

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

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INVESTMENT IN HUMAN CAPITAL
For the Year Ended September 30, 2010
(in Millions)

Responsibility Segment Program	2010	2009	2008	2007	2006
Administration for Children and Families					
Administration on Developmental Disabilities	\$ 9	\$ 10	\$ 8	\$ 8	\$ 7
National Institutes of Health					
Research Training and Career Development	1,915	1,862	1,792	1,756	1,747
Totals	\$ 1,924	\$ 1,872	\$ 1,800	\$ 1,764	\$ 1,754

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

Administration for Children and Families

The ACF is able to estimate Investment in Human Capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 34 grants are anticipated to be awarded for Projects of National Significance (PNS). As of September 30, 2010, all of the 34 PNS grants have been awarded for FY 2010. PNS grants are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. These monies also support the development of national and State policy to serve this community. Grants awarded total \$9 million as of September 30, 2010.

National Institutes of Health

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

INVESTMENT IN RESEARCH AND DEVELOPMENT
As of September 30, 2010
 (in Millions)

Responsibility Segments	2010				Total				Grand Total
	Basic	Applied	Develop-mental	Total	2009	2008	2007	2006	
ACF	\$ -	\$ 9	\$ -	\$ 9	\$ 16	\$ 25	\$ 16	\$ 39	\$ 105
AHRQ	263	-	-	263	203	184	198	175	1,023
CDC	-	465	-	465	755	440	563	478	2,701
FDA	42	-	6	48	36	67	40	37	228
HRSA	-	-	-	-	-	-	-	28	28
NIH	18,805	12,537	-	31,342	27,889	27,302	26,131	25,780	138,444
Totals	\$ 19,110	\$ 13,011	\$ 6	\$ 32,127	\$ 28,899	\$ 28,018	\$ 26,948	\$ 26,537	\$ 142,529

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

Administration for Children and Families

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

Agency for Healthcare Research and Quality (AHRQ)

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

Food and Drug Administration (FDA)

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

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

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

Centers for Disease Control and Prevention (CDC)

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

National Institutes of Health (NIH)

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

REQUIRED SUPPLEMENTARY INFORMATION

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COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2010
(in Millions)

	CMS			Other Agency Budgetary Accounts ¹	Agency Combined Totals
	Medicare HI	Medicare SMI	Medicaid		
Budgetary Resources:					
Unobligated Balance, Brought Forward, Oct 1	\$ 54	\$ 54	\$ 8,163	\$ 42,107	\$ 50,378
Recoveries of Prior Year Unpaid Obligations	755	158	14,010	2,759	17,682
Budget Authority	252,321	224,644	285,272	445,889	1,208,126
Nonexpenditure Transfers, Net, Anticipated & Actual	(22)	(73)	(3,744)	3,176	(663)
Temporarily not available pursuant to Public Law	-	(11,238)	-	(58)	(11,296)
Permanently not available (-)	5	7	-	(5,309)	(5,297)
Total Budgetary Resources	\$ 253,113	\$ 213,552	\$ 303,701	\$ 488,564	\$ 1,258,930
Status of Budgetary Resources:					
Obligations Incurred	\$ 253,113	\$ 213,552	\$ 286,701	\$ 446,239	\$ 1,199,605
Unobligated Balances – Available	-	-	14,240	34,640	48,880
Unobligated Balances – Not Available	-	-	2,760	7,685	10,445
Total Status of Budgetary Resources	\$ 253,113	\$ 213,552	\$ 303,701	\$ 488,564	\$ 1,258,930
Relationship of Obligations to Outlays:					
Obligated Balance, Net	\$ 23,707	\$ 21,202	\$ 24,977	\$ 95,175	\$ 165,061
Obligations Incurred, Net (+/-)	253,113	213,552	286,701	446,239	1,199,605
Less: Gross Outlays	(252,697)	(212,466)	(269,781)	(436,178)	(1,171,122)
Less: Recoveries of Prior Year Unpaid Obligations	(755)	(158)	(14,010)	(2,759)	(17,682)
Change in Uncollected Customer Payments	54	54	-	(609)	(501)
Obligated Balance, Net, End of Period	23,422	22,184	27,887	101,868	175,361
Net Outlays	\$ 229,125	\$ (67,135)	\$ 269,009	\$ 423,108	\$ 854,107

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	\$ 59,757	\$ 59,757	\$ 55,561
AoA	1,561	1,561	1,511
AHRO	1,141	1,141	83
CDC	12,556	12,556	10,711
CMS	317,606	317,606	298,057
FDA	3,794	3,794	2,039
HRSA	9,538	9,538	8,410
IHS	6,597	6,597	4,270
NIH	41,263	41,263	32,926
OS	29,326	29,326	5,759
PSC	1,638	1,638	464
SAMHSA	3,787	3,787	3,317
	\$ 488,564	\$ 488,564	\$ 423,108

¹ "Other Agency Budgetary Accounts" includes the budgetary accounts of the 11 HHS agencies other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid. This includes budgetary resources of \$3.77 billion and net outlays of \$3.76 billion for the Vaccine for Children Program which are appropriated to the Medicaid program and transferred to the CDC.

DEFERRED MAINTENANCE
For the Years Ended September 30, 2010 and 2009

Deferred maintenance is maintenance that was not performed when it should have been, was scheduled and not performed, or was delayed for a future period. Maintenance is the act of keeping fixed assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components and other activities needed to preserve the asset so that it continues to provide acceptable services and achieves its expected life. Maintenance does not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance expense is recognized as incurred. The Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA) all use the condition assessment survey for all classes of property. The Indian Health Service (IHS) uses two types of surveys to assess installations – annual general inspections and deep look surveys.

Category of Asset (in Millions)	Condition	Estimated Cost to Return to Acceptable Condition	
		2010	2009
General PP&E			
Buildings	1 - 4	\$ 1,940	\$ 2,012
Equipment	4	12	12
Other Structures	1 - 4	34	47
Total		\$ 1,986	\$ 2,071

Asset condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A "fair" or 3 rating is considered acceptable operating condition. Although PP&E categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of "fair" or above may still report necessary costs to return them to acceptable condition.

STEWARDSHIP PROPERTY, PLANT, AND EQUIPMENT

As of September 30, 2010

The HHS has Indian Trust Lands that are considered a type of property, plant, and equipment (PP&E) for stewardship reporting purposes. Indian Trust Lands are those lands that do not meet the definition of stewardship land (i.e., land other than those acquired for or used in connection with general (capitalized) PP&E), but have always been held by IHS as separate and distinct, because of the Government's long-term trust responsibility. All Trust Lands, when no longer needed by the IHS in connection with its general use PP&E, must be returned to the Department of the Interior's Bureau of Indian Affairs, for continuing Trust responsibilities and oversight.

For the purpose of Statements of Federal Financial Accounting Standards No. 29, *Heritage Assets and Stewardship Land*, heritage assets are any real property assets that are individually listed on the National Register of Historic Places. As of September 30, 2010, IHS has no individually listed properties.

The IHS accountability reports differentiate Indian Trust Land parcels from general PP&E situated thereon. The IHS Trust Land balances are removed from the HHS FY 2010 Balance Sheet and reported as Stewardship Assets - Indian Trust Lands.

The Distribution of Stewardship Assets by Type and Area, as of September 30, 2010, is summarized below:

Distribution of Stewardship Assets by Type and Area

	Indian Trust Lands	
	Number of Sites	Total Hectares
Aberdeen	9	75
Albuquerque	4	4
Bemidji	2	9
Billings	7	48
Navajo	35	255
Oklahoma City	1	2
Phoenix	11	14
Portland	3	1
Tucson	5	12
Total	<u>77</u>	<u>420</u>

SOCIAL INSURANCE

As of September 30, 2010

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

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

RSI material is generally drawn from the *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections shown here incorporate the effects of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010*. This legislation, referred to collectively as the "*Affordable Care Act*," contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse, and initiating a major program of research and development for alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and/or reduce its costs to Medicare.

