5,005**
Other than Intragovernmental Liabilities							
Accounts Payable	13	1,753	106	-	1,872	-	1,872
Entitlement Benefits Due and Payable (Note 10)	-	66,380	115,321	-	181,701	-	181,701
Federal Employee Salary, Leave and Benefits Payable (Note 11)	16	1,273	10	12	1,311	-	1,311
Pensions and Post-Employment Benefits Payable (Note 11)	3	22,419	-	-	22,422	-	22,422
Advances from Others and Deferred Revenue	-	1,792	2,052	-	3,844	-	3,844
Other Liabilities:							
Accrued Liabilities (Note 12)	753	16,836	-	729	18,318	-	18,318
Contingencies and Commitments (Note 14)	-	21,702	1,050	-	22,752	-	22,752
Other Liabilities (Note 13)	-	1,294	5,010	12	6,316	-	6,316
Total Other than Intragovernmental Liabilities	**785**	**133,449**	**123,549**	**753**	**258,536**	**-**	**258,536**
Total Liabilities	**894**	**137,896**	**255,259**	**765**	**394,814**	**(131,273)**	**263,541**
Net Position							
Unexpended Appropriations – Funds from Dedicated Collections (Note 19)	-	3,901	341,379	-	345,280	-	345,280
Unexpended Appropriations – Funds from Other Than Dedicated Collections	16,597	278,081	-	43,028	337,706	-	337,706
Total Unexpended Appropriations	**16,597**	**281,982**	**341,379**	**43,028**	**682,986**	**-**	**682,986**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 19)	-	24,359	387,517	-	411,876	-	411,876
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	183	5,938	-	51	6,172	-	6,172
Total Cumulative Results of Operations	**183**	**30,297**	**387,517**	**51**	**418,048**	**-**	**418,048**
Total Net Position	**16,780**	**312,279**	**728,896**	**43,079**	**1,101,034**	**-**	**1,101,034**
Total Liabilities and Net Position	**$ 17,674**	**$ 450,175**	**$ 984,155**	**$ 43,844**	**$ 1,495,848**	**$ (131,273)**	**$ 1,364,575**

Other Financial Information

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2026
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra-HHS Eliminations		Consolidated Totals
						Cost (-)	Revenue	
ACF	$ 16,684	$ -	$ -	$ 55,377	$ 72,061	$ (269)	$ 16	$ 71,808
ACL	2,544	-	-	-	2,544	(19)	1	2,526
AHRQ	-	264	-	-	264	(17)	3	250
ASPR	-	1,988	-	-	1,988	(56)	1	1,933
CDC	-	15,874	-	-	15,874	(250)	78	15,702
CMS	-	762,958	1,074,511	-	1,837,469	(302)	18	1,837,185
FDA	-	2,881	-	-	2,881	(340)	10	2,551
HRSA	-	14,330	-	-	14,330	(245)	11	14,096
IHS	-	11,781	-	-	11,781	(303)	1	11,479
NIH	-	45,807	-	-	45,807	(224)	446	46,029
OS	-	8,269	-	-	8,269	(363)	257	8,163
PSC	-	701	-	-	701	(97)	1,215	1,819
SAMHSA	-	7,516	-	-	7,516	(63)	-	7,453
Totals	**$ 19,228**	**$ 872,369**	**$ 1,074,511**	**$ 55,377**	**$ 2,021,485**	**$ (2,548)**	**$ 2,057**	**$ 2,020,994**

Gross Cost and Earned Revenue

For the Year Ended September 30, 2026
(in Millions)

Responsibility Segments	Intragovernmental						Other than Intragovernmental		Consolidated Net Cost of Operations
	Gross Cost			Less: Earned Revenue			Gross Cost	Less: Earned Revenue	
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated			
ACF	$ 893	$ (269)	$ 624	$ (26)	$ 16	$ (10)	$ 71,211	$ (17)	$ 71,808
ACL	51	(19)	32	(1)	1	-	2,495	(1)	2,526
AHRQ	43	(17)	26	(4)	3	(1)	225	-	250
ASPR	205	(56)	149	(29)	1	(28)	1,812	-	1,933
CDC	1,214	(250)	964	(152)	78	(74)	14,893	(81)	15,702
CMS	1,767	(302)	1,465	(24)	18	(6)	2,033,673	(197,947)	1,837,185
FDA	1,869	(340)	1,529	(26)	10	(16)	4,694	(3,656)	2,551
HRSA	395	(245)	150	(11)	11	-	14,081	(135)	14,096
IHS	2,141	(303)	1,838	(83)	1	(82)	13,009	(3,286)	11,479
NIH	2,407	(224)	2,183	(531)	446	(85)	44,232	(301)	46,029
OS	1,154	(363)	791	(406)	257	(149)	7,543	(22)	8,163
PSC	662	(97)	565	(1,459)	1,215	(244)	1,499	(1)	1,819
SAMHSA	124	(63)	61	(33)	-	(33)	7,517	(92)	7,453
Totals	**$ 12,925**	**$ (2,548)**	**$ 10,377**	**$ (2,785)**	**$ 2,057**	**$ (728)**	**$ 2,216,884**	**$ (205,539)**	**$ 2,020,994**

Summary of Financial Statement Audit and Management Assurances

As described in the "Management's Discussion and Analysis" section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to any material weakness identified during the audit, as well as conformance with the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and compliance with the *Federal Financial Management Improvement Act of 1996* (FFMIA).

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Six Financial Statements Disclaimed Opinion on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
No Material Weaknesses Noted	0	-	-	-	0
Total Material Weaknesses	*0*	-	-	-	*0*

Definition of Terms – Tables 1 and 2

(Reference: Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements*, May 29, 2026, page 109)

Beginning Balance: The beginning balance must agree with the ending balance from the prior year.

New: The total number of material weaknesses/non-conformances identified during the current year.

Resolved: The total number of material weaknesses/non-conformances that dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a finding does not meet the criteria for materiality or is redefined as more correctly classified under another heading).

Ending Balance: The year-end balance will be the beginning balance next year.

Summary of Financial Statement Audit and Management Assurances

Table 2: Summary of Management Assurances
Effectiveness of Internal Control over Reporting (FMFIA Section 2)

Statement of Assurance	Unmodified					
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
No Material Weakness Noted	0	-	-	-	-	0
Total Material Weaknesses	*0*	*-*	*-*	*-*	*-*	*0*

Effectiveness of Internal Control over Operations and Compliance with Laws and Regulations (FMFIA Section 2)

Statement of Assurance	Modified					
Material Weaknesses/ Non-Compliances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Payment Integrity Information Act of 2019 (PIIA)*	2	0	1[#]	-	-	1
Total Material Weaknesses/ Noncompliances	*2*	*0*	*1*	*-*	*-*	*1*

* HHS identified material noncompliance with PIIA due to not reporting an improper payment estimate for the Temporary Assistance for Needy Families program.

[#] Head Start program did not report a PIIA error rate above 10% threshold in FY 2026.

Conformance with Federal Financial Management System Requirements (FMFIA Section 4)

Statement of Assurance	Federal Systems Conform to Financial Management System Requirements					
Non-Conformances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
None	0	-	-	-	-	0
Total Non-Conformances	*0*	*-*	*-*	*-*	*-*	*0*

Summary of Financial Statement Audit and Management Assurances

Compliance with Section 803(a) of the FFMIA

	Agency	Auditor
1. Federal Financial Management System Requirements	No lack of substantial compliance noted	No lack of substantial compliance noted
2. Applicable Federal Accounting Standards	No lack of substantial compliance noted	No lack of substantial compliance noted
3. U.S. Standard General Ledger at Transaction Level	No lack of substantial compliance noted	No lack of substantial compliance noted

Civil Monetary Penalty Adjustment for Inflation

The *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015* (the 2015 Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. To improve compliance with the 2015 Act, agencies are required to publish annual inflation adjustments in the Federal Register and should report annually in their Agency Financial Report.

The 2015 Act applies to eight Divisions: Administration for Children and Families; Agency for Healthcare Research and Quality; Centers for Medicare & Medicaid Services; Food and Drug Administration; Health Resources and Services Administration; Office for Civil Rights; Office of the General Counsel; and Office of Inspector General. Refer to the Federal Register (unaudited) for the Annual Civil Monetary Penalties Inflation Adjustment for HHS.

Biennial Review of User Fees

The *Chief Financial Officers Act of 1990* and OMB Circular A-25, *User Charges*, require federal agencies to review biennially the fees, royalties, rents, and other charges imposed for services and things of value provided by the Government. The objective of the review is to determine whether those charges recover the direct and indirect costs of providing the service and to recommend revisions where they do not. OMB Circular A-25 also directs agencies to consider whether charges should be assessed for services for which fees are not currently imposed. Because HHS programs operate under a variety of statutory and regulatory authorities, the mechanisms for establishing, reviewing, and adjusting user fees vary across the Department.

Twenty-three user fees are governed by specific statutory or regulatory requirements and fall outside the biennial review process. FDA administers 19 of them — including Prescription Drug, Medical Device, and Generic Drug User Fees — under authorizing statutes that set the fee structure, prescribe annual adjustments, and require periodic reauthorization by Congress. CDC reported three fees not subject to biennial review, including fees related to Biology Products, DNA Sales and National Death Index Data Linkage Services, and the National Institute for Occupational Safety and Health's Respirator Approval Program. CDC's and NIH's Technology Licensing and Patent Fees are royalties from licensing NIH-developed technologies to private sector entities; the governing statute requires negotiated commercial terms rather than a cost-based fee formula.

Twelve user fees are subject to biennial review and adjustment through annual rulemaking or other established processes. For each, Divisions evaluated the authority for the charge, the method and frequency by which the fee is set or reviewed, changes in program costs and other relevant factors, and whether a revision was warranted.

CMS administers nine of the 12 user fees. The largest, the Exchange User Fee, is assessed on health insurance issuers participating in the Federally-facilitated and State-based Exchanges to fund Exchange operations. CMS reviews the fee annually through the *HHS Notice of Benefit and Payment Parameters* rulemaking, setting the rate at the level needed to cover projected Exchange costs for the coming plan year. For plan year 2027, CMS proposed reducing the rate from 2.5 percent to 1.9 percent of premiums for the Federally-facilitated Exchange and from 2.0 percent to 1.5 percent for State-based Exchanges on the Federal platform. The proposed rule was published for public comment; as of September 30, 2026, the rule had not been finalized. The Risk Adjustment User Fee, which funds operation of the risk adjustment program, is reviewed through the same annual rulemaking process and is proposed to decrease from $0.20 to $0.18 per member per month for 2027. The Medicare Advantage and Part D Plan User Fee, which funds beneficiary outreach and education under Medicare Parts C and D, is reviewed twice a year, during the President's Budget and Mid-Session Review, and is expected to increase 3.3 percent for 2027.

HRSA's 2026 review of the National Practitioner Data Bank query fee found the current $2.50 fee appropriate relative to the cost of providing query services, and HRSA retained the fee at that level for 2027. OIG's review of its Advisory Opinion Fee recommended further evaluation of the hourly rate used to calculate the fee to ensure the rate remains commensurate with the cost of the services provided; OIG expects to complete that evaluation before the next biennial review. CDC implemented the Vessel Sanitation fee to facilitate comprehensive sanitation programs in the cruise line industry. The current fee structure was implemented in 2025 to sustain services over the next five years to safeguard public health and provide services requested by the cruise line industry.

HHS will continue to annually report the significant results of the Divisions' user fees reviews. While most HHS Divisions' fees are not subject to biennial review, CDC, CMS, HRSA, and OIG all report fees that require reviews to determine appropriateness every two years or more often based on the fee type. Based on the results of those reviews, Divisions may adjust user fees through their established processes in accordance with governing authorities and OMB Circular A-25.

Grants Closeout Reporting

To promote the efficient administration of HHS grants programs, all reporting entities must submit a brief high-level summary of expired, but not closed, federal grants and cooperative agreements (awards).

Table 1: HHS Expired-but-not-Closed Awards with a Period of Performance (POP) End Date Exceeding 2 Years

Category	2-3 Years FYs 2023 – 2024	3-5 Years FYs 2021 – 2023	More than 5 Years Before FY 2021
Number of Grants/Cooperative Agreements with Zero Dollar Balances	1,301	903	97
Number of Grants/Cooperative Agreements with Undisbursed Balances	1,248	1,029	673
Total Amount of Undisbursed Balances	**$2,665,493,937.33**	**$2,038,315,934.29**	**$563,797,637.56**

Since FY 2022, HHS has made significant progress in closing HHS grant awards, with 97% of grants closed through improved intra-Department collaboration, data standardization, and reporting tools that support reconciliation and closure. HHS continues to make grant closeout a priority by reengineering business process improvements and enhancing grant systems to prevent the future growth of backlogs. When the number of grants and cooperative agreements reported in **Table 1** above are totaled, HHS has 5,251 grant awards with POP end dates of September 30, 2024, or earlier that are expired but not yet closed.

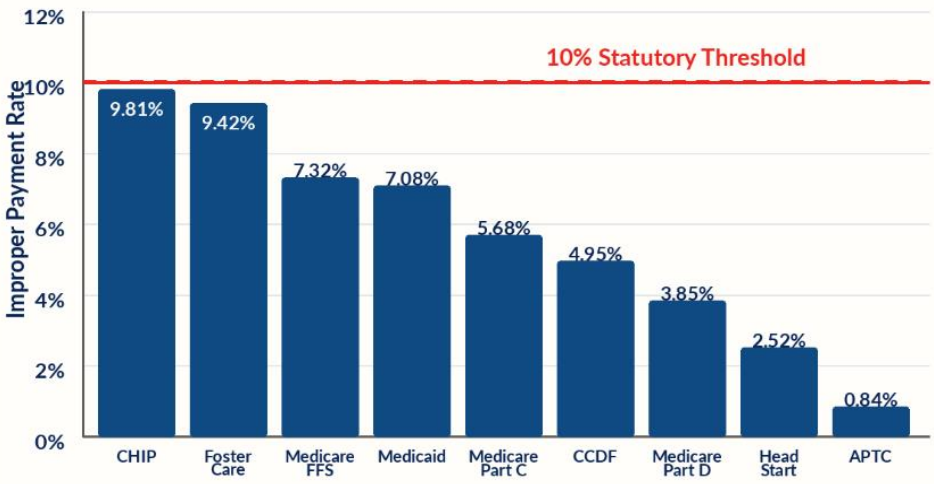
HHS remains committed to addressing and remediating the complexities that prevent the closeouts of open but expired accounts. The remaining backlog is primarily due to expired amounts permitted under appropriations law and statutory authority, including awards with extended liquidation periods. In FY 2027, HHS will continue its work in optimizing the grants closeout process through a comprehensive reengineering initiative. Enhanced technology infrastructure will support timely actions and more efficient grant closeouts. Systems have also been actively engaged in streamlining business processes—tailored to their unique workflows—to facilitate better data sharing across platforms.

