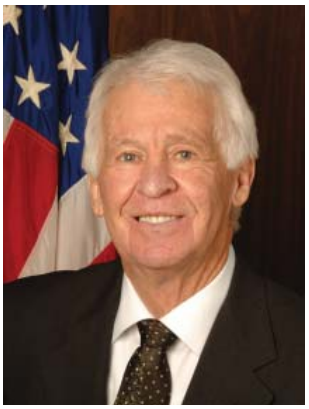
Section II: Financial

FY 2007 Agency Financial Report


Charles E. Johnson

Message From the Chief Financial Officer

As the Chief Financial Officer of the Department of Health and Human Services (HHS), I recognize that our Department is accountable to our ultimate stakeholders—the American Public. We are vigilant to use taxpayer resources wisely to carry out the Department's mission to enhance the health and well-being of Americans. With net outlays in excess of $650 billion in fiscal year (FY) 2007, we are one of the largest, most complex financial organizations in the world. Incorporating the tenets of the President's Management Agenda (PMA) into our daily routines is central to our continued success in accomplishing ambitious goals and delivering on the promise of the PMA.

This year, we have chosen to participate in the FY 2007 Office of Management and Budget's (OMB) pilot approach to improving performance and accountability reporting. Pursuant to OMB Circular A-136, Financial Reporting Requirements, this *Agency Financial Report* represents the accountability report for FY 2007. The *FY 2007 Performance Report* and *FY 2009 Performance Plan* will be included as part of our *Congressional Budget Justification* due to the Congress on February 4, 2008. As part of this pilot approach, we will also produce a "Highlights" document, which will be available at www.hhs.gov on February 4, 2008. HHS anticipates that this approach will make information more transparent and useful to the President, Congress and American people.

This report also contains our audited annual financial statements. For the ninth year in a row, I am pleased to report that our independent auditors have issued an unqualified or "clean" opinion.

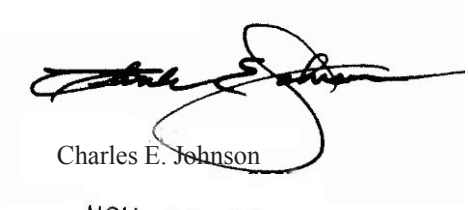
During FY 2007, the Department successfully sustained its standards for reporting and management controls. We have improved our reporting processes and successfully performed our second internal control assessment as required by OMB Circular A-123, *Management's Responsibility for Internal Control*. The Secretary's annual Statement of Assurance reflecting the results of our assessment is presented in Section I of this report.

With respect to our financial reporting capabilities, the Department successfully executed the next stage implementing our Unified Financial Management System (UFMS). In this phase of the system implementation, we now have all but one operating division reporting from UFMS. The last operating division was successfully converted to UFMS during the month of October 2007, and we will be completing our efforts with the implementation of the consolidated reporting solution at the end of fiscal year 2008. Key to this year's accomplishment was the full deployment of Federally mandated Treasury Reporting.

The independent auditors' report identifies material weaknesses that must be corrected relating to: (1) financial reporting systems and processes, (2) budgetary accounting, (3) financial management information systems, and (4) Medicare claims processing controls. The primary catalyst for addressing our financial reporting systems and processes, and budgetary accounting deficiencies is the full implementation of UFMS, most of which has been completed. We still have significant financial reporting and budgetary accounting process improvements necessary to resolve the noted weaknesses.

In addition, Financial Management Information System and Medicare claims process weaknesses were identified as material weaknesses relating to electronic data processing vulnerabilities identified in the Department and contractors. In addition to implementing UFMS, the Department continues a program to implement FFMIA-compliant systems at Medicare contractors by 2010. The Department recognizes the importance of effective internal control and is committed to resolving these material weaknesses promptly.

Finally, I want to thank our employees and partners – who work each day to achieve our Nation's noblest human aspirations for safety, compassion, and trust. This report -- and the accomplishments it describes -- is a reflection of their extraordinary dedication to our mission. Together we look forward to tackling our ambitious agenda for the future in 2008.



Charles E. Johnson

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Audit Reports

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Office of Inspector General Transmittal

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

NOV 14 2007

TO: The Secretary

Through: DS _____

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FROM: Inspector General

SUBJECT: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2007 (A-17-07-00001)

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2007 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (Public Law 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 PricewaterhouseCoopers, LLP (PwC), to audit the HHS consolidated balance sheet as of September 30, 2007, and the related consolidated statements of net cost and changes in net position, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2007. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, Audit Requirements for Federal Financial Statements.