The *Affordable Care Act* improved the financial outlook for Medicare substantially, mainly as a result of permanent price update reductions for most fee-for-service providers, substantial reductions in payments to private health plans, and an increase in the Part A payroll tax rate for high-income earners. It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. These outcomes are far from certain, however, many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees report, which must be based on current law. In addition, the FASAB rules governing the Statement of Social Insurance (SOSI) also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the *Affordable Care Act*. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next three years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, the Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, where possible, the potential understatement of Medicare costs and projections results. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under this theoretical alternative to current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on this theoretical alternative to current law is provided in Note 25 in these financial statements, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

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

ACTUARIAL PROJECTIONS

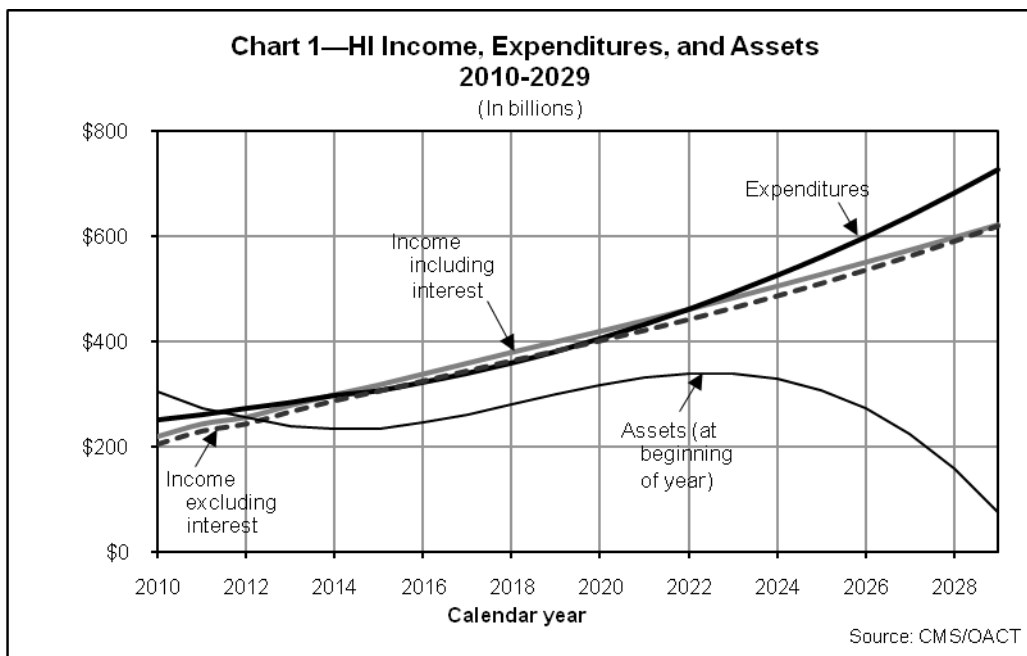
Cashflow in Nominal Dollars

Using nominal dollars for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances.² Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that can be reasonably comprehended in today's experience.

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented in this section. Instead, nominal-dollar estimates for the HI Trust Fund are displayed only through the projected date of asset depletion, currently the year 2029. Corresponding estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI Trust Fund is automatically in financial balance every year.

- *HI*

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the years 2010 through 2029, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the HI Trust Fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the "open group" population - all persons who will participate during the period as either HI taxpayers or beneficiaries, or both - and consist of payments from, and on behalf of, employees now in the workforce, as well as those who are expected to enter the workforce through 2029. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.



HI expenditures initially exceeded income in 2008. As Chart 1 shows, they are expected to continue to do so through 2013, but then are projected to fall just below income each year through 2021 under the intermediate assumptions. This situation arises due to lower expenditures and additional revenues instituted by the *Affordable Care Act*. The HI Trust Fund is estimated to again start redeeming its assets in 2022; by the end of 2029, the assets would be depleted. Despite this improvement, the HI Trust Fund does

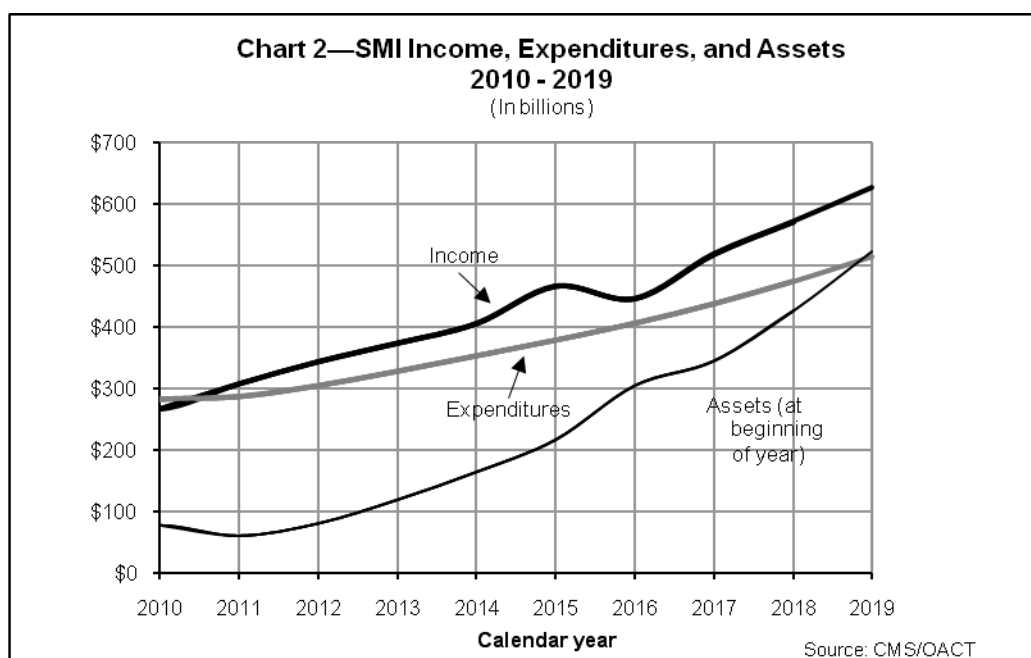
² Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

not meet an explicit test of short-range financial adequacy for the seventh year in a row, since assets are predicted to fall below expenditures within the next 10 years.

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

- *SMI*

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2010 through 2019, in nominal dollars. Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, fees related to brand-name prescription drugs, and interest earned on the U.S. Treasury securities held by the SMI Trust Fund.^{3,4} Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.⁵ Expenditures include benefit payments as well as administrative expenses.



SMI income is normally very close to expenditures because of the financing mechanism for Parts B and D. In particular, income for SMI Part B and Part D includes a combination of monthly beneficiary premiums and transfers from the general fund of the U.S. Treasury - both of which are established annually to cover the following year's expenditures. Under present law, both SMI accounts are automatically in financial balance every year, regardless of future economic and other conditions. The current-law projections shown in Chart 2 reflect the 30-percent reduction in Medicare payment rates for physician services that would be

³ Delivery of Social Security benefit checks normally due January 3, 2016 is expected to occur on December 31, 2015. Consequently, the Part B premiums withheld from the checks and the associated general revenue contributions are expected to be added to the Part B account on December 31, 2015. These amounts are excluded from the premium income and general revenue income for 2016, resulting in the income pattern shown in Chart 2.

⁴ Special payments from the States to the Part D account represent a portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. Beginning in 2011, the *Affordable Care Act* imposes fees on manufacturers and importers of brand-name prescription drugs; the revenue from these fees is allocated to the Part B account of the SMI Trust Fund.

⁵ Interest income is generally about one to two percent of total SMI income.

required in 2010-2012. Due to the high probability that these reductions will be overridden by new legislation, it is necessary to maintain a Part B contingency reserve that is much larger than normally required. The projected level of Part B income required for this purpose is significantly larger than the projected level of expenditures under current law, thus leading to the imbalance shown in Chart 2. In practice, either the physician reductions will occur (and a larger contingency reserve will be unnecessary) or, more likely, the reductions will not occur (and actual expenditures will be roughly in line with the projected income amounts shown above).

Maintaining adequate Part B premium and general revenue income, despite the impact of the premium "hold-harmless" provision, would require substantial premium increases for the roughly 25 percent of beneficiaries who are not subject to this provision. Such increases are assumed to occur, since no other mechanism is available under current law to ensure adequate income. The 2010 Medicare Trustees Report provides additional information on this issue.

HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI Trust Fund are prepared for the next 75 years. 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 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to the 2006 Trustees Report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus one percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future.

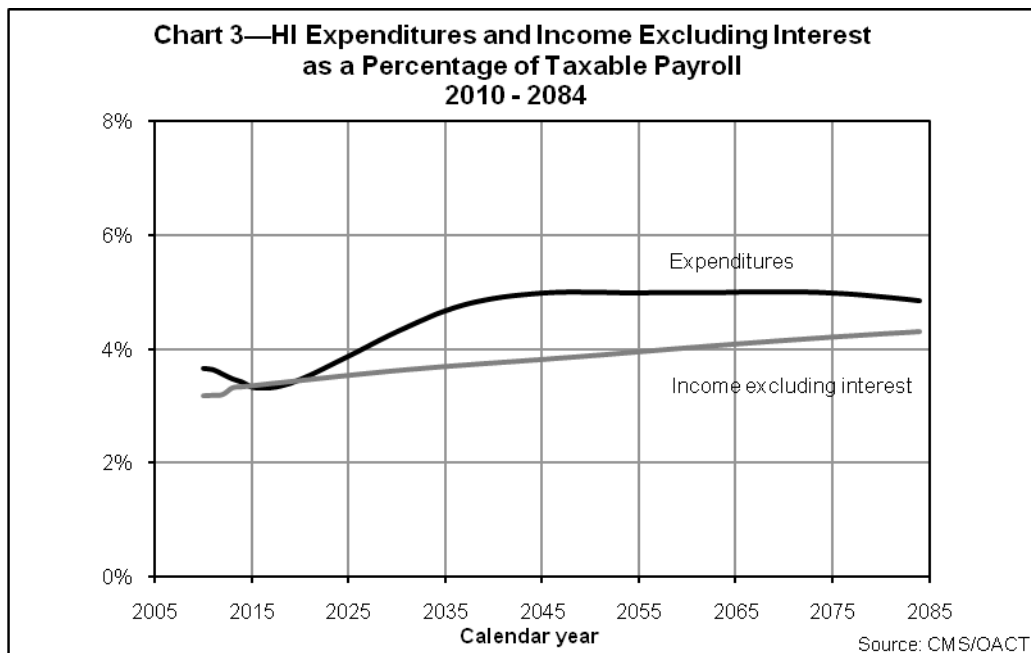
This same approach was used to establish "baseline" long-range growth rate assumptions for the 2010 Medicare Trustees Report, prior to the incorporation of the provisions in the *Affordable Care Act*. Under the Office of the Actuary's economic model, in 2034 the pre-*Affordable Care Act* growth rate for all Medicare services is assumed to be about 1.3 percentage points above the rate of GDP growth for that year (before demographic impacts). This differential gradually declines to about 0.8 percentage point in 2054 and to 0.3 percentage point in 2084. Compared to a constant "GDP plus one percent" assumption, the pre-*Affordable Care Act* baseline growth assumption is initially higher, but subsequently lower.

In order to incorporate the effects of the permanent Medicare price update reductions required by the *Affordable Care Act*, adjustments were made to the per capita growth rates produced by the economic model for Parts A and B.⁶ Since all Part A fee-for-service providers are affected, the assumed adjustment in each year is the full update reduction (1.1 percent).

For SMI Part B, only certain provider categories - for example, outpatient hospitals, ambulatory surgical centers, diagnostic laboratories, and most other non-physician services - are affected by the price update reductions. Accordingly, these services are subject to the same assumed long-range growth rate as Part A services. In contrast, Part B physician expenditures per beneficiary are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law. All other Part B outlays, which constitute an estimated 16.8 percent of total Part B expenditures in 2019, have an assumed average growth rate of per capita GDP plus 1 percent (adjusted by the economic model), as determined for the pre-*Affordable Care Act* "baseline" growth trend.

Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI Trust Fund fails this test, as it has for many years.

⁶ The price update reductions do not affect Part D, and therefore the growth assumption for this account continues to be based on the pre-*Affordable Care Act* baseline growth of GDP plus one percent, as adjusted by the economic model.



Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Under the *Affordable Care Act*, however, high-income workers will pay an additional 0.9 percent of their earnings above \$200,000 (for single workers) or \$250,000 (for married couples filing joint income tax returns) in 2013 and later. Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently, total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 3 shows, the income rate is expected to gradually increase over current levels.

As indicated in Chart 3, the cost rate will initially decline as the economy recovers from the recent recession and as the savings provisions of the *Affordable Care Act* take effect. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. If the slower price updates are not feasible in the long range, and are phased out during 2020-2034, then the HI cost rate would be 4.5 percent in 2030 and 8.9 percent in 2080. These levels are about 5 percent and 80 percent higher, respectively, than the current-law estimates under the intermediate assumptions, illustrating the very strong impact of the market basket reductions scheduled in current law.

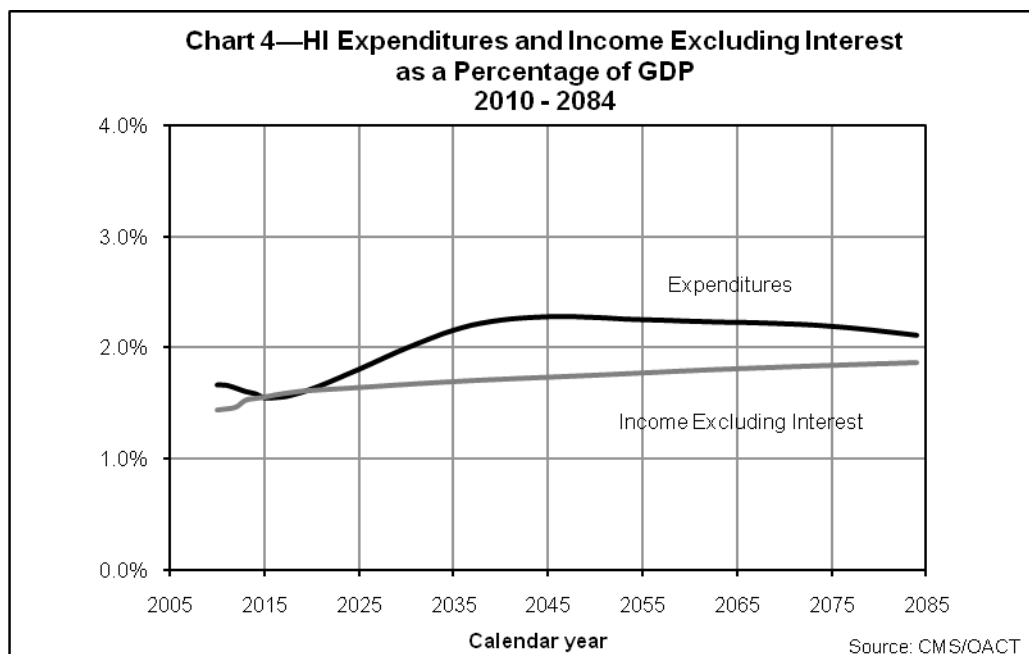
HI and SMI Cashflow as a Percentage of GDP

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

- *HI*

Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2009, the expenditures were \$242.5 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then decrease throughout the remainder of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the

illustrative alternative projections⁷, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2084.