FY 2026 PAYMENT INTEGRITY REPORT

Program Results at a Glance

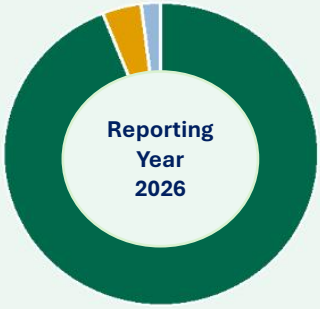
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROGRAM RESULTS



Program	Improper Payment Rate	Improper Payments (in Billions)
Medicare FFS	7.32%	$33.96
Medicare Part C	5.68%	$23.86
Medicare Part D	3.85%	$5.16
Medicaid	7.08%	$46.84
CHIP	9.81%	$2.26
APTC	0.84%	$0.83
Foster Care	9.42%	$0.11
CCDF	4.95%	$0.56
Head Start	2.52%	$0.31
TANF	*Not reported due to statutory limitations*	

BREAKDOWN OF IMPROPER PAYMENTS



- 94% Overpayments
- 4% Underpayments
- 2% Technically Improper

TOP ROOT CAUSES

- Insufficient documentation
- Eligibility determination errors
- State compliance with federal requirements

HOW HHS IS RESPONDING

- **Strengthened eligibility verification**
- **Do Not Pay pre-payment screening**
- **Data analytics and predictive tools**
- **Fraud Defense Operations Center** **$1.98 billion** *suspended in FY 2026*
- **Training and technical assistance**

OVERPAYMENTS RECOVERED

$990.74 million through recovery audits

$14.83 billion through recovery audits

$15.82 billion total recovered

HHS was not fully compliant with PIIA for FY 2025.

Payment Integrity Report

EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) continues to strengthen payment integrity, reduce improper payments, and protect taxpayer resources. In alignment with the *Payment Integrity Information Act of 2019* (PIIA), HHS conducts annual risk assessments, measures improper and unknown payments for risk-susceptible programs, and implements corrective actions to address documented root causes.

During FY 2026, HHS continued to strengthen its payment integrity framework by expanding Do Not Pay screening, enhancing risk assessment processes, improving data analytics and oversight capabilities, and implementing additional corrective actions across high-risk programs. These enhancements support HHS's ongoing efforts to prevent improper payments, improve compliance with PIIA, and strengthen stewardship of federal funds.

Risk Assessments

HHS conducts risk assessments on a rolling triennial cycle, assessing each program with outlays over $10M that is not already reporting annual improper payment estimates. In FY 2026, HHS completed 84 risk assessments for programs with annual outlays over $10M and identified no new programs as likely to be susceptible to significant improper payments. Programs not scheduled for assessment were monitored through ongoing oversight activities, internal controls reviews, and continuous use of federal data matching tools.

Improper Payment Estimates

HHS published improper and unknown payment estimates for 9 risk-susceptible programs in RY 2026: Medicare Fee-for-Service (Parts A and B), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, the Children's Health Insurance Program (CHIP), the Advance Payments of the Premium Tax Credit (APTC), Foster Care, the Child Care and Development Fund (CCDF), and Head Start. The Temporary Assistance for Needy Families (TANF) program does not report an improper payment estimate due to statutory limitations that preclude HHS from requiring states to participate in a TANF improper payment measurement.

Across risk-susceptible programs, HHS estimated $113.90B (6.18 percent) in improper and unknown payments in RY 2026, an increase of 0.29 percentage points from 5.89 percent ($98.34B) in RY 2025. The increase primarily reflects continued errors in Medicaid and CHIP eligibility determinations and provider screening as states completed the unwinding of COVID-19 public health emergency flexibilities, partially offset by a significant decrease in Head Start driven by process improvements to the improper payment review**.** The most common root causes of improper payments were insufficient documentation, eligibility determination errors, and state compliance with federal requirements.

Corrective Actions

HHS continued to advance corrective actions designed to prevent and reduce improper payments. Key efforts in FY 2026 included:

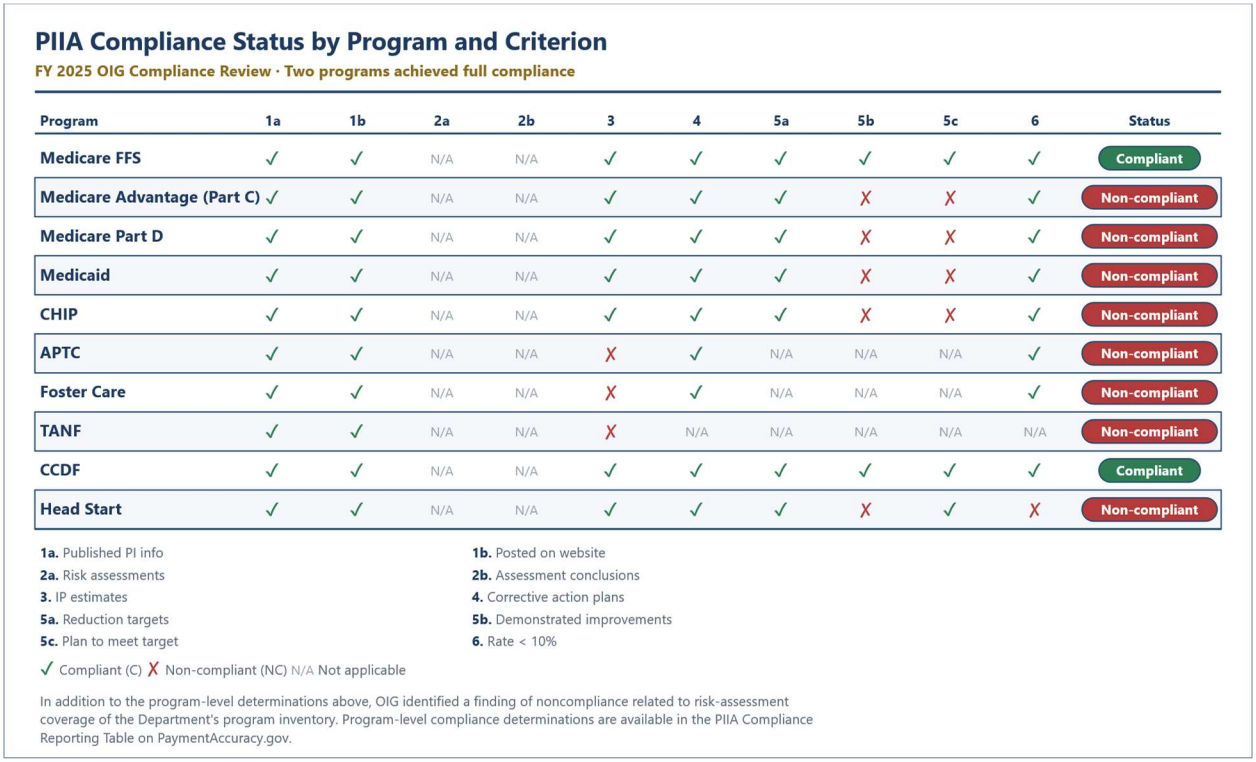
- **Pre-payment controls and eligibility verification:** Treasury activated Payment Verification screening for all HHS payments initiated through Treasury's Standard Payment Request beginning April 9, 2026, screening 1.12M payments worth $393B and returning, rather than disbursing, 1,417 payments for deceased payees. This service replaced a prior one that disbursed such payments and merely notified the payor agency of the death. HHS also expanded access to the Death Master File by providing states the ability to screen Medicaid beneficiaries through the Data Exchange System, extending use beyond provider screening, and continued use of the Public Assistance Reporting Information System for cross-state eligibility verification.

- **Provider and eligibility oversight:** HHS conducted onsite visits to 43 states to assess Medicaid provider screening and enrollment compliance, initiated Medicaid beneficiary eligibility audits covering renewal compliance and immigration status verification, and initiated 1,553 new Risk Adjustment Data Validation audits of Medicare Advantage contracts from payment years 2020, 2021, and 2024.
- **Fraud detection and payment suspensions:** Through the Fraud Defense Operations Center, HHS used advanced data analytics and real-time investigations to identify and act on high-risk payments, suspending $1.98B in payments. Through the Hospice Rapid Payment Suspension Project, HHS suspended payments to 822 hospices with unusually high live discharge rates.
- **Training and technical assistance:** HHS provided targeted training and technical assistance to states, providers, and grantees to address root causes of improper payments. The Medicaid Integrity Institute delivered over 80 hours of training to approximately 3,787 state and territory Medicaid program integrity staff, covering coding, compliance, and program integrity topics through virtual courses and in-person engagement. In the Foster Care Program, HHS conducted 16 Title IV-E reviewer training sessions reaching 137 state and federal staff. For Head Start recipients, HHS delivered fiscal integrity and specialized documentation training, with over 90 percent of improper payment review participants attending documentation training and reporting improved clarity on submission requirements. For CCDF, HHS delivered training and technical assistance on sampling, case review, and error analysis to states reporting improper payment in RY 2026 and expanded program integrity training through national and regional initiatives including Peer Learning Groups focused on oversight, risk management, and fraud prevention.
- **Automation and system improvements:** HHS implemented automation improvements in the Advance Payments of the Premium Tax Credit program, including enhanced person matching and overlap detection scripts that terminated or cancelled approximately 39,000 duplicate enrollment policies through June 2026, and updated data matching issue expiration processing effective July 1, 2026, to align with regulatory requirements and prevent consumers from receiving premium tax credits beyond their allotted resolution period. HHS also deployed a data validation tool in the Head Start program that reduced recipient follow-ups from an average of 3 to 5 to 1 to 2 per review, and lengthened the improper payment review period, resulting in a reduction in extension requests of over 15 percent.
- **Demonstrated improvements:** Corrective actions implemented in prior years produced measurable results in FY 2026. In the CCDF program, all reporting states achieved improper payment rates below the 10 percent threshold in RY 2026, including one state that reduced its rate from 15.89 percent in RY 2023 to 8.87 percent following targeted technical assistance and a Corrective Action Plan. In the Head Start program, a final adjudication of transactions sampled in the RY 2025 improper payment review recalculated the reported improper payment rate from 10.29 percent to 0.84 percent, with all 173 unknown payments resolved upon receipt of additional documentation.

PIIA Compliance Status for FY 2025

HHS was not fully compliant with PIIA for FY 2025. The HHS Office of Inspector General (OIG) identified nine findings across ten risk-susceptible programs. HHS is actively addressing each finding through expanded corrective actions, enhanced internal controls, and increased coordination with states, contractors, and program partners. Two programs — Medicare Fee-for-Service (Parts A and B) and the Child Care and Development Fund — achieved full compliance with all applicable PIIA requirements in FY 2025, reflecting the Department's sustained progress in payment integrity improvement. **Figure 1** illustrates the PIIA compliance status for all risk-susceptible programs.

Figure 1: HHS Risk-Susceptible Programs' PIIA Compliance Status for FY 2025



PIIA Compliance Status by Program and Criterion

FY 2025 OIG Compliance Review · Two programs achieved full compliance

Program	1a	1b	2a	2b	3	4	5a	5b	5c	6	Status
Medicare FFS	✓	✓	N/A	N/A	✓	✓	✓	✓	✓	✓	Compliant
Medicare Advantage (Part C)	✓	✓	N/A	N/A	✓	✓	✓	✗	✗	✓	Non-compliant
Medicare Part D	✓	✓	N/A	N/A	✓	✓	✓	✗	✗	✓	Non-compliant
Medicaid	✓	✓	N/A	N/A	✓	✓	✓	✗	✗	✓	Non-compliant
CHIP	✓	✓	N/A	N/A	✓	✓	✓	✗	✗	✓	Non-compliant
APTC	✓	✓	N/A	N/A	✗	✓	N/A	N/A	N/A	✓	Non-compliant
Foster Care	✓	✓	N/A	N/A	✗	✓	N/A	N/A	N/A	✓	Non-compliant
TANF	✓	✓	N/A	N/A	✗	N/A	N/A	N/A	N/A	N/A	Non-compliant
CCDF	✓	✓	N/A	N/A	✓	✓	✓	✓	✓	✓	Compliant
Head Start	✓	✓	N/A	N/A	✓	✓	✓	✗	✓	✗	Non-compliant

1a. Published PI info
1b. Posted on website
2a. Risk assessments
2b. Assessment conclusions
3. IP estimates
4. Corrective action plans
5a. Reduction targets
5b. Demonstrated improvements
5c. Plan to meet target
6. Rate < 10%

✓ Compliant (C) ✗ Non-compliant (NC) N/A Not applicable

In addition to the program-level determinations above, OIG identified a finding of noncompliance related to risk-assessment coverage of the Department's program inventory. Program-level compliance determinations are available in the PIIA Compliance Reporting Table on PaymentAccuracy.gov.

The OIG's findings and HHS's planned corrective actions are summarized below. Full program-level compliance determinations are available in the PIIA Compliance Reporting Table on PaymentAccuracy.gov.

1. **Risk Assessment Coverage — Agency Wide:** The OIG found that HHS did not complete improper payment risk assessments for all programs with annual outlays greater than $10M at least once every three years. HHS updated its program inventory in FY 2026 to align with the Federal Program Inventory as directed by OMB, identifying 281 programs and activities across the Department subject to the three-year assessment cycle. Of these, approximately 85 percent have completed a risk assessment within the past three years, reflecting sustained progress toward full compliance. HHS is committed to achieving full assessment coverage of all qualifying programs by FY 2028 and is implementing process enhancements to support this goal, including extending the risk assessment period, maintaining a complete cycle-status inventory, streamlining the risk assessment questionnaire, and applying a modified approach for programs with outlays between $10M and $100M.
2. **TANF — No Estimate Reported:** HHS did not calculate or report an improper payment estimate for the TANF program due to statutory limitations under 42 U.S.C. § 617, which preclude HHS from requiring states to participate in a TANF improper payment measurement. HHS continues to advocate for legislative authority that would enable TANF improper payment measurement and will continue working with OMB and other stakeholders to identify viable pathways to full PIIA compliance for the TANF program.
3. **Foster Care — Incomplete State Coverage:** The OIG found that the Foster Care improper payment estimate does not yet encompass the full population of states, as HHS uses a three-year review cycle to test all jurisdictions. HHS resumed Title IV-E reviews in FY 2024 following a COVID-19 pandemic pause, expanding to include 42 states in FY 2026. HHS now anticipates completing reviews covering all 50 states, the District of Columbia, and Puerto Rico by FY 2028. This timeline reflects a delay resulting from the implementation of a new information system that temporarily reduced the volume of Title IV-E claims available to support the required review sample.