Results of Independent Audit

Based on its audit, PwC found that the FY 2007 HHS financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. However, PwC noted four matters involving internal controls over financial reporting that were considered to be material weaknesses under standards established by the American Institute of Certified Public Accountants:

- *Financial Reporting Systems and Processes.* HHS continued to have serious internal control weaknesses in its financial management systems and reporting processes. Substantial manual procedures, numerous adjusting entries, and untimely and incomplete reconciliations and accrual processes hindered its ability to produce timely and reliable financial statements. HHS's financial management systems did not substantially comply with Federal financial management systems requirements or the U.S. Government Standard General Ledger at the transaction level.

- *Budgetary Accounting.* HHS lacked sufficient controls over its accounting and business processes to ensure that budgetary transactions were properly recorded, monitored, and reported. Management routinely used high-level analysis to develop adjustments and to derive budgetary balances for financial reporting purposes. Improved procedures are needed to ensure accurate reporting of the status of budgetary resources.

- *Financial Management Information Systems.* General control issues in both the design and the operation of key controls were noted. Of particular concern was the lack of pervasive information technology security standards for areas such as security settings on platforms, policies regarding the control and use of passwords, and policies regarding control over changes to applications.

- *Medicare Claim-Processing Controls.* Although improvements were made, HHS continued to have weaknesses in the Centers for Medicare & Medicaid Services (CMS) Medicare claim-processing controls. Concerns related primarily to direct update access to Medicare

claim data, controls over edit settings in application systems, controls governing the use of supplemental software used to process claims, and lack of CMS oversight of contractor compliance with internal control requirements.

Evaluation and Monitoring of Audit Performance

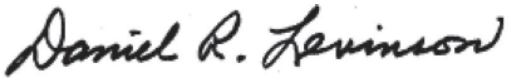
In accordance with the requirements of OMB Bulletin 07-04, we reviewed PwC's audit of the HHS financial statements by:

- 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 related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

PwC is responsible for the attached reports dated November 14, 2007, and the conclusions expressed in the 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 HHS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which PwC did not comply, in all material respects, with U.S. generally accepted government auditing standards.

Page 4 – The Secretary

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-07-00001.



Daniel R. Levinson

Attachment

cc:
Charles E. Johnson
Assistant Secretary for Resources and Technology

Sheila Conley
Deputy Assistant Secretary, Finance

Report of Independent Auditors

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Report of Independent Auditors

To the Secretary of the Department of Health of Human Services and the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Department of Health and Human Services (HHS) as of September 30, 2007 and 2006, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the years then ended, and the statements of social insurance as of January 1, 2007 and 2006. These financial statements are the responsibility of HHS's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits 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 No. 07-04, *Audit Requirements for Federal Financial Statements*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above, present fairly, in all material respects, the financial position of HHS as of September 30, 2007 and 2006, and its net cost of operations, changes in net position and budgetary resources for the years then ended, and its social insurance program as of January 1, 2007 and 2006, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, the Office of Management and Budget has exempted HHS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*. Specifically, for the Medicare program, HHS is exempted from reporting refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that HHS report all Medicare cash collections as an offsetting receipt.

As discussed in Note 27 to the financial statements, the statements of social insurance present the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust

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funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statements of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statements. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates.

As discussed in Note 28 to the financial statements, the projected SMI Part B expenditure growth reflected in the statement of social insurance as of January 1, 2007 (the "2007 SOSI") is likely understated due to the structure of physician payment updates, which under current law would result in multiple years of significant reductions in physician payments, totalling an estimated 41 percent over the next nine years. Since these reductions are required in the future under the current-law payment system, they are reflected in the 2007 SOSI as required under generally accepted accounting principles. However, in practice it is not possible to anticipate what actions Congress might take, either in the near or long term, to alter the physician payment updates. For example, Congress has overridden scheduled reductions in physician payments for each of the last five years. The potential magnitude of the understatement of Part B expenditures, due to the physician payment updates can differ materially from the amount presented in the 2007 SOSI. In Note 28, management has illustrated the potential effects using two hypothetical examples of changes to current law. Under current law and as presented in the 2007 SOSI, the projected 75-year present value of future Part B expenditures is $18.2 trillion. In management's hypothetical examples, if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.6 trillion. Alternatively, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $25.4 trillion. Management's hypothetical examples have not been audited, and accordingly, we express no opinion on them.