- *SMI*

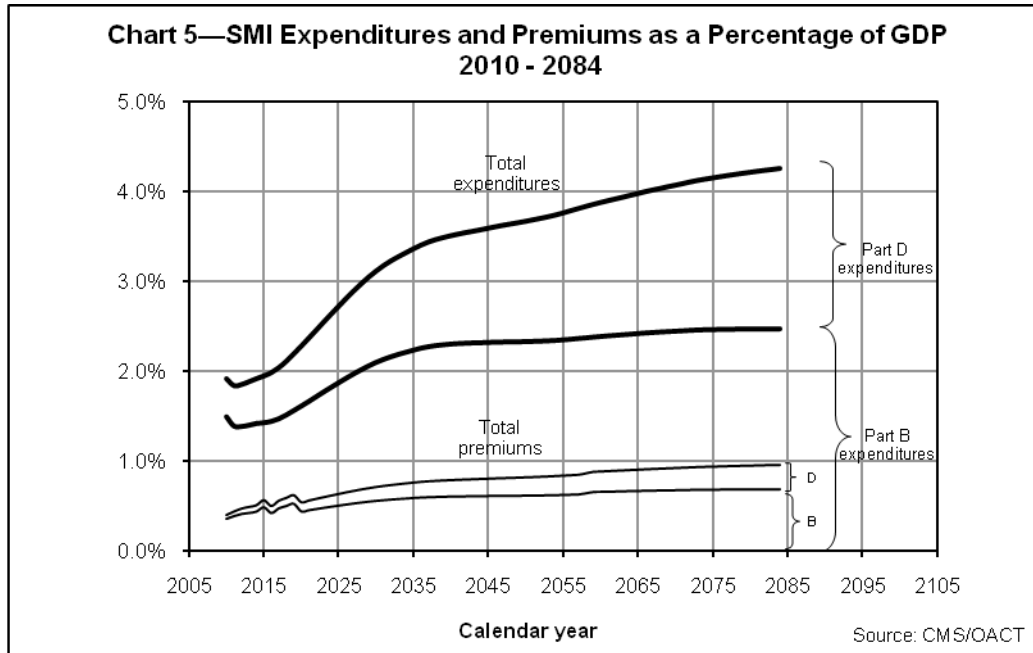
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and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

Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary incorporates the effects of the *Affordable Care Act*. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

Under the intermediate assumptions, annual SMI expenditures were \$266.5 billion, or about 1.9 percent of GDP, in 2009. Then, in about 25 years, they would grow to roughly 3.3 percent of GDP and to approximately 4.3 percent by the end of the projection period. Total SMI expenditures in 2084 would be almost 7 percent of GDP under the illustrative alternative projection⁸.

⁷ At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under this theoretical alternative to current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

⁸ At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections under this theoretical alternative to current law, which assumes that the (i) physician payment rates would be updated using the Medicare economic index, rather than through the sustainable growth rate (SGR) process; and (ii) the productivity adjustments would be gradually phased out starting in 2020. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

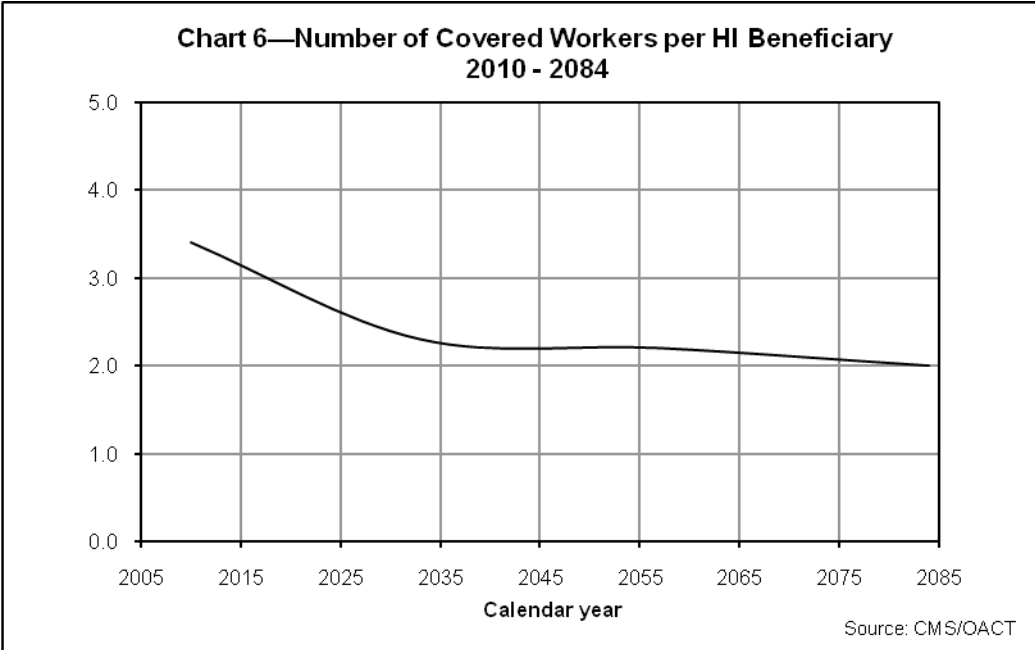


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2011 by about 4.3 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States’ forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

- *HI*

Another way to evaluate the long-range outlook of the HI Trust Fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2009, every beneficiary had 3.5 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2084.



SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions may likely differ from the projections presented here, since the future cannot be anticipated with certainty.

In order to illustrate the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.⁹ The assumptions varied are the health care cost factors, real-wage differential, consumer price index (CPI), real-interest rate, fertility rate, and net immigration.¹⁰

For this analysis, the intermediate economic and demographic assumptions in the *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2010, and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied.¹¹ The charts depicting the estimated net cashflow indicate that, for the most part, net cashflow decreases through 2084 under both the intermediate assumptions and the more pessimistic assumptions. However, under the more optimistic assumptions, net cashflow begins to increase at different times throughout the projection period, depending on the assumptions being varied. This increase is the result of the combined effect of (i) lower expenditures due to the continued provider payment update reductions required by the *Affordable Care Act*, and (ii) higher income as more and more workers become subject to the additional HI payroll tax rate, which is also mandated by the new legislation.

On the present value charts, under all three scenarios the present values initially increase, as the effects of the *Affordable Care Act* result in trust fund surpluses, and then decrease until about 2040 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

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

⁹ Sensitivity analysis is not done for Parts B or D of the SMI Trust Fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

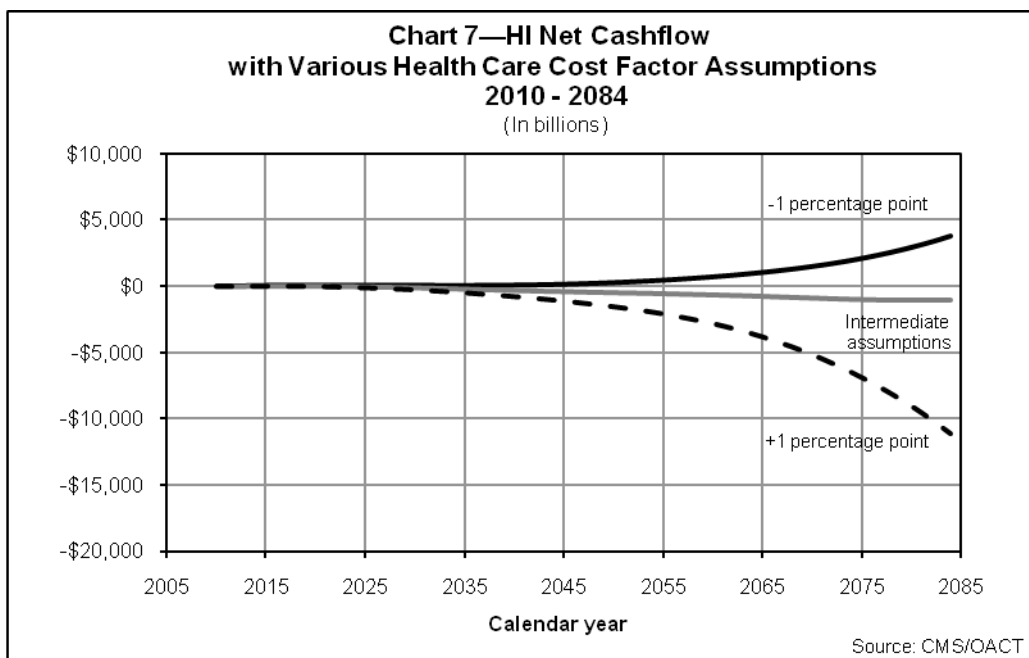
¹⁰ The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