4. **Head Start — Improper Payment Rate Above 10 Percent:** The Head Start program reported an improper payment and unknown payment rate of 10.29 percent in RY 2025, above the 10 percent PIIA compliance threshold. Following the initial measurement, HHS conducted a formal final adjudication review of RY 2025 transactions, allowing recipients additional time to submit required documentation and resolve improper payments identified during the initial review. Upon receipt of additional documentation, all 173 unknown payments were resolved, and the final adjudicated RY 2025 rate was 0.84 percent, demonstrating that the initial rate reflected documentation access challenges rather than underlying payment inaccuracy. In FY 2026, HHS implemented process changes to address these challenges, including lengthening the review timeline, deploying a data validation tool that reduced recipient follow-ups, and delivering specialized documentation training attended by review participants.
5. **Medicare Part C — Recovery Audit Delays:** The OIG found that recovery audit activities for Medicare Advantage (Part C) were delayed, with Risk Adjustment Data Validation (RADV) audit recoveries not yet made or reported for payment years 2018 and 2019. In FY 2026, HHS continued RADV audits for payment years 2018 - 2021 and 2024 through an expanded audit methodology and issued audit findings for payment years 2014–2015. On September 25, 2025, the U.S. District Court for the Northern District of Texas vacated CMS' 2023 RADV Final Rule, which would have allowed HHS to extrapolate audit results across an entire contract population and recover substantial amounts. HHS appealed this decision on November 21, 2025; nonetheless, HHS will fully comply with the district court's order as long as it remains in effect, while continuing to pursue upcoming RADV payment year audits.
6. **APTC — State-based Exchange Measurement Gap:** HHS has not calculated or reported an improper payment estimate for State-based Exchanges, which represents approximately 19.57 percent of total APTC payments. HHS plans to begin sampling and estimation on January 1, 2027, and report its first improper payment rate in FY 2028.
7. **Medicare Part C — Demonstrated Improvements:** The OIG found that HHS did not effectively demonstrate improvements to the Medicare Part C payment integrity rate in FY 2025. In FY 2026, HHS conducted three national audits of plan sponsors, with one completed audit resulting in the recovery of $648,022, and continued outreach and education reaching approximately 1,016 Medicare Part C and Part D contracts through Health Plan Management System memos on high-risk drugs, audit findings, and best practices. HHS notes that at a 95 percent confidence level, the confidence intervals for RY 2024 (4.93–6.29 percent) and RY 2025 (5.40–6.78 percent) overlap significantly, meaning the observed difference does not constitute a statistically meaningful change.[24] HHS will continue working with plan sponsors to improve payment accuracy and documentation practices.
8. **Medicare Part D — Demonstrated Improvements:** The OIG found that HHS did not effectively demonstrate improvements to the Medicare Part D payment integrity rate in FY 2025. For details on FY 2026 plan sponsor audit and outreach activities that address both Medicare Part C and Part D, see Finding #7 above. HHS notes that the confidence intervals for FY 2024 (3.31–4.15 percent) and FY 2025 (3.57–4.46 percent) overlap,[1] and the difference does not constitute a statistically meaningful change.
9. **Medicaid and CHIP — Demonstrated Improvements:** The OIG found that HHS did not effectively demonstrate improvements to the Medicaid and CHIP payment integrity rates in FY 2025. HHS notes that rate increases are directly attributable to the unwinding of COVID-19 public health emergency flexibilities. In FY 2026, HHS conducted onsite visits to 43 states to assess provider screening and enrollment compliance, initiated audits in seven states to review whether states determined beneficiary eligibility correctly, and

[24] The confidence intervals reported reflect corrections to typographical errors in the ranges reported in OAS-26-17-042 Report of Independent Auditors on HHS's Compliance with the Payment Integrity Information Act of 2019.

completed 18 state Medicaid Eligibility Quality Control reviews of Calendar Year 2025 eligibility determinations.

HHS remains committed to achieving full PIIA compliance. In accordance with OMB guidance, HHS develops and submits annual compliance plans to OMB through the PaymentAccuracy.gov data call process, describing the actions the agency is taking to achieve compliance for each non-compliant program. For programs non-compliant for three or more consecutive years, including Foster Care, APTC, and TANF, HHS submits separate reports to Congress as required under PIIA and OMB Circular A-123, Appendix C, describing actions being taken and timelines for achieving compliance. HHS expects to demonstrate continued progress as corrective actions mature and operational improvements take effect.

DO NOT PAY DISCUSSION

HHS uses Treasury's Do Not Pay (DNP) system at multiple points in the payment lifecycle to prevent improper payments and strengthen program integrity. In FY 2026, HHS continued to modernize its connection to DNP services, including beginning the transition to an Application Programming Interface (API) and direct file sharing through DNP's Connect product for all payment and award systems as part of the DNP Agency Onboarding Initiative under Executive Order 14249, *Protecting America's Bank Account Against Fraud, Waste, and Abuse*.

Services Used

HHS uses multiple DNP services throughout the payment lifecycle. Grant awarding agencies use the DNP portal and customers of the GrantSolutions platform have access to an API connection to DNP to support award eligibility reviews. HHS uses the Continuous Monitoring service to screen grant recipients and other payees against multiple eligibility data sources, including the Social Security Administration's Death Master File, the Treasury Offset Program, System for Award Management exclusion and registration records, the List of Excluded Individuals and Entities, Office of Foreign Assets Control sanctions records, and federal incarceration data. Treasury's Payment Verification service screens payments submitted through the Standard Payment Request process prior to certification and disbursement against death data sources, with Taxpayer Identification Number validation and bank account verification also available through this service.

Frequency of Use

HHS uses DNP services across multiple stages of the payment lifecycle, including pre-award, pre-payment, pre-certification, and post-award monitoring. All payments initiated through Treasury's Standard Payment Request process are screened through Payment Verification before disbursement. All grant payments made through the HHS Payment Management System are subject to Continuous Monitoring, with the enrolled grantee population updated monthly for daily screening. CMS and HRSA also use Continuous Monitoring for recurring screenings of potential payees, and operating divisions such as NIH use the DNP portal for eligibility reviews at earlier stages of the award and payment process.

Payments Reviewed and Improper Payments Prevented or Recovered

Between January 23, 2026 and September 30, 2026, Treasury's Payment Verification service screened approximately 1.4M HHS payments valued at approximately $712.9B prior to certification and disbursement, returning 1,417 payments associated with deceased payees — valued at $868,831 — before payment processing was completed.

As of September 30, 2026, the HHS Payment Management System submitted approximately 23,428 enrolled grantees for daily Continuous Monitoring screening. CMS submitted approximately 5.8M potential payees and HRSA submitted approximately 150 potential payees for recurring screening against applicable DNP data sources.

In FY 2026, CMS screened over 1.1B Medicare and Medicaid payments through Treasury's DNP portal, stopping 324,690 payments and preventing an estimated $2.74B in improper payments.

Except for CMS prevention results reported above, HHS cannot reliably quantify the number or dollar amount of improper payments prevented or recovered through its other DNP screening activities or calculate a comprehensive Department-wide total. DNP activities are decentralized, matches may occur at multiple stages of the payment lifecycle, and certain matches — such as Treasury Offset Program matches — support offset or debt collection actions rather than payment prevention. DNP match results therefore cannot be directly aggregated into a Department-wide prevention or recovery total. DNP services strengthen HHS's payment integrity framework by identifying potentially ineligible recipients and high-risk transactions before disbursement and through ongoing monitoring.

Incorrect Information Identified in DNP Data Sources

HHS does not maintain a centralized mechanism for tracking incorrect information in DNP data sources. However, match accuracy challenges have been observed, particularly with name-based matching that may produce false positives or false negatives. Treasury and HHS continue to improve match quality through expanded use of Taxpayer Identification Number verification and inclusion of Taxpayer Identification Number Type data in payment files, enhancements expected to increase true-positive match rates and reduce false positives.

RECOVERY AUDIT CONTRACTOR RECOMMENDATIONS

In accordance with 31 U.S.C. § 3352(i)(1)(D) and OMB Circular A-136, HHS reports below on actions taken during FY 2026 in response to recommendations received from recovery audit contractors regarding the prevention of overpayments.

No recommendations received: In FY 2026, HHS did not receive overpayment-prevention recommendations from recovery audit contractors that required agency action beyond existing corrective action plans and program integrity activities already underway.

REPORTS AVAILABLE ON PAYMENTACCURACY.GOV

In accordance with PIIA and OMB Circular A-136, HHS publishes payment integrity reports on PaymentAccuracy.gov. The following reports, required under 31 U.S.C. §§ 3352–3353, are available for HHS on PaymentAccuracy.gov and are incorporated by reference in this Agency Financial Report:

- **(i)** The **Annual Risk Assessment Report**, required under 31 U.S.C. § 3352(a)(3)(C), lists each HHS program assessed for improper payment risk, the date of its most recent assessment, and any programs for which HHS made substantial changes to its risk assessment methodology.
- **(ii)** The **Annual High-Priority Program Report**, required under 31 U.S.C. § 3352(b)(2)(A)–(C), describes actions taken or planned to recover improper payments and prevent future improper payments for HHS programs with monetary loss exceeding $100M annually. High-priority programs for HHS include Medicare Fee-for-Service (Parts A and B), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, the Children's Health Insurance Program (CHIP), the Advance Payments of the Premium Tax Credit (APTC), and Child Care Development Fund (CCDF).
- **(iii)** The **Annual Improper Payment Estimation Report**, required as accompanying materials under 31 U.S.C. § 3352(c), provides statistically valid improper and unknown payment estimates for each HHS risk-susceptible program that measures and reports.
- **(iv)** The **Annual Report on Actions to Reduce Improper Payments**, required as accompanying materials under 31 U.S.C. § 3352(d), describes the root causes of improper payments, corrective actions planned or underway, reduction targets, and the steps HHS has taken to ensure accountability for meeting those targets.
- **(v)** The **Annual Report on Actions to Recover Improper Payments Identified in a Recovery Audit**, required as accompanying materials under 31 U.S.C. § 3352(e), describes the recovery audit methods HHS uses,

the amounts HHS identified and recovered, the amounts outstanding or determined uncollectable, and the conditions that gave rise to improper payments and the steps HHS is taking to resolve them.

(vi) The **Agency Compliance Plan**, required under 31 U.S.C. § 3353(b)(1), describes the actions HHS will take to achieve PIIA compliance for programs identified as non-compliant by the HHS Office of Inspector General, including measurable milestones, designated senior accountable officials, and accountability mechanisms.

(vii) The **Agency Noncompliance Report**, required under 31 U.S.C. § 3353(b)(5), lists each HHS program determined to be non-compliant and the actions planned to achieve compliance.

These reports may be accessed by navigating from the Resources page on PaymentAccuracy.gov to the Congressional Reports page and then selecting the relevant report from the dropdown list for HHS and the applicable fiscal year.

BACKGROUND

About This Report

HHS estimates, reports, and works to reduce improper payments — payments that do not meet legal requirements, are made in incorrect amounts, or go to ineligible recipients — and unknown payments, which lack sufficient documentation to determine whether the payment is proper. These efforts are conducted in compliance with the Payment Integrity Information Act of 2019 (PIIA), OMB Circular A-136, and Appendix C of OMB Circular A-123 (M-21-19). Improper payment estimates are not fraud estimates; while all fraud payments are monetary loss improper payments, not all monetary loss improper payments result from fraud.

Risk-Susceptible Programs and Statutory Thresholds

Risk-susceptible programs are programs identified as vulnerable to significant improper or unknown payments. A program is considered risk-susceptible if its improper and unknown payments exceed the statutory thresholds for significant improper payments:

- 1.5 percent of program outlays and $10M in a fiscal year, or
- $100M, regardless of the percentage.

High-priority programs are those with reported monetary loss of $100M or more in a reporting year. Under OMB guidance, these programs must report quarterly, in addition to annual AFR reporting, on their actions to prevent and recover improper payments. HHS distinguishes between reporting year (RY) and fiscal year (FY) in this report because improper payment measurements reported in RY 2026 may not align with payments made in FY 2026. Measurement methodologies vary by program and may include payments under review from prior fiscal years.

The following programs are risk-susceptible and require annual improper payment measurement and reporting; programs designated as high-priority for calendar year (CY) 2026 are marked with an asterisk (*):

- Medicare Fee-for-Service (Parts A and B)*
- Medicare Advantage (Part C)*
- Medicare Prescription Drug Benefit (Part D)*
- Medicaid*
- Children's Health Insurance Program (CHIP)*
- Advance Payments of the Premium Tax Credit (APTC)*
- Temporary Assistance for Needy Families (TANF)
- Foster Care
- Child Care and Development Fund (CCDF)*
- Head Start

IMPROPER PAYMENT RESULTS

HHS conducted 84 risk assessments in FY 2026 for programs with annual outlays exceeding $10M and identified no new programs likely to be susceptible to significant improper payments. HHS estimates and reports proper payments, improper payments, and unknown payments. Improper payments are further categorized into:

- **Monetary loss:** Overpayments that should not have been made and that in theory could be recovered.
- **Non-monetary loss:** Underpayments or technically improper payments (payments made to the right recipient for the correct amount but where the payment process failed to meet all applicable statutory or regulatory requirements).

All risk-susceptible programs complied with OMB sampling and estimation guidance and reported improper payment estimates, except TANF, which cannot calculate or report an improper payment estimate due to statutory limitations. The APTC program's estimate does not yet include payments from State-based Exchanges.

HHS estimated 6.18 percent improper payments in all risk-susceptible programs, totaling $113.90B in RY 2026. This represents an increase of $15.56B and 0.29 percentage points from the $98.34B (5.89 percent) reported in RY 2025. The increase primarily reflects continued errors in Medicaid and CHIP eligibility determinations and provider screening as states completed the unwinding of COVID-19 public health emergency flexibilities, partially offset by a significant decrease in Head Start driven by process improvements to the improper payment review. Across all of HHS's risk-susceptible programs, the most common root causes of improper payments were insufficient documentation, eligibility determination errors, and state compliance with federal requirements.

Figure 2 illustrates the estimated proper, improper, and unknown payments, including a breakdown of overpayments, underpayments, and technically improper payments across all risk-susceptible programs.