The Management's Discussion and Analysis (MD&A), Required Supplementary Stewardship Information (RSSI) and Required Supplementary Information (RSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Circular A-136, *Financial Reporting Requirements.* We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A, RSSI and RSI. However, we did not audit the information and express no opinion on it.

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Our audits were conducted for the purpose of forming an opinion on the consolidated and combined financial statements of HHS taken as a whole. The additional information presented on the statements of social insurance as of January 1, 2007 and 2006, is presented for purposes of additional analysis and is not a required part of the consolidated or combined financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The other accompanying information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards,* we have also issued reports dated November 14, 2007 on our consideration of HHS's internal control and a report dated November 14, 2007on its compliance and other matters for the year ended September 30, 2007. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audits.

PricewaterhouseCoopers LLP

November 14, 2007

Report on Internal Control

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Report of Independent Auditors on Internal Control

To the Secretary of the Department of Health and Human Services and the Inspector General of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2007 and the statement of social insurance for the year ended January 1, 2007, and have issued our report dated November 14, 2007. We conducted our audit 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 No. 07-04, *Audit Requirements for Federal Financial Statements.* The management of HHS is responsible for maintaining effective internal control over financial reporting.

In planning and performing our audit, we considered HHS's internal control over financial reporting by obtaining an understanding of the design effectiveness of HHS's internal control, determining whether these controls had been placed in operation, assessing control risk, and performing tests of HHS's controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal controls. Accordingly, we do not express an opinion on the effectiveness of the HHS's internal control over financial reporting.

We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and assets are safeguarded against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in compliance with laws governing the use of budget authority, government-wide policies and laws identified in Appendix E of OMB Bulletin No. 07-04, and other laws and regulations that could have a direct and material effect on the financial statements; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982.

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A control deficiency 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 misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects HHS's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of HHS's financial statements that is more than inconsequential will not be prevented or detected by HHS's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by HHS's internal control. Our consideration of internal control was for the limited purpose described in the second paragraph of this report and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We noted eight matters, discussed below, involving the internal control and its operation that we consider to be significant deficiencies (of which four are considered to be material weaknesses).

Material Weaknesses

I. Financial Reporting Systems and Processes

I.1 *Coordination and Communication*

HHS lacks a coordinated end-to-end process among cross-functional teams of financial management, information technology, actuarial and operations personnel to monitor business activities and identify those situations where accounting evaluation or decision-making may be necessary. The lack of coordination led to the following:

I.1.1 *Prescription Drug Program Accrual*

In FY 2006, HHS implemented the Part D Drug Program. The implementation of the new program created an enormous challenge for the agency, not only on the programmatic side but also for accounting challenges, that continues today. Management continues to identify and implement processes and controls to enable the agency to reflect the accounting impact of this complex and challenging program within their financial statements.

Throughout the plan contract year (calendar year), HHS makes prospective payments to the Part D plans. In general, the payment amounts are based on information in the approved plan bids, which includes the plans' estimate of direct and indirect remuneration, and on data provided by HHS that updates payments throughout the year.

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Subsequent to the contract year, HHS is required to reconcile the prospective Part D plan payments made during the year to actual drug costs incurred by the plans. Because the Part D program commenced operations in January 2006, the fiscal year ended September 2007 is the first year of the reconciliation. An accrual as of September 2007 was recorded on the books that included the contract year reconciliation (Calendar Year 2006) and estimated payable/receivables covering the fiscal year under audit.

In order to calculate the CY 2006 accruals, HHS developed a mechanism to obtain actual drug cost data from the plans, the Payment Reconciliation System (PRS), to automate the reconciliation process - including robust system documentation - and a SAS program to validate the calculation performed by the PRS system. The systems used to obtain actual drug data from the plans include edit checks that reject invalid data. In addition, management performs several outlier and analytical analyses to ensure the validity of the PRS results including analysis over the DIR amounts submitted by the plans.