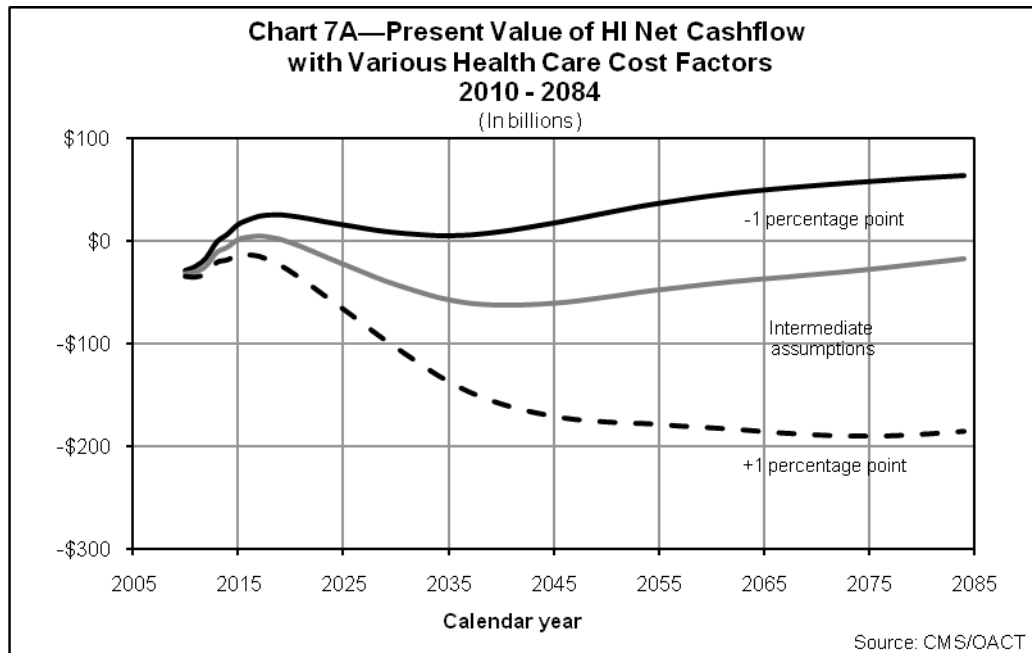
¹¹ As noted previously, long-range projections expressed in nominal dollar amounts can be very difficult to interpret, due to the changing value of the dollar over time. Amounts expressed in present values are less subject to this difficulty.

Table 1 demonstrates that if the ultimate growth rate assumption is one percentage point lower than the intermediate assumptions, the deficit decreases by \$4,829 billion. On the other hand, if the ultimate growth rate assumption is one percentage point higher than the intermediate assumptions, the deficit increases substantially, by \$7,663 billion.

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)	\$2,146	\$(2,683)	\$(10,346)

Charts 7 and 7A show projections of the net cashflow in nominal and present value dollars, respectively, under the three alternative annual growth rate assumptions presented in Table 1.





This assumption has a dramatic impact on projected HI cashflow. The net cashflow under the ultimate growth rate assumption of one percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI Trust Fund as a result of the *Affordable Care Act*. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 7 and 7A indicate, the financial status of the HI Trust Fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

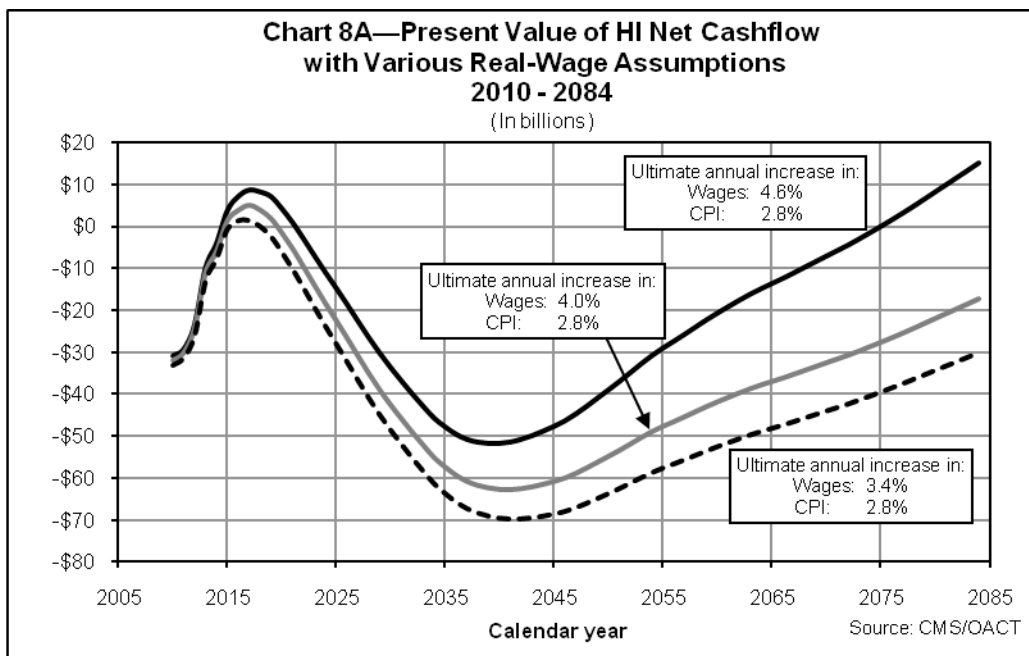
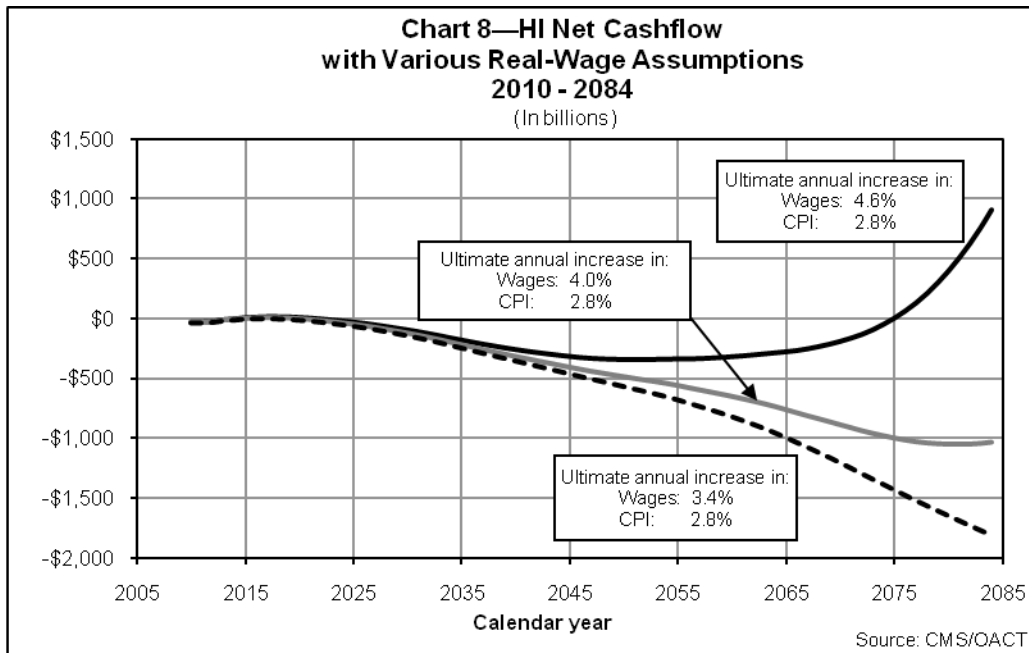
Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.¹² In each case, the ultimate CPI increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 4.0, and 4.6 percent, respectively.

	3.4 - 2.8	4.0 - 2.8	4.6 - 2.8
Ultimate percentage increase in wages - CPI	3.4 - 2.8	4.0 - 2.8	4.6 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	\$(3,284)	\$(2,683)	\$(1,507)

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit - expressed in present-value dollars - increases by approximately \$740 billion.

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

¹² The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.



As illustrated in Charts 8 and 8A, faster real-wage growth results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. These results are different than in past reports mainly due to the much closer financial balance under the *Affordable Care Act*. In prior reports, the deficit was increased under the higher real-wage assumptions on both a nominal-dollar and present-value basis, since the dollar impact on expenditures was higher than the dollar impact on income. This is not the case with this year's projections because (i) expenditures are substantially reduced from last year due to the continued payment update reductions for all HI fee-for-service providers that are required by the new legislation, and (ii) income is higher than last year's projection as a result of the additional HI tax rate for high-income earners, which is also required by the

Affordable Care Act. This reversal in the direction of the impact of higher real-wage growth illustrates a limitation of the use of nominal or present-value cashflows as a measure of financial status; in practice, faster real-wage growth always improves the financial status of the HI Trust Fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI Trust Fund under the *Affordable Care Act* depends on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong likelihood that certain of these changes will not be viable in the long range. Specifically, the annual price updates for most categories of non-physician health services will be adjusted downward each year by the growth in the economy-wide productivity.