Figure 2: Breakdown of FY 2026 HHS Estimated Payments by Category and Type (Dollar Amounts in Billions)

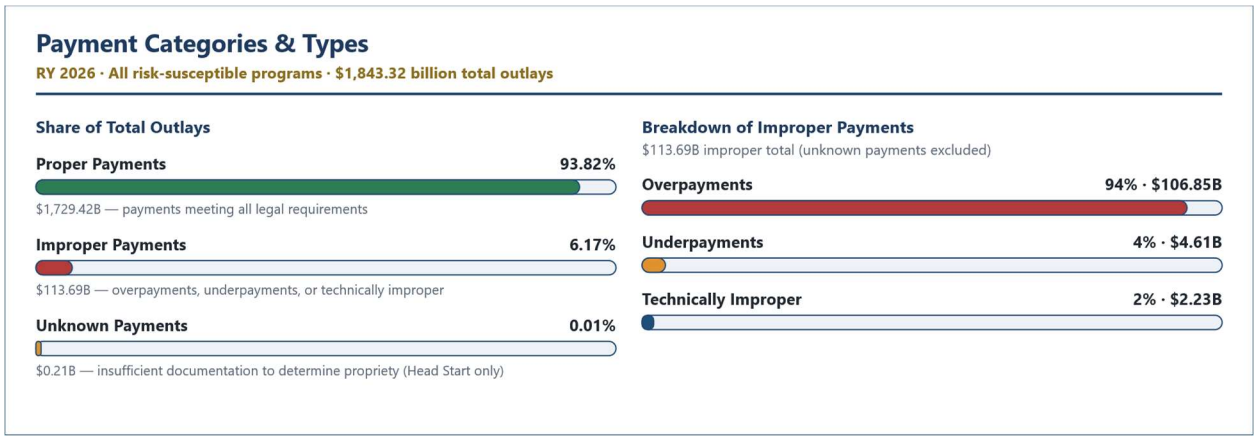


Table 1 summarizes RY 2026 proper payments (PP), improper payments (IP), and unknown payments (UP) by program. As required under OMB Circular A-123, Appendix C, HHS establishes an improper payment reduction target for each program with an established baseline that reports an estimate. Because each reporting year's estimate measures payments made in an earlier period, corrective actions developed in response to a given estimate may take several years to appear in subsequent estimates. As a result, reduction targets reported for the next reporting year may reflect payment periods in which some or all payments have already been made.

Payment Integrity Report

Table 1: HHS's Risk-Susceptible Programs' Improper Payment Results

RY 2026 (in Millions)[1]

Program or Activity	RY Outlays $	RY PP %	RY IP + UP $ [2]	RY IP + UP % [2]	RY+1 Reduction Target %
Medicare FFS [a]	$ 464,114.02 [b]	92.68%	$ 33,956.91	7.32% [c]	7.22%
Medicare Part C	$ 419,935.41 [d]	94.32%	$ 23,861.44	5.68%	6.07% [e]
Medicare Part D	$ 134,092.86 [f]	96.15%	$ 5,162.90	3.85%	N/A [g]
Medicaid [h]	$ 661,558.80 [i]	92.92%	$ 46,839.59	7.08% [j]	8.21% [k]
CHIP [h]	$ 23,067.37 [l]	90.19%	$ 2,263.47	9.81% [m]	10.23% [k]
APTC	$ 99,473.40 [n]	99.16%	$ 830.37	0.84% [o]	N/A [p]
TANF	$ 16,199.00 [q]	N/A	N/A	N/A [r]	N/A
Foster Care [h]	$ 1,173.00 [s]	90.58%	$ 110.50	9.42%	N/A [t]
CCDF [h]	$ 11,394.42 [u]	95.05%	$ 563.63	4.95%	4.19%
Head Start	$ 12,312.00 [v]	97.48%	$ 309.83	2.52%	7.47% [w]

[1] Totals may differ from the sum of the rounded components.

[2] Head Start is the only program with unknown payments. Limitations in verifying transaction-level data prevented a determination of whether these payments were proper or improper at the time of this report.

ACCOMPANYING NOTES FOR TABLE 1: HHS'S RISK-SUSCEPTIBLE AND HIGH-PRIORITY PROGRAMS' IMPROPER PAYMENT RESULTS AND OUTLOOK

a) Medicare FFS includes Part A and Part B. The Railroad Retirement Board (RRB) administers Medicare Part B benefits for railroad retirees.
b) Medicare FFS RY outlays are from the FY 2026 Medicare FFS Improper Payments Report and reflect claims submitted from July 2024 – June 2025.
c) HHS calculated an adjustment factor using a statistical subset of inpatient claims for services that should have been provided on an outpatient basis. This factor reflects the difference between the Medicare Part A inpatient payments and the amounts payable had the claims been properly submitted under Medicare Part B. Applying this factor reduced the overall improper payment rate by 0.17 percentage points to 7.32 percent ($33.96B). See pages 166-167 of HHS's FY 2012 AFR for additional information.
d) Medicare Part C RY 2026 outlays reflect 2024 payments reported in the FY 2026 Medicare Part C Error Rate Findings and Results Report available on the Medicare Part C Improper Payment Measurement website.
e) HHS expects the RY 2027 Medicare Part C rate to be statistically similar to the RY 2026 rate and will continue to monitor fluctuations when setting RY+1 targets. For RY 2027, HHS established a relationship mid-way between the upper limit of the 95 percent confidence interval, and the current year improper payment estimate to provide a realistic outyear target.
f) Medicare Part D RY 2026 outlays reflect 2024 payments reported in the FY 2026 Medicare Part D Error Rate Findings and Results Report available on the Medicare Part D Improper Payment Measurement website.
g) HHS does not expect the RY 2027 Medicare Part D rate to be statistically similar to prior years because of an updated methodology, if approved, would take effect with RY 2027 reporting. HHS therefore has not established a comparable RY 2027 target.
h) For Medicaid, CHIP, Foster Care, and CCDF, estimates use rolling three-year samples, with data updated for one-third of states each year.
i) Medicaid RY outlays reflect FY 2025 current-law expenditures excluding CDC's Vaccines for Children program.
j) National Medicaid estimates use measurements from RYs 2024–2026. Component improper payment estimates are 5.35 percent for Medicaid FFS, 0.00 percent for Medicaid Managed Care, and 5.11 percent for Medicaid Eligibility.
k) Medicaid and CHIP RY 2027 targets exceed RY 2026 rates because states are expected to conduct more eligibility redeterminations and provider screenings following the public health emergency. The target assumes increases similar to those measured this year from unwinding emergency flexibilities, partially offset by observed improvements in improper payments unrelated to unwinding.
l) CHIP RY outlays reflect FY 2025 expenditures.
m) National CHIP estimates use measurements from 2024–2026. Component improper estimates are 6.06 percent for CHIP FFS, 0.83 percent for CHIP Managed Care, and 7.74 percent for CHIP Eligibility.
n) APTC RY outlays cover only the Federally-facilitated Exchange and reflect benefit year 2024 (January 1, 2024 to December 31, 2024).
o) APTC improper payment results cover only the Federally-facilitated Exchange. HHS is developing a measurement methodology for State-based Exchanges, which account for 19.57 percent of total APTC payments, and will report progress in future AFRs.
p) HHS will report a RY+1 reduction target once State-based Exchanges are included in the measurement and a full baseline is established.
q) TANF RY outlays use the *FY 2026 President's Budget* baseline, including the Healthy Marriage Promotion and Responsible Fatherhood Grants and excluding the TANF Contingency Fund.
r) HHS is not reporting TANF estimates for RY 2026 because statutory limitations preclude HHS from requiring state participate in improper payment measurement.
s) Foster Care RY outlays use the *FY 2026 President's Budget* baseline and reflect the federal share of maintenance payments.
t) HHS resumed Title IV-E reviews in 2024. The RY 2026 estimate includes 42 states or territories operating traditional Title IV-E programs: 16 added this year and 26 states reviewed in RYs 2024–2025. HHS will report a RY+1 reduction target after all states have been reviewed and the program's baseline is reestablished.
u) CCDF RY outlays use the *FY 2026 President's Budget* baseline.
v) Head Start RY outlays use the *FY 2026 President's Budget* baseline.
w) Head Start RY 2027 target exceeds the RY 2026 rate based on historical performance and anticipated measurement variability during a period of program transition. Because the review methodology is retrospective, the full impact of FY 2026 corrective actions is expected in RY 2028 rather than RY 2027. In addition, recipient implementation of revised 2 CFR Part 200 requirements and the pending final rule for the Head Start Program Performance Standards may affect documentation quality and payment determinations.

Table 2 provides a breakdown of improper payments by type for each risk-susceptible program, distinguishing between monetary loss improper payments (overpayments that should not have been made) and non-monetary loss improper payments, which include underpayments and technically improper payments. Unknown payments are not included in Table 2; see the *Improper Payment Results* section of this report for payment category definitions.

Table 2: Amounts Improperly Paid by Program[1]

RY 2026 (in Millions)

	Monetary Loss			Non-Monetary Loss		
Program or Activity	**Overpayments**	**Percent of Total Payments**	**Underpayments**	**Technically Improper**	**Percent of Total Payments**
Medicare FFS	$ 32,679.47	7.04%	$ 1,277.44	$ 0.00	0.28%
Medicare Part C	$ 21,601.58	5.14%	$ 2,259.86	$ 0.00	0.54%
Medicare Part D	$ 4,830.45	3.60%	$ 332.46	$ 0.00	0.25%
Medicaid	$ 44,120.49	6.67%	$ 671.90	$ 2,047.20	0.41%
CHIP	$ 2,173.23	9.42%	$ 8.87	$ 81.37	0.39%
APTC	$ 830.37	0.84%	$ 0.00	$ 0.00	0.00%
Foster Care	$ 98.42	8.39%	$ 12.08	$ 0.00	1.03%
CCDF	$ 514.71	4.52%	$ 48.92	$ 0.00	0.43%
Head Start	$ 1.90	0.02%	$ 2.66	$ 96.58	0.81%
Total [2]	**$ 106,850.62**	**5.85%**	**$ 4,614.19**	**$ 2,225.15**	**0.37%**

[1] Table 2 excludes unknown payments, which are reported only by Head Start. Missing or insufficient documentation prevented HHS from determining whether these payments were proper at the time of this report. See the *Improper Payment Results* section of this report for payment category definitions.

[2] Totals may differ from the sum of the rounded components.

MITIGATION STRATEGIES & CORRECTIVE ACTIONS

HHS programs with significant improper payments have set reduction targets and implemented corrective actions to address root causes. Efforts include both cross-cutting strategies that strengthen payment integrity across programs and program-specific actions tailored to unique risks. Additional information on CMS program actions is available at www.cms.gov/fraud.

HHS identified improper payments resulting from factors both within and outside of the agency's control. HHS addresses root causes within its authority through corrective actions such as strengthening oversight of disbursements, improving eligibility verification, and automating documentation and payment controls. When factors outside the agency's control contribute to improper payments, HHS supports its partners through measures such as training and technical assistance for states, providers, prescription drug plans, and grantees. Because improper payment estimates are measured on a payment year lag, the full impact of corrective actions HHS implemented in FY 2026 may not appear until that payment year is measured and reported.

Cross-Cutting Mitigation Strategies

- **Strengthened eligibility verification:** Expanded access to the Death Master File, including providing states the ability to screen Medicaid beneficiaries through the Data Exchange System beyond provider screening, and enhanced checks during enrollment and redeterminations.
- **Provider screening and oversight:** Increased use of the Do Not Pay system, more rigorous provider enrollment reviews, and contract audits.
- **Do Not Pay:** HHS screens payments across the payment lifecycle through Treasury's Do Not Pay system and continues to modernize its connection, including transitioning payment and award systems to DNP's

Connect product to enable pre-certification checks prior to submission to Treasury. For a full discussion of HHS's use of Do Not Pay, including screening volumes, confirmed improper payments prevented, and an evaluation of program effectiveness, see the *Do Not Pay Discussion* section of this report.

- **Public Assistance Reporting Information System:** Provides state public assistance agencies in all 50 states, the District of Columbia, and Puerto Rico with data-matching capabilities to verify program eligibility and deter improper payments in public assistance programs such as TANF, Medicaid, CHIP, Workers' Compensation, child care programs, and Supplemental Nutrition Assistance Program with cross-state data-matching.
- **Training and technical assistance:** Ongoing education for state partners and providers to improve compliance with documentation and eligibility requirements.
- **Data analytics and predictive tools:** Expanded use of data sharing, automated edits, and predictive analytics to detect high-risk claims and prevent improper payments before they occur.
- **Fraud Defense Operations Center:** Integrated data analytics, investigators, and policy experts to detect and stop fraud in real time, suspending $1.98B in payments during FY 2026 and preventing losses to Medicare.
- **Interagency coordination:** Strengthened collaboration with federal and state partners to share data, coordinate audits, and align corrective action plans.

Program-Specific Mitigation Strategies

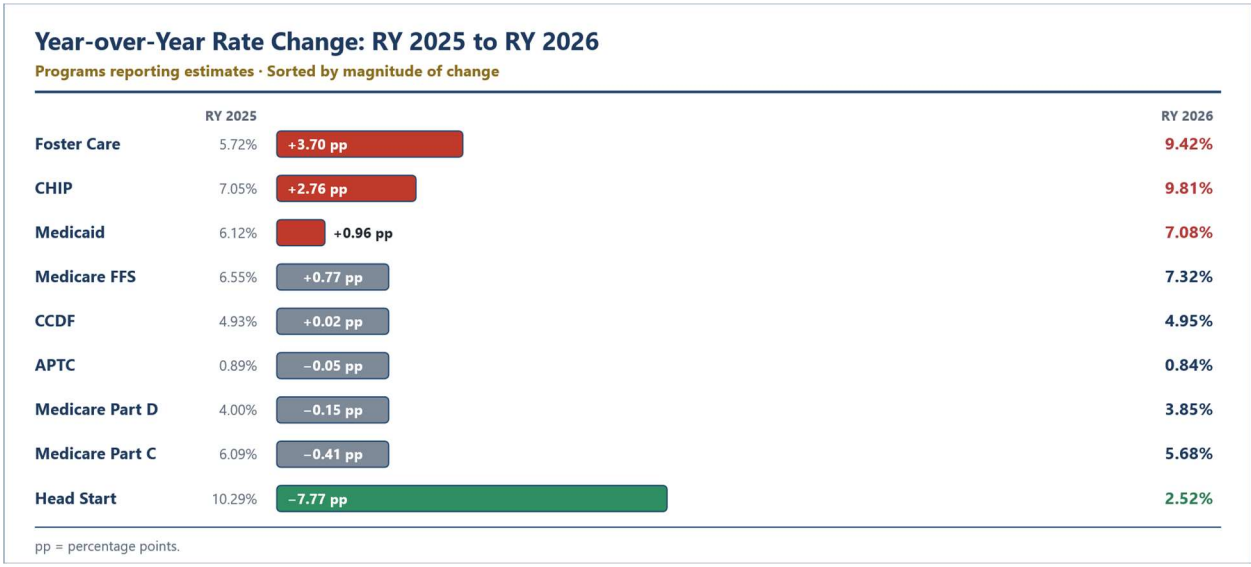
HHS reviews corrective actions annually and revises strategies as needed when they do not achieve reductions or demonstrate improvements. HHS tailors these actions to address program-specific root causes, such as beneficiary eligibility determination errors in Medicaid and CHIP, provider and plan documentation issues in Medicare, and recordkeeping deficiencies in Head Start. Detailed program-specific corrective actions, including the root causes they address and measurable results, are described in the program-specific sections of this report.