The estimated accrual for the period of January 2007 to September 2007 was developed by actuarial analysis. HHS refined the methodology used during FY 2006 to better reflect the cyclical nature of the accrual, documented the methodology used to develop the estimate and retained appropriate evidence of the calculation.

The Part D reconciliation and accrual process, for all intended purposes, was a new process for HHS. This new process has not yet been fully developed and therefore; faced the following challenges during the current year.

- Validation of Actual Drug Costs and Direct and Indirect Remuneration (DIR)
  HHS does not currently have a monitoring control in place to ensure the accuracy of the prescription drug data (PDEs) submitted by the plans which forms the basis for the reconciliation. HHS relies on the plans to certify the accuracy of this data. Unsupported or erroneous drug cost data submitted by the plans could lead to inaccuracies within the reconciliation and erroneous payments.

  Similarly, HHS does not currently have monitoring controls in place to ensure the completeness and accuracy of the DIR information (commonly referred to as rebates). Management acknowledges the importance of complete and accurate DIR information due to the significant impact that it has on reimbursements to the plans.

- Timing of Estimate Development
  As of July 2007, HHS had not calculated the 2006 contract year reconciliation which would cover the period of January 2006 to December 2006, nor had HHS calculated the estimated accrual for the period of January 2007 to June 2007. The lack of timely calculation of the estimate resulted in inaccurate reporting within the interim financial statements.

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- Documentation of the Estimation Process
  HHS documented the procedures used to develop the 2006 Part D reconciliation within their Part D cycle memo; however, procedures and related controls to develop the FY 2007 Part D estimate, including the estimate related to invalidly rejected PDE data, was not documented within this memo. The calculation of the FY 2007 estimate was based upon an actuarial analysis. The methodology used by HHS to develop this estimate was significantly different from what was used during the prior fiscal year. In addition, as of September 2007, the methodology used by management to develop the estimate related to invalidly rejected PDE data and related controls had not been documented.

  Although all the elements of the estimate were eventually documented, all relevant controls have not yet been documented. According to OMB Circular A-123 *Implementation Guide* the level of detail of documentation should ensure management understands the entire financial reporting process and can identify how processes relate to financial reporting assertions, potential errors or misstatements, and control objectives.

I.1.2 *Obsolete Reports/Lack of Data*

With the Medicare Contractors transition to HIGLAS, HHS no longer requires the contractors to report certain data. This data which was collected in the Fiscal Intermediary Benefit Payment Report (IBPR) via the Contractor Administrative Budget and Finance Management (CAFM) systems is no longer available for those contractors who have implemented HIGLAS, which resulted in the following:

- Impact on the Statement of Social Insurance (SOSI):
  The IBPR provided data used by HHS to develop aspects of the SOSI projection. A total of six SOSI data sources and one validation source previously provided by the IBPR are no longer reported by contractors who have transitioned to HIGLAS. HHS was able to find suitable replacements for three of the data sources; however; it has not yet identified an appropriate source of data for the remaining three sources and for the validation source. Although the lack of data sources does not pose a significant risk to the current year SOSI calculation, because of the nature of the projection, the risk could increase on future projections.

- Entitlement Benefit Due and Payable Liability:
  The Entitlement Benefit Due and Payable Liability line item on the balance sheet is mainly composed of an estimate of claims incurred but not reported (IBNR). A key report used by HHS in the calculation of the IBNR liability is the National Claims History (NCH) processing report. Before this report is considered reliable and appropriate for use, management performs certain analytical procedures between the data in the report and data obtained from CMS-456 Intermediary Benefit Payment Report. However, since the CMS-456 report was produced from the CAFM system and is no longer submitted by those contractors that transition to HIGLAS, the appropriate NCH processing

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report validation procedures were not performed. In response to the issue, management has created a special HIGLAS query to generate the data previously reported by the CMS-456 report for the contractors under HIGLAS and is in the process of identifying an appropriate NCH processing report validation source.

I.2 *Controls Over Trust Fund Draws*

In order to ensure amounts drawn from the HI and SMI trust funds are accurate and complete, management reconciles "cash" payment amounts recorded by HHS and the Department of the Treasury with the corresponding "incurred" claims amounts from Medicare claims data. However, this reconciliation is not performed at a level that allows management to detect errors timely.