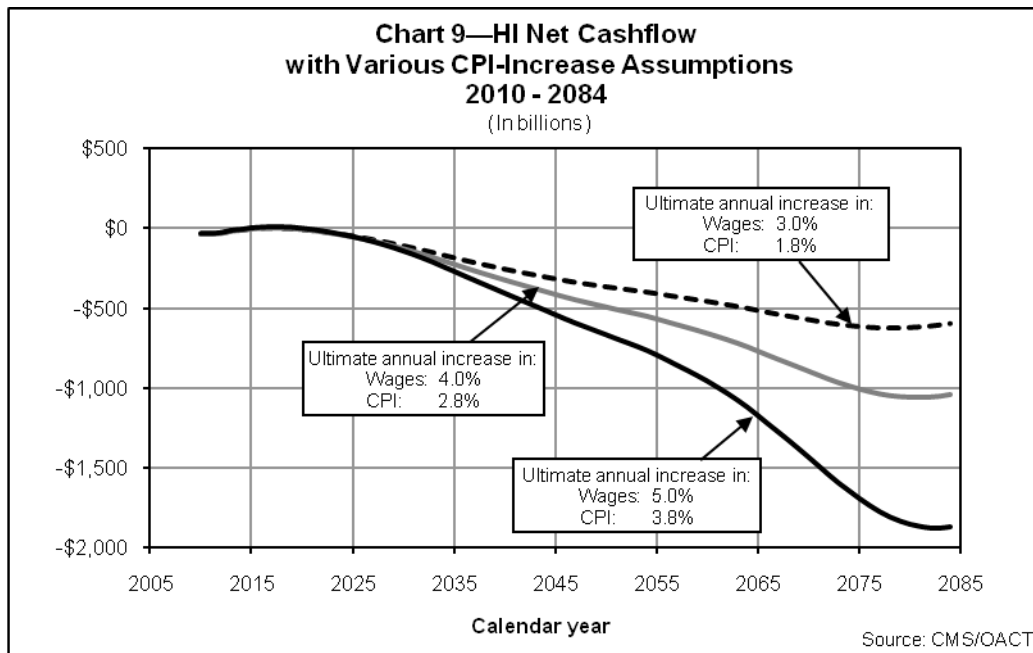
Consumer Price Index

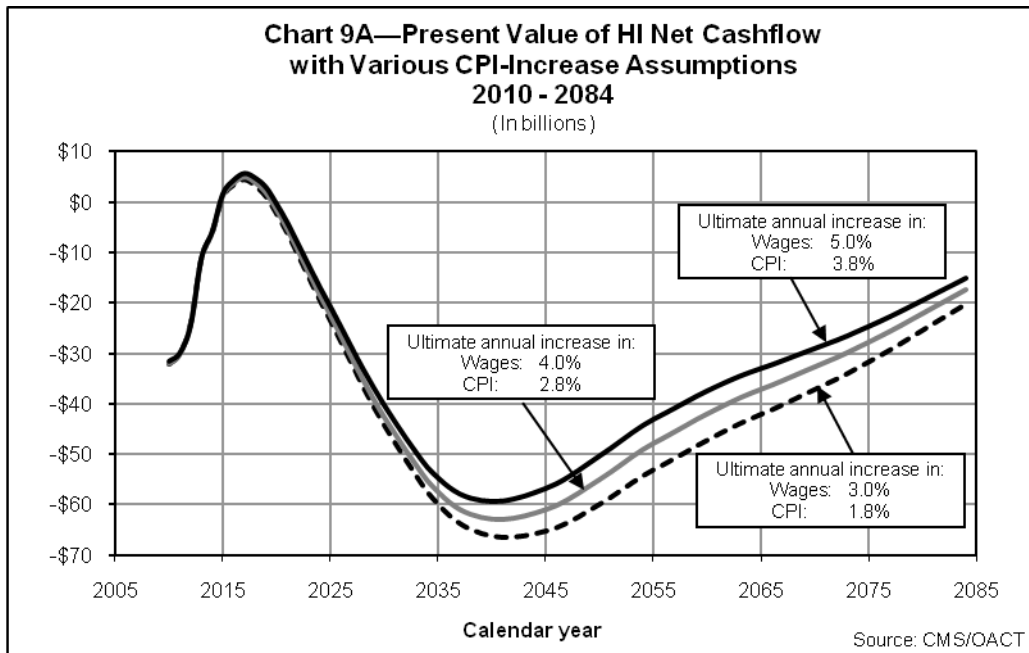
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.2 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.0, 4.0, and 5.0 percent, respectively.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions			
Ultimate percentage increase in wages - CPI	3.0 - 1.8	4.0 - 2.8	5.0 - 3.8
Income minus expenditures (in Billions)	\$(2,924)	\$(2,683)	\$(2,466)

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by \$241 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by \$217 billion.

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





As Charts 9 and 9A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars and a much smaller impact when the cashflow is expressed as present values. For the nominal cashflow, Chart 9 appears to suggest that the outlook for the HI Trust Fund worsens substantially with faster CPI growth. In practice, however, higher or lower long-term trends in inflation have only a modest impact on the financial status of the trust fund. Moreover, the impact is in the opposite direction of that suggested by the nominal cashflow sensitivity. In this instance, the results expressed in nominal dollar terms do not reveal the full implications of faster or slower growth in inflation. That is, under high-inflation conditions, a given deficit “looks bigger” in nominal dollars but is much smaller when expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the *Affordable Care Act* for workers with earnings above \$200,000 or \$250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice-versa.

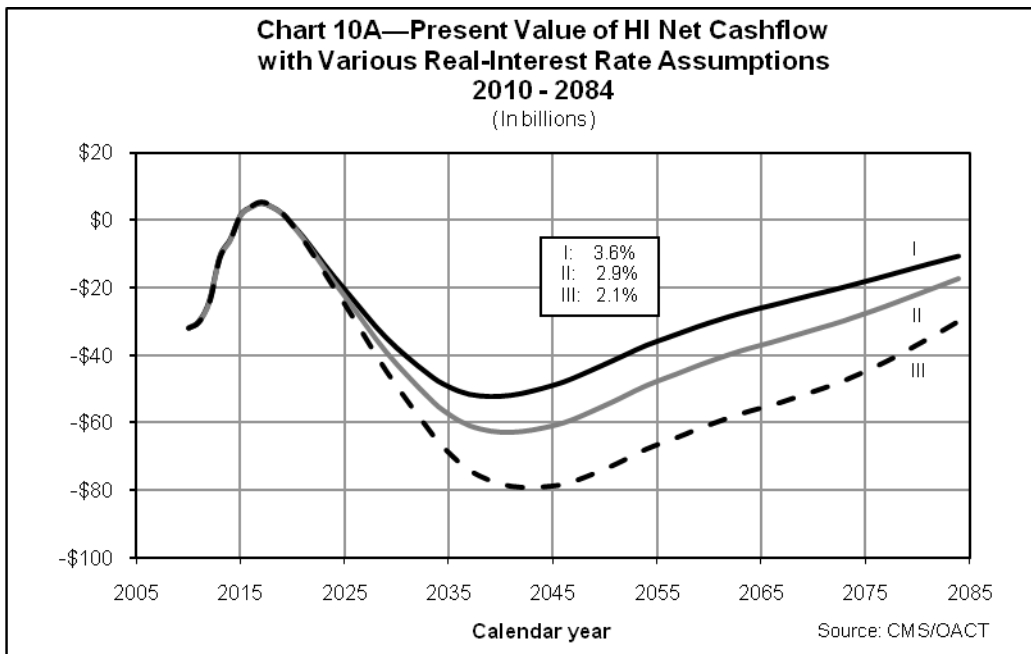
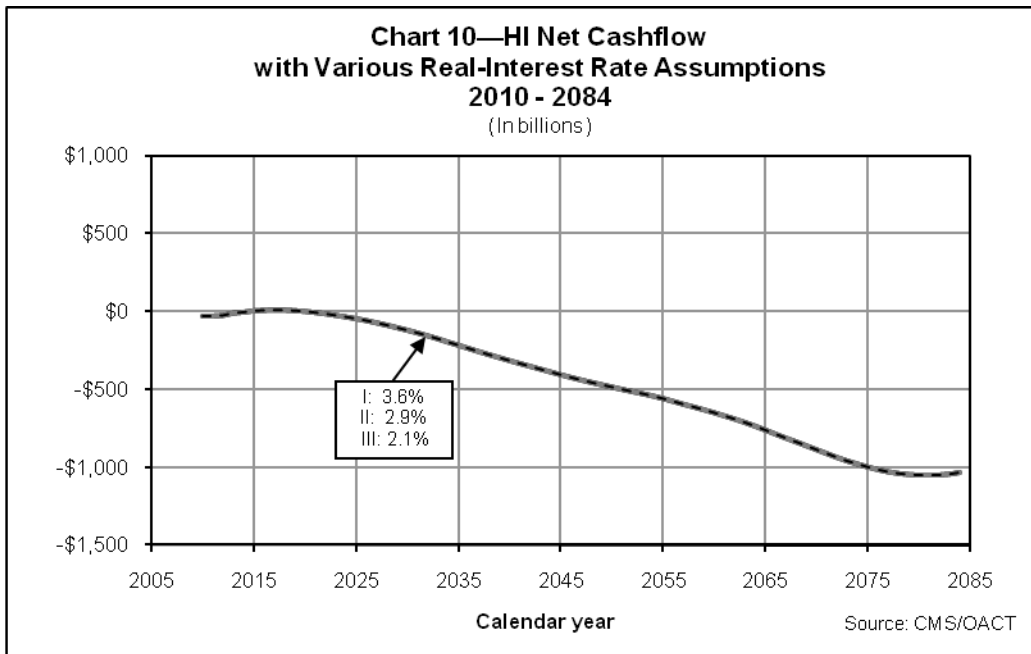
Real-Interest Rate