PROGRAM-SPECIFIC REPORTING

Improper and unknown payment estimates and corrective actions for each HHS program are available on PaymentAccuracy.gov. Available materials include the Annual Improper Payment Estimation Report and the Annual Report on Actions to Reduce Improper Payments, which are incorporated by reference in this Agency Financial Report.

Figure 3 illustrates the estimated improper and unknown payment rate changes from FY 2025 to FY 2026 for all risk-susceptible programs reporting estimates.

Figure 3: Estimated Year-over-Year Improper and Unknown Payment Rate Change by Program



MEDICARE FEE-FOR-SERVICE (PARTS A AND B)

Medicare FFS estimated improper payments were 7.32 percent ($33.96B) in RY 2026, representing no statistically significant change from 6.55 percent ($28.83B) in RY 2025.

The primary root cause was insufficient documentation, particularly in hospital outpatient, skilled nursing facility (SNF), lab tests-other (Non-Medicare Fee Schedule), and hospice claims. Specific documentation gaps included missing orders for hospital outpatient claims, missing documentation of the billed code and coverage criteria for SNF claims, missing medical necessity documentation for lab tests-other claims, and missing certification or recertification for hospice claims.

HHS implements corrective actions targeting the primary root causes of Medicare FFS improper payments, including insufficient documentation in hospital outpatient and SNF claims, missing medical necessity documentation for laboratory tests, and missing hospice certification documentation. Key actions in FY 2026 include:

- **Hospice Oversight:** HHS suspended payments to 822 hospices for unusually high live discharge rates and location-based analyses, holding $29.7 million in payments as of September 30, 2026. HHS also expanded enhanced oversight through the Provisional Period of Enhanced Oversight (PPEO) to an additional two states; the PPEO (now in six states) has resulted in 715 Medicare enrollment revocations based on medical review findings and affiliations that pose an undue risk of fraud, waste or abuse. In May 2026, HHS imposed a six-month nationwide moratorium on new Medicare hospice enrollments.
- **Laboratory Oversight:** Using advanced analytics and payment controls through the Fraud Defense Operations Center, HHS suspended $62.73M in potentially improper laboratory Medicare payments as of the end of RY 2026.
- **Prior Authorization and Pre-Claim Review:** HHS continued and expanded prior authorization and pre-claim review programs across hospital outpatient, durable medical equipment and supplies, ambulatory surgical center, inpatient rehabilitation facility, home health, and ambulatory transport services. Through these programs, HHS provisionally affirmed (approved) 2,538,328 items and services and denied 499,692 claims that did not meet Medicare.

Because the Comprehensive Error Rate Testing (CERT) measurement reflects claims from a prior period, actions implemented in FY 2026 are expected to be reflected in future CERT measurement cycles.

Medicare FFS improper payment data is available on the Comprehensive Error Rate Testing (CERT) website.

MEDICARE ADVANTAGE (PART C)

Medicare Part C estimated improper payments were 5.68 percent ($23.86B) in RY 2026, representing no statistically significant change from 6.09 percent ($23.67B) in RY 2025.

The primary root cause was medical record discrepancies, where diagnoses submitted by Medicare Advantage Organizations for payment calculations were not substantiated by supporting medical record documentation. Medicare Advantage Organizations are responsible for collecting, maintaining, and submitting accurate diagnosis data; however, medical records, the source document for diagnosis data, are not required to be collected or submitted to HHS at the time payment determinations are made. As a result, unsupported diagnoses may not be identified until after payment has occurred.

HHS implements corrective actions targeting the primary root cause of Medicare Part C improper payments, including diagnoses unsupported by medical record documentation. RADV Audits remain HHS's primary corrective action for Part C. In FY 2026, HHS initiated 1,553 new RADV audits of Medicare Advantage contracts from payment years 2020, 2021, and 2024, and issued results for 404 completed audits from payment years 2014–2015. HHS is processing appeals related to audit findings from payment years 2011–2015.

Because these actions influence Medicare Advantage Organization’s documentation practices over time rather than producing immediate rate changes, their effect is expected to be reflected in later measurement years as audits are finalized and recoveries are processed.

Medicare Part C improper payment data is available on the Medicare Part C Improper Payment Measurement website.

MEDICARE PRESCRIPTION DRUG BENEFIT (PART D)

Medicare Part D estimated improper payments were 3.85 percent ($5.16B) in RY 2026, representing no statistically significant change from 4.00 percent ($4.23B) in RY 2025.

The primary root causes were missing or insufficient documentation from plan sponsors to support prescription drug event data that determines payment, and discrepancies in drug pricing. Part D sponsors administer the program under contract and are responsible for maintaining documentation to support each payment; however, prescriptions, the source documentation, are not submitted to HHS at the time payment determinations are made. As a result, gaps in supporting documentation may not be identified until after payment has occurred.

HHS implements corrective actions targeting the primary root cause of Medicare Part D improper payments, including missing or insufficient documentation submitted by plan sponsors to support prescription drug event data. In FY 2026, HHS conducted three national audits of plan sponsors, with one completed audit resulting in the recovery of $648,022. Seven self-audits and four Program Integrity Audits are currently underway. HHS also continued outreach and education to plan sponsors through Health Plan Management System memos on high-risk drugs, audit findings, and best practices, reaching approximately 1,016 Medicare Part C and Part D contracts.

Because these actions influence plan sponsor documentation practices over time rather than producing immediate rate changes, their effect is expected to be reflected in future Part D measurement cycles as sponsors improve the accuracy and completeness of prescription drug event data.

Medicare Part D improper payment data is available on the Medicare Part D Improper Payment Measurement website.

MEDICAID

Medicaid estimated improper payments were 7.08 percent ($46.84B) in RY 2026, an increase from 6.12 percent ($37.39B) in RY 2025, driven by eligibility redetermination and provider screening errors as states unwound COVID-19 flexibilities. Under the triennial review cycle, RY 2026 covers the second group of states measure during the unwinding period. The national Medicaid improper payment estimate includes three components: Medicaid Fee-for-Service, Medicaid Managed Care, and Medicaid Eligibility. For more information on Medicaid measurement, see the Payment Error Rate Measurement (PERM) website.

The primary root causes were missing or insufficient documentation and state compliance with federal requirements. Missing or insufficient documentation accounted for the largest share of improper payments, occurring when states failed to provide required eligibility verifications such as income or resource checks, or when medical records lacked the information needed to establish medical necessity. State noncompliance with federal requirements included inadequate screening of newly enrolled or revalidated providers, payments to providers not enrolled in the program, and claims paid without the required National Provider Identifier.

HHS implements corrective actions targeting the primary root causes of Medicaid improper payments, including missing or insufficient documentation to verify eligibility determinations and state compliance with provider screening and enrollment requirements. Key actions in FY 2026 include:

- **Beneficiary Eligibility Audits:** HHS initiated seven audits, two focused on state compliance with federal eligibility renewal requirements and five focused on individuals with unsatisfactory immigration status. Case reviews are complete and final reports are expected by December 2026.
- **Medicaid Eligibility Quality Control Program:** Eighteen states completed Cycle 3 reviews of Calendar Year 2025 eligibility determinations. HHS will track deficiencies related to insufficient documentation, states required to take corrective action, and deficiencies resolved. Results will inform future Payment Error Rate Measurement cycles.
- **Technical Assistance on Screening and Enrollment:** HHS conducted onsite visits to 43 states as of September 2026 to assess provider screening and enrollment compliance.

Because Medicaid estimates use a rolling three-year PERM sample and current measurements reflect states still unwinding from COVID-19 public health emergency flexibilities, HHS does not expect FY 2026 corrective actions to be fully reflected in the measured rate until RY 2028, when the first cycle of states measured after the conclusion of COVID-19 flexibilities will be included in the estimate.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP estimated improper payments were 9.81 percent ($2.26B) in RY 2026, an increase from 7.05 percent ($1.37B) in RY 2025, driven by eligibility redetermination and provider screening errors as states unwound COVID-19 flexibilities. Under the triennial review cycle, RY 2026 covers the second group of states measured during the unwinding period. The national CHIP improper payment estimate includes three components: CHIP Fee-for-Service, CHIP Managed Care, and CHIP Eligibility. For more information on CHIP measurement, see the PERM website.

The primary root causes were missing or insufficient documentation, state compliance with federal requirements, and improper determinations of beneficiary eligibility. Missing or insufficient documentation accounted for the largest share of improper payments, occurring when states failed to provide required eligibility verifications such as income or resource checks or required signatures, or when medical records lacked the information needed to establish medical necessity. State noncompliance with federal requirements included inadequate screening of newly enrolled or revalidated providers, payments to providers not enrolled in the program, claims paid without the required National Provider Identifier, and claims paid despite the presence of qualifying third-party insurance. Improper eligibility determinations, a root cause specific to CHIP, occurred when states incorrectly claimed beneficiaries under Title XXI (CHIP) instead of Title XIX (Medicaid). These errors resulted from beneficiaries falling below the applicable income limit or from mistakes involving income calculations, household composition, third-party insurance status, or tax-filer status.

HHS implements corrective actions for CHIP consistent with those described for Medicaid, as both programs share primary root causes. State-specific Corrective Actions Plans, technical assistance on screening and enrollment, and enhanced training continue to address CHIP improper payment drivers. As with Medicaid, HHS does not expect FY 2026 corrective actions to be fully reflected in the measured CHIP rate until RY 2028.

ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT (APTC)

The Premium Tax Credit has two payment streams: APTC and the Net Premium Tax Credit (Net PTC) claimed on individual tax returns. HHS measures APTC improper payments and the Internal Revenue Service (IRS) measures Net PTC improper payments.[25] The combined HHS and IRS Premium Tax Credit estimated improper payments were 1.37 percent ($1.38B) in RY 2026.[26] This combined estimate excludes APTC payments made by State-based Exchanges and repayments of excess APTC by State-based Exchange enrollees when filling their taxes. For more information on APTC measurement, see the Exchange Improper Payment Measurement website.

Federally-facilitated Exchange APTC estimated improper payments were 0.84 percent ($830.37M) in RY 2026, representing no statistically significant change from 0.89 percent ($657.46M) in RY 2025.

The primary root causes of improper payments in RY 2026 were duplicate enrollment errors, where limitations in person matching logic within the Federally-facilitated Exchange allowed duplicate APTC enrollments to go undetected before payment, and manual processing errors, where eligibility workers failed to properly examine consumer-submitted documents. Unlike prior years, no technically improper payments were identified in RY 2026. HHS is improving person matching automation to reduce or eliminate duplicate enrollment instances.

HHS partially meets the requirement to publish improper payment estimates for the APTC program because estimates do not yet include payments from State-based Exchanges. In CY 2024, 18 states and the District of Columbia operated State-based Exchanges, administering approximately 19.57 percent of total APTC payments.

In May 2026, HHS published the Notice of Benefit and Payment Parameters for 2027 final rule, which included provisions to implement the State Exchange Improper Payment Measurement program. HHS plans to begin sampling and estimation on January 1, 2027, and report its first improper payment rate in FY 2028.

[25] Treasury's Annual Financial Report is available on U.S. Department of the Treasury: Agency Financial Report.

[26] The combined rate incorporates each agency's APTC and PTC estimates into a single rate and confidence interval for all federal premium subsidies.

HHS implements corrective actions targeting the primary root causes of APTC improper payments, including manual processing errors in eligibility verification and technically improper payments from missed periodic data matches. Key actions implemented in FY 2026 include:

- **Person Matching and Automation Improvements:** In February 2026, HHS enhanced person matching and overlap detection scripts to identify and eliminate duplicate enrollments with APTC. Through June 2026, approximately 39,000 policies have been terminated or cancelled as a result of these improvements. HHS also updated the Verify Lawful Presence Hub Service in April 2026 to improve accuracy of eligibility determinations for noncitizens.
- **Data Matching Issue Expiration Timing:** Effective July 1, 2026, HHS updated data matching issue expiration processing to expire the day following the data matching issue clock end date, replacing the prior ten-day grace period. This directly addresses a source of technically improper payments resulting from adjudications occurring outside the regulatory timeframe for data matching issue resolution.
- **Agent and Broker Compliance:** HHS standardized Social Security number and immigration document verification requirements across all application submission channels and conducted risk-based monitoring and investigations, resulting in over 550 Notices of Intent to Terminate for missing Social Security numbers and 1,090 total agent and broker terminations in calendar year 2026.
- **Eligibility Personnel Training:** HHS implemented income verification tool training and processing updates, with 634 eligibility service workers completing training. HHS is also implementing enhanced knowledge check training to improve documentation escalation compliance.

Because the APTC measurement reflects benefit year data from a prior period, FY 2026 actions are expected to be reflected in the RY 2028 Exchange Improper Payment Measurement cycle.

Temporary Assistance for Needy Families (TANF)

Due to statutory limitations under 42 U.S.C. § 617, HHS is precluded from requiring states to participate in a TANF improper payment measurement and therefore does not report an improper payment estimate or corrective actions. Statutory changes are needed for HHS to collect the data required to estimate TANF's improper payment rate.

HHS continues to examine options that would allow TANF to collect information from states needed to calculate and report an improper payment estimate and develop corrective actions. HHS remains committed to working with OMB and other stakeholders to identify viable pathways to full PIIA compliance for the TANF program. HHS supports state program integrity efforts through data-matching using the Public Assistance Reporting Information System and eligibility verifications using the Systematic Alien Verification for Entitlements system. HHS also reviews single audit findings, conducts monitoring of state compliance, and assesses penalties according to statutory guidelines to strengthen program integrity in the absence of direct measurement authority.

Foster Care

Foster Care estimated improper payments were 9.42 percent ($110.50M) in RY 2026, compared to 5.72 percent ($74.07M) in RY 2025; however, because RY 2026 incorporates data from 42 states compared to 26 states in RY 2025, year-over-year comparisons warrant caution. The first Title IV-E review cycle is expected to be completed in FY 2028. The final state scheduled in the cycle has been deferred to the first quarter of FY 2028 due to delays in implementing a new information system that resulted in insufficient Title IV-E claims to support the required review sample. Once all jurisdictions are represented, HHS will establish a complete baseline and publish a reduction target.

The primary root causes were administrative errors by state agencies in case classification and payment processing. Administrative errors in Foster Care case classification and payment processing primarily reflect the complexity of Title IV-E eligibility determinations, which require state agencies to apply detailed federal criteria including judicial findings, removal circumstances, and placement requirements that vary in interpretation across state systems and caseworker training levels, and which are not consistently supported by automated eligibility verification tools at the state level. Limitations in state automated systems and data management may be another factor. Some states faced challenges with poor data quality, inaccurate or delayed system updates, programming or configuration issues, and quality assurance controls.

HHS implements corrective actions targeting the primary root causes of Foster Care improper payments. Actions to strengthen state compliance with Title IV-E eligibility and claiming requirements include:

- **Detailed Review of State Payment Histories:** In advance of each on-site Title IV-E eligibility review, HHS reviewed and analyzed payment histories associated with the review sample to identify potential claiming errors and areas requiring additional scrutiny. HHS reviewed approximately 100 to 200 payment histories for each of the 17 states during the reporting period, strengthening detection and correction of improper claims.
- **Quality Improvement Collaboration with States:** HHS continued providing ongoing quality improvement assistance to states following Title IV-E reviews, including support for the development and implementation of Program Improvement Plans to address identified eligibility and claim deficiencies. Eight Program Improvement Plans were developed and two were completed.

HHS also continues to strengthen the integrity of the Title IV-E measurement process through the following activities:

- **Title IV-E Review Instrument Training:** HHS provided training on the Title IV-E Review Instrument to state and federal reviewers in advance of on-site reviews. During the FY 2026 reporting cycle, 17 training sessions were conducted, reaching approximately 102 state staff and 35 federal staff. This training supports more consistent and accurate application of Title IV-E requirements and improves reviewers' ability to identify eligibility and claiming errors.

Because Foster Care improper payment estimates are developed through Title IV-E reviews conducted across jurisdictions over a rolling three-year cycle, improvements resulting from FY 2026 corrective actions may not be reflected in the national improper payment rate until affected jurisdictions are reviewed and their results are incorporated into the national estimate.

Child Care and Development Fund (CCDF)

CCDF estimated improper payments were 4.95 percent ($563.63M) in RY 2026, a slight increase from 4.93 percent ($921.46M) in RY 2025. Although the RY 2026 improper payment rate increased slightly, estimated improper payment dollars decreased because total CCDF outlays were lower than in RY 2025. The decline in outlays likely reflects states' transition from American Rescue Plan supplemental funding to more typical annual funding levels. CCDF uses a rolling three-year sample where one-third of states report triennially; for RY 2026, new data from 18 states replaced the RY 2023 data for those same states. While all RY 2026 reporting states achieved improper payment rates below the 10 percent threshold, some fluctuation occurred across reporting states. States from RY 2025 and RY 2024 that remain above the 10 percent threshold will continue to affect national results until they report again in RY 2027 and RY 2028.

The primary root causes were missing or insufficient documentation in case records, such as missing pay stubs to verify income eligibility, and administrative errors in applying eligibility policies, such as miscalculation of income

resulting in an incorrect family copayment amount. Reporting states attributed errors to workforce challenges — including eligibility staff turnover, staff shortages, hiring freezes, increased caseloads, and training gaps for new staff — and system challenges including outdated or legacy systems and transitions to new systems during the reporting period.

HHS implements corrective actions targeting the primary root cause of CCDF improper payments, including missing or insufficient information from client case files to verify eligibility at the time of subsidy determination or redetermination, and administrative errors in applying eligibility policies.

Following RY 2025 error rate results, HHS provided targeted training, technical assistance, and oversight to CCDF Lead Agencies, including federal-state joint case reviews and Corrective Action Plans for states above the 10 percent improper payment threshold, with intensive support through onsite visits and monthly implementation check-ins. These efforts produced measurable results: in RY 2026, all reporting states had improper payment rates below the 10 percent threshold. One state on a Corrective Action Plan following an improper payment rate of 15.89 percent in RY 2023 reduced its rate to 8.87 percent in RY 2026 and is no longer subject to corrective actions.

HHS is developing a plan to move from a triennial to a biannual or annual reporting cycle and is implementing a new option for states above the 10 percent threshold to calculate their next error rate sooner than their regular triennial schedule, allowing improved rates to be reflected in the national estimate earlier. HHS will also implement and enforce stronger accountability measures for states that exceed the 10 percent threshold. HHS will continue to provide technical assistance and training, including support for states to implement systems that prevent improper payments. The full impact of FY 2026 corrective actions is expected to be reflected in future results.

HEAD START

Head Start estimated improper and unknown payments were 2.52 percent ($309.83M) in RY 2026, a decrease from 10.29 percent ($1.21B) originally reported in RY 2025 and a compliance milestone as the rate decreased below the 10 percent PIIA threshold.

The primary root causes for improper payments were missing or insufficient documentation, and compliance with statutory requirements for expenditures related to contracts, salaries, wages and fringe benefits, and other budget categories. The largest contributing improper payment types were unknown and technically improper, which resulted from noncompliance with established fiscal and grant management policies and procedures — for example, the inability to access documentation or accounting adjustment required to correct expenditures initially charged to the federal award in error.

HHS implements corrective actions targeting the primary root causes of Head Start improper payments, including missing or insufficient administrative documentation in expenditures related to salaries, wages, and fringe benefits, and limitations in verifying transaction-level data.

FY 2025 Final Adjudication: In February 2026, HHS conducted a formal final adjudication review of transactions identified as improper or unknown in the initial FY 2025 improper payment sample, giving recipients an additional opportunity to submit required transaction documentation. Of the 241 transactions originally classified as errors, including 173 unknown payments, reviewers were able to make a final determination on all transactions upon receipt of the additional documentation. All 173 unknown payments were resolved, with the majority determined to be proper payments. As a result, the RY 2025 improper payment rate was recalculated from 10.29 percent to 0.84 percent, with unknown payments reduced to zero. This result demonstrates that Head Start recipients can provide complete transaction documentation with adequate support and lead time, and that the initial rate substantially overstated the program's actual payment error level due to documentation access challenges rather than underlying

payment inaccuracy. The 0.84 percent reflects a one-time recalculation of the FY 2025 sample following late documentation submission, while the 2.52 percent reported for RY 2026 reflects the current measurement cycle; the two figures are therefore not directly comparable.

To address the documentation access and submission challenges identified as primary drivers of the FY 2025 rate, HHS implemented the following corrective actions in FY 2026:

- **Timeline and Process Changes:** In January 2026, HHS lengthened the lead time for the improper payment review, resulting in a reduction in extension requests of over 15 percent and earlier submission of documentation by recipients.
- **Data Validation Tool:** In January 2026, HHS deployed a data validation tool to support recipients with reconciling transaction-level data. Of 198 improper payment review participants, 101 utilized the tool. Recipients using the tool required an average of 1 to 2 follow-ups, compared to 3 to 5 follow-ups on average for recipients who did not use the tool.
- **Documentation Training:** In May 2026, HHS held a specialized training session on documentation requirements. Over 90 percent of the 198 improper payment review participants attended, and over 90 percent reported increased clarity on documentation submission requirements. Documentation received following the training showed significant improvement in completeness and accuracy.
- **Fiscal Integrity Forum:** In April 2026, HHS delivered a two-day fiscal integrity forum for high-risk and Stratum 5 recipients. Twenty-two recipients and 54 participants attended. Fewer than 50 percent of attendees required additional support and follow-up following the forum, and attendees received extended deadlines for documentation submission.

Building on these implemented actions, HHS has planned the following additional steps for FY 2027:

- Lengthening the improper payment review period by an additional 3 to 4 weeks to further support timely documentation submission, with an expected reduction in extension requests of at least 25 percent.
- Requiring use of the Data Validation Tool for all participants, following Paperwork Reduction Act approval received in spring 2026, with an expected reduction in follow-ups of at least 30 percent.
- Delivering a 2.5-day Fiscal Accountability, Integrity and Risk Forum for high-risk recipients and improper payment review participants, with rate impact expected to be measurable by the FY 2028 review.
- Conducting a FY 2026 retest of identified improper payments beginning October 2026, with an expected rate reduction of at least 25 percent upon final adjudication.

RECOVERY AUDITS AND ACTIVITIES

HHS and states conducted recovery audits and activities in Medicare, Medicaid, and other programs to identify and recover overpayments and inform corrective actions. HHS uses recovery audit results to implement corrective actions, enhance program oversight, and reduce future improper payments. More detailed information on recovery activities and topics approved for recovery audit contractor review is available at the Medicare Recovery Audit Program Website.

The Annual Report on Actions to Recover Improper Payments Identified in a Recovery Audit is available on PaymentAccuracy.gov and is incorporated by reference in this Agency Financial Report.

Table 3 provides information on HHS's overpayment recovery results, including amounts identified and recovered through recovery audits and through recovery activities conducted outside of formal recovery audits.

Table 3: Overpayments Recovered

RY 2026 (in Millions)

Audit or Activity	Overpayments Recovered through Recovery Audits			Overpayments Recovered through Recovery Activities	
	Amount Identified	Amount Recovered [1]	Recovery Rate	Amount Identified	Amount Recovered [1]
CMS Error Rate Measurements [2]				$ 31.98	$ 22.69
Medicare FFS Recovery Auditors	$ 917.26	$ 679.59	74.09%		
Medicare Part C RADV Audits [3]	$ 24.63	N/A	N/A		
Medicare Part D Prescription Drug Audits	$ 1.44	$ 0.65	45.14%		
MSP Recovery Auditor	$ 521.52	$ 266.59	51.12%		
Medicare Contractors [4]				$ 21,623.83	$ 14,735.34
Medicaid Integrity Contractors—Federal Share [5]				$ 71.25	$ 10.96
State Medicaid Recovery Auditors—Federal Share [6]	N/A	$ 43.91	N/A		
ACF Error Rate Measurements [7]				$ 3.65	$ 3.56
ACF OIG Reviews [8]				$ 0.03	$ 2.23
Single Audits [9]				$ 56.21	$ 57.74
TOTAL [10]	**$ 1,464.85**	**$ 990.74**	**67.63%**	**$ 21,786.95**	**$ 14,832.52**

Notes:

1. Unless otherwise noted, Amount Recovered reflects recoveries in FY 2026, regardless of when HHS identified the overpayment.
2. Includes Medicare FFS recoveries through the Comprehensive Error Rate Testing (CERT) program and Medicaid and CHIP recoveries through the PERM program. The RY 2026 CERT sample identified $29,339,132.29 in overpayments. Medicare Administrative Contractors (MACs) recover these amounts through standard payment recovery methods. As of October 2026, MACs collected $22,375,496.74 or 76.27 percent. HHS works with states to recover Medicaid and CHIP overpayments identified in sampled FFS and managed care claims. The Act and related regulations govern these recoveries, and states reimburse the federal share to HHS. Section 1903(d) of the Act generally allows states up to one year after discovery to recover or attempt to recover overpayments from the provider or supplier before refunding the federal share. The RY 2026 PERM sample identified $2,286,079.01 in Medicaid overpayments and $354,843.18 in CHIP overpayments. HHS recovered $188,351 for Medicaid and $126,609 for CHIP. These recoveries relate to prior reporting periods and therefore do not represent recovery rates for the FY 2026 sample.
3. Only the amount identified is available. HHS plans to begin issuing PY 2018 audit findings in mid-calendar year 2027, including instructions on how the overpayments will be collected.
4. Amounts reported by Medicare FFS Contractors, excluding the amounts reported separately for the Medicare FFS Recovery Auditors and the Medicare FFS Error Rate Measurement contractor.
5. Medicaid Integrity Contractors (UPICs) identified both federal and state shares of Medicaid overpayments, HHS reports only the federal share. Recoveries may differ from those in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared before state reporting is finalized.
6. Only the Amount Recovered is available. Recoveries may differ from those in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared before state reporting is finalized.
7. Amount Identified reflects reviews supporting the RY 2026 estimates for CCDF, Foster Care, and Head Start. Amounts Recovered may include recoveries related to FY 2026 estimates and amounts identified in prior years. For CCDF, states must recover fraudulent child care payments but may choose whether to recover nonfraudulent misspending, such as in cases of unintentional worker errors. CCDF contributed $89,137 to the Amount Identified and $1,290 to the Amount Recovered. The recoveries occurred in FYs 2023 through 2025 and relate to Year One states' RY 2023 reviews. Foster Care eligibility reviews in 16 states and revised findings for 8 additional states identified $3,557,375 in Title IV-E improper payments, all which HHS recovered. This includes $2,327,865 in disallowed maintenance payments and $1,229,510 in disallowed administrative payments. Head Start reviews for RY 2026 identified $63,175 in improper payments, including $123 in overpayments. HHS sent recovery notices to affected recipients in FY 2026 and plans to continue recoveries through the disallowance process.
8. Amount Identified includes questioned costs from HHS OIG reports covering recipients across ACF programs that ACF sustained between August 1, 2025 and July 31, 2026.
9. Includes all Divisions and reflects results for the full FY 2025.
10. Totals may differ from the sum of the rounded component.

FY 2026 Top Management and Performance Challenges Identified by the Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

DATE: October 27, 2026

TO: Robert F. Kennedy, Jr.
Secretary

THROUGH: Liesl I. Fowler
Executive Secretary

FROM: T. March Bell
Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2026

This memorandum transmits the Office of Inspector General's (OIG's) list of top management and performance challenges facing the Department of Health and Human Services (HHS or the Department). The Reports Consolidation Act of 2000, P.L. No. 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

HHS's top management and performance challenges for fiscal year 2026 are:

1. Medicare and Medicaid
2. Grants and Contracts
3. Public Health
4. Beneficiary Safety
5. Technological Advancement and Cybersecurity

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the people who are enrolled in these programs. If you have any questions or comments, please contact me, or your staff may contact Megan Tinker, Chief of Staff, at (202) 539-6271 or Megan.Tinker@oig.hhs.gov.