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

Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions			
Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures (in Billions)	\$(3,603)	\$(2,683)	\$(2,107)

As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately \$100 billion.

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



As shown in Charts 10 and 10A, the projected HI cashflow when expressed in present values is more sensitive to the interest assumption than when it is expressed in nominal dollars. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI Trust Fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2029. 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.

Compared to past reports, however, the sensitivity of present values to different real-interest rate assumptions is substantially reduced as a result of the *Affordable Care Act*. Under the new legislation, annual deficits would decrease due to the compounding effects of the price update reductions for HI fee-for-service providers. Discounting a relatively level series by high or low interest factors has much less effect than when the series is increasing rapidly, as with the pre-*Affordable Care Act* projections.

Fertility Rate

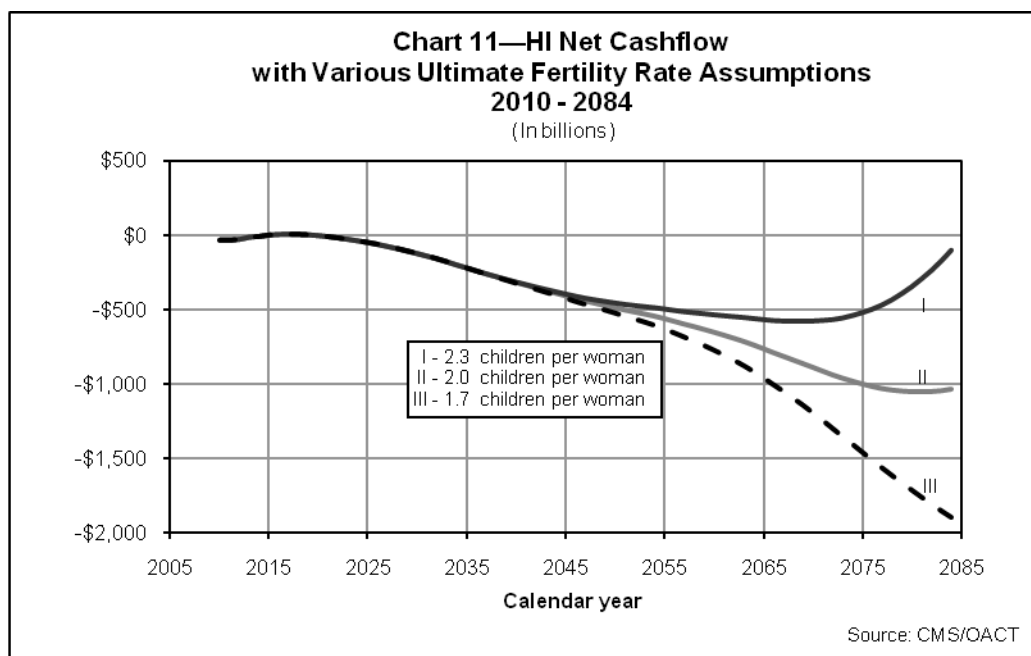
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

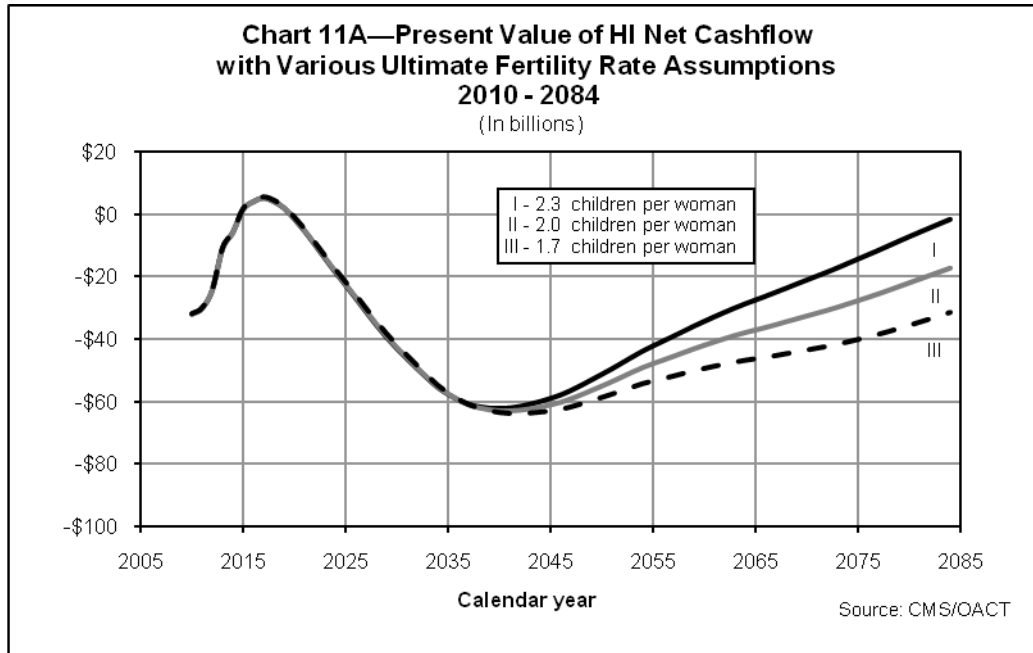
Table 5—Present Value of Estimated HI Income Less Expenditures Under Various Fertility Rate Assumptions			
Ultimate fertility rate ¹	1.7	2.0	2.3
Income minus expenditures (in Billions)	\$(3,035)	\$(2,683)	\$(2,308)

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

As Table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately \$360 billion.

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





As Charts 11 and 11A indicate, the fertility rate assumption has a fairly large impact on projected HI cashflows. This result is different than in past reports mainly due to the additional HI tax on high-income earners required by the *Affordable Care Act*. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on both a nominal- and present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit.