Top Management & Performance Challenges Facing HHS



2026

Department of Health and Human Services

Office of Inspector General

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Introduction

The Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) issues its *Top Management and Performance Challenges Facing HHS* annually as required by statute. This report is intended to help the Department improve the effectiveness and efficiency of its programs and operations.

Fraud is a serious threat to HHS's effectiveness and efficiency. It wastes taxpayer dollars and can put people in harm's way. In 2026, HHS took new actions to fight fraud in its programs. However, program integrity risks continue to make it harder for the Department to carry out its mission.

Program integrity concerns play a role in each of the Department's five top management and performance challenges. The sections below summarize each challenge and why addressing them matters. OIG's website offers additional resources, including all reports and enforcement actions mentioned here, OIG recommendations to improve Department programs and strengthen their integrity, and actions taken to address those recommendations.

1 | Medicare and Medicaid

Elements of the Challenge

- Combating fraud, waste, and abuse
- Improper payments in Medicare and Medicaid
- Ensuring that Medicare Advantage delivers value
- Ensuring the effectiveness and efficiency of the Medicaid program

HHS must ensure that Medicare and Medicaid deliver high-quality, cost-effective care to the millions of Americans who rely on these programs.

Combating Fraud, Waste, and Abuse

Combating fraud, waste, and abuse in Medicare and Medicaid is imperative to ensure that every dollar invested in these programs is used to provide high-quality health care. The Centers for Medicare & Medicaid Services (CMS) partnered effectively with OIG to suspend billions of dollars in payments to suspected fraud perpetrators as part of the 2026 National Health Care Fraud Takedown, continued to build the Fraud Defense Operations Center to combat fraud in Medicare, and established the Medicaid Fraud War Room to combat fraud in Medicaid. CMS must build on these important steps and continue to improve its ability to stop improper and fraudulent payments.

These efforts should focus on fraud prevention (e.g., provider enrollment screening and revalidation), detection (e.g., claims processing, prepayment review, data analysis), and administrative enforcement actions (e.g., payment suspension, recovery of overpayments, termination, revocation). CMS should consider additional program-specific safeguards (e.g., including ordering providers' National Provider Identifiers on managed care claims). CMS should also ensure that States and Medicaid managed care organizations identify and report suspected fraud.

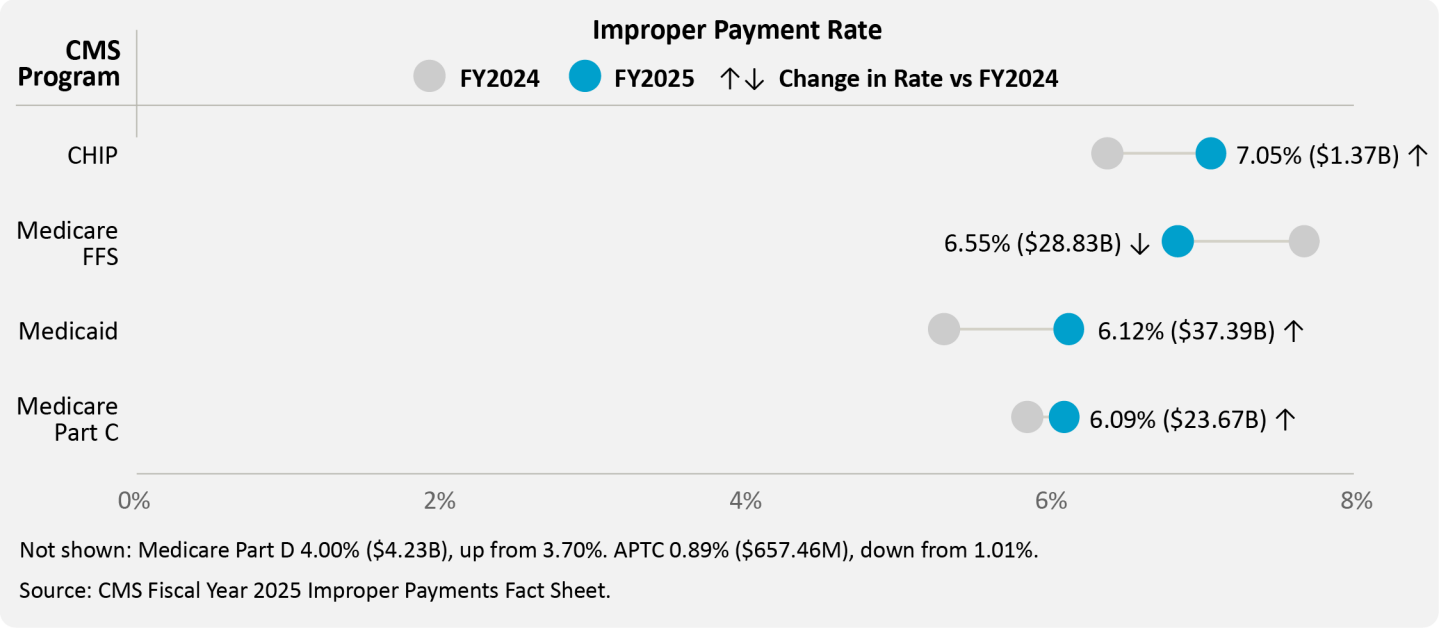
Health care fraud schemes are increasingly complex and global in scope, often migrating from one medical item or service to another. Items and services at high risk of fraud include durable medical equipment, prescription drugs, hospice care, genetic and clinical laboratory testing, wound care, and treatment for substance use disorder. Different CMS programs (e.g., managed care, traditional Medicare, value-based care models) have different risks because they pay for services and provide coverage differently. As HHS refines payment policies and incentives, it must anticipate and guard against exploitation of specific payment designs.



Improper Payments in Medicare and Medicaid

HHS measures programwide improper payment rates annually for Medicare and Medicaid. In fiscal year (FY) 2025, improper payments for Medicare, Medicaid, and the Children's Health Insurance Program were estimated at $95.49 billion. An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount. However, although all fraudulent payments are improper, not all improper payments indicate fraud. HHS must be vigilant in identifying and recovering improper payments promptly and continue developing actions to prevent improper payments from being made.

The Medicare Fee-for-Service improper payment rate was the only one of four programs to improve in FY 2025.



Not shown: Medicare Part D 4.00% ($4.23B), up from 3.70%. APTC 0.89% ($657.46M), down from 1.01%.

Source: CMS Fiscal Year 2025 Improper Payments Fact Sheet.

Ensuring That Medicare Advantage Delivers Value

Medicare Advantage has become the primary method through which Medicare enrollees receive care. Administering a program with 35 million enrollees and $522 billion in Federal spending in calendar year 2025 presents challenges in ensuring that payments are accurate and people enrolled in these plans have access to needed care that plans are being paid to provide. In FY 2025, improper payments reported for the program, based on errors in diagnoses information submitted for risk-adjusted payment for 2023, totaled $23.67 billion, or 6.09 percent of program outlays. CMS must strengthen program oversight to ensure that plans do not upcode to receive increased risk-adjusted payments. Rigorous oversight by CMS is needed to ensure that enrollees receive appropriate care without undue administrative or financial burden and that plans deliver

value to the taxpayers funding this care. CMS also needs to ensure that plans do not inappropriately deny payment to providers and do not engage in misleading and deceptive marketing or enrollment practices. Finally, CMS must ensure that complete and accurate data about payments are readily available from plans for effective monitoring and oversight of the Medicare Advantage program.

Ensuring the Effectiveness and Efficiency of the Medicaid Program

OIG work has identified vulnerabilities in the Medicaid program related to payment accuracy, eligibility determinations, provider taxes, and service delivery. The largest portion of the Medicaid improper payment measure relates to eligibility, with errors due to insufficient documentation. Ensuring accuracy of enrollment data is a particular challenge in the Medicaid program. OIG audits have shown that some individuals are concurrently enrolled in Medicaid programs in two States and found payments made to Medicaid plans for individuals who are deceased. Other risk areas include timely return of overpayments and access to covered care, particularly in rural areas. CMS has taken steps to address some of these risks, and as it does so, must ensure effective coordination and communication between the Federal Government and States.

Examples of OIG's Related Work

- *States Have Missed Some Opportunities To Improve Medicaid Managed Care Organizations' Provider Fraud Referrals*
- *Medicare Payments for Continuous Glucose Monitors and Supplies Exceeded Supplier Costs and Retail Market Prices, Indicating Medicare Can Save at Least Tens of Millions of Dollars in One Year*
- *Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees*
- *CMS Potentially Overpaid Medicare Advantage Organizations $462 Million Based on Certain Unsupported Acute Stroke Diagnosis Codes*
- *Medicare Advantage Industry Segment-Specific Compliance Program Guidance*
- *Utilization Trends and Medicare Part B Billing for Office-Based Peripheral Vascular Procedures Raise Questions About Program Integrity*

2| Grants and Contracts

Elements of the Challenge

- Ensuring program integrity and recipient compliance
- Managing complex risks and exploitation

Given HHS's significant expenditures through grants, contracts, and other transaction agreements, the Department must ensure sound financial stewardship and work to combat fraud, waste, and abuse.

Ensuring Program Integrity and Recipient Compliance

Combating fraud, waste, and abuse in HHS's grants and contracts is imperative to ensure that every taxpayer dollar is used effectively to advance research, public health, and human services. As the largest grant-making agency in the Federal Government and one of its largest contracting entities, HHS awards billions of dollars annually to States, territories, Tribes, local governments, community organizations, educational institutions, and for-profit businesses. These awards support programs and services essential to HHS achieving its mission, including supporting health centers, biomedical research, child care, and preparedness for public health emergencies. The scale and importance of these programs highlight the urgency of ensuring that Federal funds are well spent and protected from misuse and other risks.

HHS must prioritize rigorous operational oversight throughout the contract and grant life cycles to ensure that the Department enforces compliance from initial award through final closeout. Administering a diverse portfolio of Federal awards presents persistent challenges in ensuring that taxpayer resources are utilized efficiently and lawfully, including securing qualified partners, tracking performance, and ensuring compliance with recipient reporting requirements to support timely action. To mitigate upfront risks, the Department must enforce contracting requirements to prevent non-compliant award terms and conduct intensive financial and performance risk assessments on grant applicants. During the post-award phase, continuous vigilance is required to track deliverable milestones, review billing, and deploy real-time electronic reporting systems to audit the flow of funds and prevent improper drawdowns. Finally, additional administrative attention must be paid to closeout deadlines, including the 120-day grant reconciliation window, to audit final costs, promptly deobligate unused balances, and recover disallowed payments.



Managing Complex Risks and Exploitation

Just as health care fraud schemes grow increasingly complex, threats to grants, contracts, and non-traditional funding awards are expanding in scope and sophistication, necessitating agile and targeted safeguards to address evolving risks. The Department must protect federally funded research from foreign government interference, academic espionage, and the unauthorized misappropriation of U.S. research. Simultaneously, accountability must also be reinforced at the subrecipient level, ensuring that prime awardees are accountable for the oversight and integrity of subrecipients. The rapid growth of flexible mechanisms, such as the National Institutes of Health's use of "Other Transactions," which ballooned from under $900 million in 2020 to $1.9 billion by 2024, requires specialized oversight to ensure that these tools deliver on clinical promises. Finally, HHS must better detect and address vulnerabilities in human service programs, such as those exposed in child care assistance programs where weak attendance tracking and self-certification were exploited.

Examples of OIG's Related Work

- *CMS Put $11.2 Billion at Risk of Fraud, Waste, and Abuse by Not Properly Closing Contracts*
- *ACF's $529 Million Sole Source Contract Award for Unaccompanied Alien Children Services Was Based on an Unsolicited Proposal, Double the Cost Estimate, and Noncompliant With Pre-Award Requirements*
- *Gaps in NIH's Oversight Put Millions in Funding for Other Transactions at Greater Risk of Fraud, Waste, or Abuse*
- *The Office of Refugee Resettlement Needs To Improve Its Monitoring of Unlicensed Unaccompanied Alien Children Program Care Providers' Compliance With Background Check Requirements*
- *ACF Did Not Monitor States' Compliance With All American Rescue Plan Child Care Stabilization Grant Provisions*
- *NIH Recipients Conducting Biospecimen Research: Gaps in Emergency Planning and Reporting*

3 | Public Health

Elements of the Challenge

- Preventing and fighting chronic disease
- Addressing the mental health and substance use disorder crises
- Ensuring the safety, effectiveness, and availability of products regulated by the Food and Drug Administration (FDA)
- Ensuring preparedness for and response to disasters and public health emergencies

HHS must efficiently use public health resources to protect and improve the health of all Americans.

Preventing and Fighting Chronic Disease

According to the Centers for Disease Control and Prevention, chronic diseases such as heart disease, cancer, and diabetes are among the top 10 leading causes of illness, death, and disability in the United States. Chronic diseases are also leading drivers of the Nation's estimated $5.7 trillion in annual health care costs. Approximately three in four American adults have at least one chronic condition, and more than half have two or more chronic conditions. Rates of chronic disease in children are rising. HHS launched a Take Back Your Health campaign, emphasizing the importance of nutrition's role in preventing disease and the benefits of physical activity, and issued an advisory on the harms of screen use. Much remains to be done to address the considerable challenge of preventing and fighting chronic disease.

Addressing the Mental Health and Substance Use Disorder Crises

In 2025, adolescents and young adults showed downward or stable trends across several behavioral health indicators, including depression, suicidal thoughts, and the use or initiation of alcohol, nicotine/vaping, marijuana, and other illicit drugs. Still, the overall burden of mental illness and substance use disorders remains substantial. Anxiety symptoms remained a notable concern among adolescents and adults. Many Americans continue to face difficulty obtaining timely, high-quality care for mental health and substance use conditions, which impedes improvement. Confronting the Nation's ongoing behavioral health challenges remains a priority.



Ensuring the Safety, Effectiveness, and Availability of Products Regulated by the Food and Drug Administration

The FDA regulates a broad range of crucial consumer products, including foods; human and veterinary drugs—including compounded drugs; biological products; medical devices; cosmetics; radiation-emitting products; tobacco products; and infant formula. Collectively, these products account for approximately 21 cents of every dollar spent by American consumers. The FDA faces a range of vulnerabilities and challenges including reliance on overseas manufacturing, increasingly complex and interconnected supply chains, cybersecurity threats, and other security risks. For example, the globalization of food supply chains has made food safety oversight increasingly complex, while inspection capacity remains under strain. Despite these challenges, the FDA must continue to ensure the safety, effectiveness, quality, security, and availability of the products it regulates. Doing so is essential to strengthening domestic resilience, mitigating vulnerabilities, and safeguarding the public.