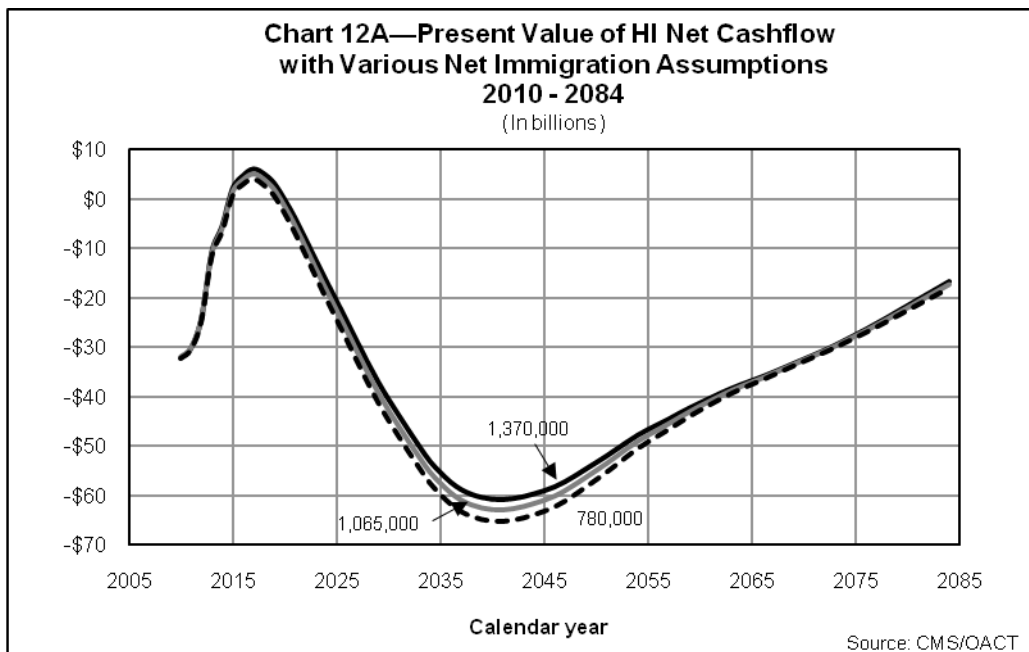
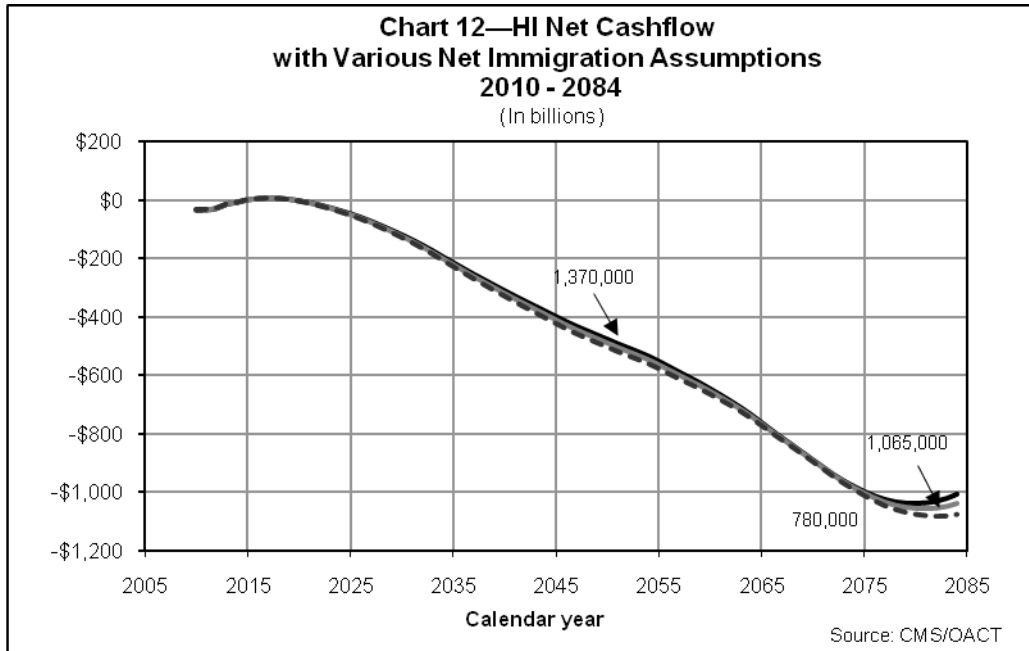
Net Immigration

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 780,000 persons, 1,065,000 persons, and 1,370,000 persons per year.

Average annual net immigration	780,000	1,065,000	1,370,000
Income minus expenditures (in billions)	\$(2,774)	\$(2,683)	\$(2,605)

As indicated in Table 6, if the average annual net immigration assumption is 780,000 persons, the deficit - expressed in present-value dollars - increases by \$91 billion. Conversely, if the assumption is 1,370,000 persons, the deficit decreases by \$78 billion.

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



As illustrated in Charts 12 and 12A, higher net immigration results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

These results are different than in past reports mainly due to the various provisions in the *Affordable Care Act*. In prior reports, the deficit was increased under the higher-net immigration assumptions on both a nominal-dollar and present-value basis, since the cost of HI benefits for the additional participants was substantially greater than their HI taxes. This is not the case with this year's projections because (i) expenditures are substantially reduced from last year due to the continued payment update reductions

for all HI fee-for-service providers required by the *Affordable Care Act*, and (ii) income is higher than last year's projection as a result of the additional HI tax for high-income earners, which is also mandated by the new health-reform law. As shown in the SOSI, the value of the additional HI payroll taxes paid by new participants in the future, on average, will be greater than the cost of their benefits, assuming that the lower HI price updates can be continued indefinitely. As noted previously, there is a significant likelihood that the reductions in Medicare provider payment updates will not be feasible indefinitely.

TRUST FUND FINANCES AND SUSTAINABILITY

HI

The financial status of the HI Trust Fund is substantially improved by the lower expenditures and additional tax revenues instituted by the *Affordable Care Act*. These changes are estimated to postpone the exhaustion of trust fund assets from 2017 under the prior law to 2029 under current law. Despite this significant improvement, however, the fund is still not adequately financed over the next 10 years. HI expenditures have exceeded income annually since 2008 and are expected to continue to do so under current law through 2013 and again after 2021. The shortfalls can be met with increasing reliance on the redemption of trust fund assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI Trust Fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security Trust Fund to become fully depleted.

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

The HI Trust Fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. These changes are needed partially as a result of the impending retirement of the baby boom generation. If the productivity adjustments to HI provider price updates cannot be continued in the long run, then the actuarial deficit would be much greater.

SMI

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

The financing established for the Part B account for calendar year 2010 is adequate to cover 2010 expected expenditures and to maintain the financial status of the account in 2010 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not feasible. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than previously estimated, primarily due to lower assumed growth rates for prescription drug expenditures in the U.S. overall.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. Such financing, however, would have to increase faster than the economy to match expected expenditure growth under current law. Absent legislation, it will probably be necessary to significantly raise Part B premiums for a subset of beneficiaries in 2011 and 2012 to ensure adequate program financing. A critical issue for the SMI Trust Fund continues to be the impact of the past and expected rapid growth of SMI costs, which place gradually increasing demands on beneficiaries, the Federal Budget, and society at large.

Medicare Overall

The *Medicare Modernization Act* requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total

Medicare outlays within the next 7 fiscal years (2010-2016).¹³ This difference first exceeded 45 percent of total expenditures at the end of calendar year 2009 and is expected to do so in fiscal year 2010, which is the first year of the 7-year test period. Consequently, the Trustees issued a determination of projected “excess general revenue Medicare funding,” as required by law. Similar determinations were made in their 2006-2009 annual reports to Congress. With this fifth consecutive finding, another “Medicare funding warning” is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning. Congress is then required to consider this legislation on an expedited basis.¹⁴ This requirement helps to call attention to Medicare’s impact on the Federal Budget.

The Medicare financial projections shown in this section represent a substantial, but very uncertain, improvement over those in recent years because of the far-reaching provisions of the *Affordable Care Act*. In the long range, much of this improvement depends on the feasibility of the *Affordable Care Act*’s downward adjustments to future increases in Medicare prices for most categories of health care providers. Although these projections show substantially improved results over last year’s, they continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected exhaustion of the HI Trust Fund, this fund’s long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare are overridden, the financial challenges in the long range would be much more severe. In their 2010 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation’s policymakers to take “prompt action ... to address these challenges.” They also stated: “Consideration of ... further reforms should occur in the near future.”

¹³ Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare Trust Funds.

¹⁴ In January 2009, the House of Representatives passed a resolution (H. Res.5, section 3(e)) stating that section 803 of the Medicare Modernization Act, governing action required by the House in response to a funding warning, would not apply to the 111th Congress.