Ensuring Preparedness for and Response to Disasters and Public Health Emergencies

The Administration for Strategic Preparedness and Response's FY 2026–FY 2029 strategic plan emphasizes resilience before, during, and after crises and a rapid, efficient Federal response supported by secure medical supply chains. HHS faces the ongoing challenge of providing and scaling Federal support that is responsive to the needs of States, territories, Tribes, and local health partners while ensuring that data systems and supply chains reflect operational realities on the ground and enabling timely, locally informed guidance and transparent communication that strengthens public trust. HHS must continue to prioritize readiness—preparing for, responding to, and recovering from public health emergencies and disasters—to build resilience and deliver meaningful results for the American people.

Examples of OIG's Related Work

- *Medicare Part D Spending for 10 Selected Diabetes Drugs Totaled $35.8 Billion in 2023, an Increase of 364 Percent From 2019*
- *Medicaid Gross Spending on 10 Selected Diabetes and 2 Selected Weight Loss Drugs Totaled More Than $9 Billion in 2023, an Increase of 540 Percent From 2019*
- *Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder*
- *FDA Food Safety Inspections of Domestic Food Facilities*
- *The Food and Drug Administration's Foreign For-Cause Drug Inspection Program Can Be Improved To Protect the Nation's Drug Supply*
- *The Food and Drug Administration's Inspection and Recall Process Should Be Improved To Ensure the Safety of the Infant Formula Supply*

4 | Beneficiary Health and Safety

Elements of the Challenge

- Safeguarding appropriate access to necessary care
- Delivering care and services in safe settings
- Ensuring care and services by qualified staff

People receiving HHS-funded care and services should be able to trust they will be protected from preventable harm.

Safeguarding Appropriate Access to Necessary Care

Timely access to care is essential for maintaining health and preventing unnecessary suffering. HHS must address concerns that eligible individuals experience improper delays or restrictions in receiving needed services. This includes building on efforts to better protect Medicare beneficiaries from problematic patterns of denials for necessary care. It also requires ensuring that Federal health care network directories are accurate, so that patients can efficiently locate in-network providers. Barriers to appropriate and necessary care can mean eligible individuals delay or forgo treatment and suffer adverse health outcomes.

Delivering Care and Services in Safe Settings

Adverse health outcomes may also be the result of errors, substandard care, and inappropriate treatment in hospitals and other care facilities. HHS must continue strengthening its oversight to ensure that all funded care settings meet required standards. For example, nursing home residents with dementia must be better protected from being given antipsychotic drugs for staff convenience, despite warnings that these drugs may increase the risk of death. HHS has made important progress in improving nursing home safety, but continued attention and action are necessary.

Vulnerable Americans face health and safety risks in other HHS-funded settings as well. Without effective preparedness and response, these risks are exacerbated in emergency situations. HHS must do more to ensure that these settings, including child and adult care facilities and foster care placements, follow health and safety requirements and identify and quickly remediate weaknesses that put individuals at risk. A recent HHS initiative, *A Home For Every Child*, seeks to ensure that all children in foster care have a safe, permanent home. This initiative has the potential to reduce many of the preventable risks faced by children in foster care, including when they go missing from care or are placed in unlicensed settings that do not have the resources or accommodations needed to care for them safely.



Ensuring Care and Services by Qualified Staff

Many HHS-funded providers and program staff hold positions of significant trust and frequently work closely with individuals in private settings. Although the vast majority of these professionals uphold that trust and strive to deliver high-quality services, some may pose risks if not properly screened. Background checks are essential for identifying individuals who are disqualified from service or who may otherwise present a threat to people served by HHS programs.

However, gaps in compliance with background check requirements are an ongoing concern in HHS-funded programs. These gaps increase the potential for preventable harms, particularly among populations at greatest risk, including children, older Americans, and people with intellectual disabilities. The Department must remain vigilant in continuous efforts to ensure that all HHS-funded providers and other staff, in all program and service settings, meet established criteria for vetting and training.

Examples of OIG's Related Work

- *Medicare Advantage Organizations Overturned Nearly All Appealed Prior Authorization Denials for Skilled Nursing Facility Admission, Raising Concerns About Initial Denials*
- *The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates*
- *Inaccurate Medicaid Managed Care Provider Directories May Limit Enrollees' Access to Maternal Health Care*
- *Nursing Homes' Inappropriate Use of Antipsychotic Drugs Poses a Risk to Residents*
- *National Overview of State-level Challenges and Efforts To Minimize or Eliminate Temporary Emergency Placements in Foster Care*
- *The Indian Health Service Did Not Ensure That Commissioned Corps Officers' Background Investigations Complied With Federal Requirements*

5 | Technological Advancement and Cybersecurity

Element of the Challenge

- Managing risks from rapid technological innovation
- Improving cybersecurity for HHS programs, related industry sectors, and individuals

As HHS leverages technological advancements, it must ensure that people, data, and operations are protected from evolving cyber risks.

Managing Risks From Rapid Technological Innovation

Super intelligence (SI) (previously termed "artificial intelligence"), large language models, and other technologies offer meaningful opportunities to gain efficiency and improve decision making across HHS programs and operations. Rapid evolution and adoption create pressure to advance quickly, although some risks may not be fully understood or tested. HHS must ensure thoughtful adoption of technology that benefits HHS programs and their mission. Responsible adoption requires clear governance, disciplined implementation, and continuous oversight so decisionmakers can weigh benefits and risks without compromising the people served by HHS or statutory obligations. HHS's 2025 Artificial Intelligence Use Case Inventory identifies 446 use cases, some of which relate to core program responsibilities. HHS is establishing policy and Department-wide training to support secure, approved use of SI tools. Maintaining human oversight of technology choices, the risks and impacts they may introduce, and the steps to mitigate those risks will remain a continuing challenge as tools and threats evolve.

Improving Cybersecurity for HHS Programs, Related Industry Sectors, and Individuals

Cyberattacks and related threats can jeopardize critical HHS operations and programs, potentially compromising the health and welfare of the individuals HHS serves. Varying approaches to cybersecurity across divisions and programs can complicate efforts to prevent or respond to cybersecurity risks. Although HHS has taken steps to modernize and strengthen its cybersecurity posture, implementation varies across programs and HHS's overall enterprise information security program has not yet reached the desired level of effectiveness. To improve, HHS must ensure consistent implementation of strong safeguards across operating divisions.



Effective cybersecurity must also extend to the thousands of HHS contractors, grantees, and other external entities engaged by HHS programs. For many HHS programs, effective cybersecurity will depend on these parties implementing solutions that mitigate cybersecurity threats specific to their operations. Protecting technology and data requires broader efforts beyond technical fixes, such as clear expectations, modernized program rules, and effective oversight. The health care industry remains a prime target as bad actors continue to threaten patient care and critical operations. Limited resources, reliance on legacy technology, and the need to recruit and retain a skilled workforce remain constraints. HHS must maintain vigilance, rapidly communicate vulnerabilities, and help the health care industry adapt to evolving threats. Working within existing Health Insurance Portability and Accountability Act authorities, HHS must adapt oversight and enforcement to contemporary risks to the privacy and security of protected health information.

Examples of OIG's Related Work

- *HHS's Grant Payment System Lacked Effective Internal Controls To Prevent $7.8 Million in Fraud, and HHS Has Begun Taking Corrective Actions To Reduce Fraud Risk*
- *Summary Report of Prior Office of Inspector General Cyber Threat Hunt Audits of Eight HHS Operating Division Networks*
- *Settlement to Resolve False Claims Act Allegations Arising from Cybersecurity Vulnerabilities in Genomic Sequencing Systems*
- *A Large Southeastern Hospital Could Improve Certain Security Controls to Enhance Its Ability To Prevent and Detect Cyberattacks*
- *The National Institutes of Health Needs To Improve the Cybersecurity of the All of Us Research Program to Protect Participant Data*
- *HHS Office of the Secretary Needs To Improve Key Security Controls to Better Protect Certain Cloud Information Systems*

Conclusion

HHS has taken steps to address its top management and performance challenges, but further progress is needed. Leveraging its resources and opportunities for collaboration across Government and with other sectors to solve these challenges is vital to Americans' health and well-being.

Stay in Touch

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Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.



TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act of 1974, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Appendices

- Appendix A: Acronyms
- Appendix B: Connect with HHS

Appendix A: Acronyms

ACF — Administration for Children and Families
ACL — Administration for Community Living
ADA — Antideficiency Act
AFR — Agency Financial Report
AHRQ — Agency for Healthcare Research and Quality
AI/AN — American Indians and Alaska Natives
ANDA — Abbreviated New Drug Application
APTC — Advance Payments of the Premium Tax Credit
ASPR — Administration for Strategic Preparedness and Response
BARDA — Biomedical Advanced Research and Development Authority
CCDF — Child Care and Development Fund
CDC — Centers for Disease Control and Prevention
CERT — Comprehensive Error Rate Testing
CFO Act — Chief Financial Officers Act of 1990
CFRS — Consolidated Financial Reporting System
CHIP — Children's Health Insurance Program
CI — Condition Index
CMS — Centers for Medicare & Medicaid Services
COLA — Cost of Living Adjustment
COVID-19 — Coronavirus Disease 2019
CPI — Consumer Price Index
CPI-M — Consumer Price Index-Medical
CSRS — Civil Service Retirement System
CY — Calendar Year
DATA Act — Digital Accountability and Transparency Act of 2014
DM&R — Deferred Maintenance and Repairs
DNP — Do Not Pay
DOI — Department of the Interior
DOL — Department of Labor
EO — Executive Order
FASAB — Federal Accounting Standards Advisory Board
FBIS — Financial Business Intelligence System
FBwT — Fund Balance with Treasury
FDA — Food and Drug Administration
FECA — Federal Employees' Compensation Act
FERS — Federal Employees Retirement System
FFMIA — Federal Financial Management Improvement Act of 1996
FFS — Fee-For-Service
FICA — Federal Insurance Contributions Act
FMFIA — Federal Managers' Financial Integrity Act of 1982
FMSE — Financial Management Systems Environment
FR — Financial Report of the United States Government
FY — Fiscal Year
GAAP — Generally Accepted Accounting Principles
GAO — Government Accountability Office
GDP — Gross Domestic Product
G-Invoicing — Government Invoicing
GMRA — Government Management Reform Act of 1994
GPRA — Government Performance and Results Act of 1993
Grants QSMO — Grants Quality Service Management Office
GSA — General Services Administration
GTAS — Governmentwide Treasury Account Symbol Adjusted Trial Balance System
HHS — Department of Health and Human Services
HI — Hospital Insurance
HRSA — Health Resources and Services Administration
IBNR — Incurred But Not Reported
IHS — Indian Health Service
IP — Improper Payments
IRA — Inflation Reduction Act
IT — Information Technology
LPR — Lawful Permanent Resident
MA — Medicare Advantage
MDH — Medicare-Dependent Hospital
MEPS — Medical Expenditure Panel Survey
Net PTC — Net Premium Tax Credits
NIH — National Institutes of Health
NSSP — National Syndromic Surveillance Program
OACT — Office of the Actuary
OASDI — Old-Age, Survivors, and Disability Insurance
OIG — Office of Inspector General
OMB — Office of Management and Budget
OPM — Office of Personnel Management
OS — Office of the Secretary
PARIS — Public Assistance Reporting Information System
Part A — Hospital Insurance
Part B — Medical Insurance
Part C — Medicare Advantage
Part D — Medicare Prescription Drug Benefit
PBJ — Payroll-Based Journal
PERM — Payment Error Rate Measurement
PHS — Public Health Service
PIIA — Payment Integrity Information Act of 2019
PPACA — Patient Protection and Affordable Care Act

Acronyms

PP&E — Property, Plant and Equipment
PSC — Program Support Center
PSO — Patient Safety Organization
PTF — Payments to the Health Care Trust Funds
RADV — Risk Adjustment Data Validation
RPA — Robotic Process Automation
RSI — Required Supplementary Information
RY — Reporting Year
SAMHSA — Substance Abuse and Mental Health Services Administration
SCSIA — Statement of Changes in Social Insurance Amounts
SDPI — Special Diabetes Program for Indians
SECA — Self-Employment Contributions Act
SFFAS — Statement of Federal Financial Accounting Standards
SI — Super Intelligence
SIN — Special Item Number
SMI — Supplementary Medical Insurance
SNF — Skilled Nursing Facility
SNS — Strategic National Stockpile
SOSI — Statement of Social Insurance
SSA — Social Security Administration
SSF — Service and Supply Funds
SSSA — Stop Secret Spending Act of 2025
TANF — Temporary Assistance for Needy Families
TEC — Tribal Epidemiology Center
The 2015 Act — Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015
TIN — Taxpayer Identification Number
Treasury — U.S. Department of the Treasury
UFMS — Unified Financial Management System
UP — Unknown Payments
U.S. — United States
U.S.C. — United States Code

Appendix B: Connect with HHS

On behalf of the Department, we sincerely thank and acknowledge all the individuals who provided support, either through content contribution or review feedback, to produce the FY 2026 AFR. We could not have prepared this year's report without the talent, time, and dedication of employees across the Department of Health and Human Services.

Electronic copies of this report and prior years' reports are available through the Department's website. We welcome your comments on how we can make this report more informative. Please send your comments to the following address or connect with us via social media:



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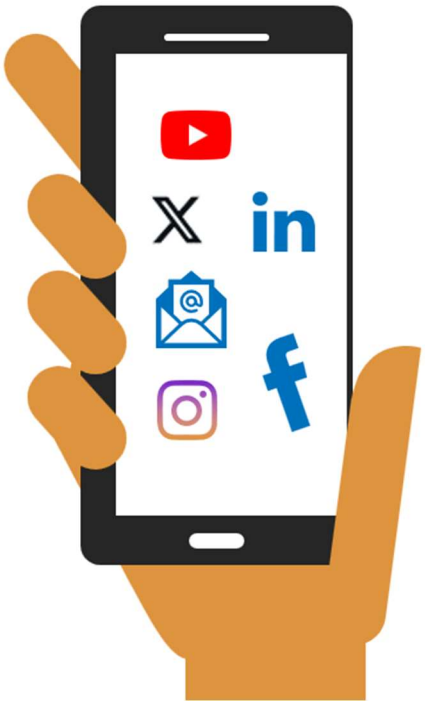
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