The lack of a reconciliation at this level affected HHS's ability to identify that payments for hospice services were incorrectly being drawn from the Part B SMI trust fund. Because Hospice care is covered only under Part A of the Medicare program, these payments should have been drawn from the HI trust fund. The error led to an overstatement of benefit expenses attributed to the Part B Medicare program and an understatement of benefit expenses attributed to the Part A program. In addition, the error led to inaccuracies within the SOSI. These errors were corrected within the final financial statements.

I.3 *Lack of Integrated Financial Management System*

Federal Agencies are required by law and OMB regulations to establish, "single integrated financial management systems" to be used to manage financial operations. As a result of implementing an integrated financial management system, agencies should be able to prepare timely and reliable financial reports, including financial statements. The completeness and accuracy of the financial statements are dependent on an integrated system which provides sufficient structure, effective internal controls and reliable data. HHS relies on decentralized processes and complex systems to accumulate data for financial reporting. In addition to an integrated financial system, a sufficient number of properly trained personnel and strong management oversight are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

Within HHS, the newly implemented UFMS is designed to have three components, HIGLAS, the NIH Business System (NBS), and UFMS (Indian Health Services will implement UFMS in FY 2008). In addition, the consolidating reporting module is expected to be implemented in FY 2009. However, HHS's financial management systems, as currently configured, are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements. More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems, and compliance with the United States Standard General Ledger (USSGL) at the transaction level and applicable Federal accounting standards.

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The lack of an integrated financial management system, non-compliance with the USSGL at the transaction level and weaknesses in internal controls and business processes impair HHS's ability to efficiently and effectively support and analyze accounts, as well as, prepare timely and reliable financial statements. HHS uses "work-arounds," cumbersome reconciliation and consolidation processes, and significant adjustments to produce the financial statements. The following matters illustrate the challenges presented by the existing systems:

- The majority of Medicare contractors currently rely on a combination of claims processing systems, personal computer based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to HHS on the "750 – Statement of Financial Position Reports" and the "751 – Status of Accounts Receivable Reports". These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because both HHS and their contractors do not have a compliant financial management system, the preparation of the 750 and 751 reports and the review and monitoring of individual accounts receivable, are dependent on labor-intensive, manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to HHS. Likewise the reporting mechanism used by the HHS contractors to reconcile and report funds expended, the "1522 – Monthly Contractor Financial Report", is heavily dependent on inefficient, labor-intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to HHS.
- HHS continues to experience significant challenges in resolving issues related to the UFMS conversion and implementation. This is evidenced by the following:
    - Despite the implementation of UFMS, HHS recorded more than 800 entries manually into the system during the year exceeding $170 billion. These entries were necessary to correct balances and accurately record transactions reported in UFMS.
    - During our testing, we noted transactions for current year activity that were inappropriately posting against opening balance accounts. These transactions were in excess of $1 billion which were not detected during the year through normal controls, but rather detected during the process of preparing the interim financial statements when it was noted that opening balances for the current financial statements were different from the ending balances of the prior financial statements.
    - HHS has not completed the development of management information reports from the UFMS system. Ad-hoc extracts from UFMS are used to support monthly reconciliations and the interim and year-end financial statements. HHS continues to use a cumbersome manual process to compile its financial statements.

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- Management is unable to provide timely and complete transaction level extracts from UFMS to support general ledger balances including:
  - Undelivered Orders
  - Unfilled Customer Orders
  - Obligations
  - Offsetting Receipts
  - Reimbursable Revenue and Expenses
- Systematic controls and front end edits have not been implemented to sufficiently mitigate the risk of Anti Deficiency Act (ADA) violations or a misstatement of financial management reports as evidenced by:
  - UFMS allows receiving transactions to be posted in excess of the corresponding obligation transactions.
  - UFMS allows the posting of grant expense accruals in excess of the funds available for grants.
  - UFMS allows the manual posting of entries which may not comply with the USSGL including inappropriate account combinations which omit the corresponding budgetary entries.

- The NBS had more than 2000 manual accounting entries for more than of $45 billion entered into the accounting system outside the automated transaction process. In addition, to prepare financial statements at year-end, 55 top-side adjustments totaling more than $85 billion were made. Processing these transactions was needed to ensure that the proprietary and budgetary accounts accurately reflected the current year activity. Additionally, the NBS does not provide for tracking manual or non-routine entries. As a result, adjustments and corrections cannot be readily identified. During our testing we noted that manual intervention is needed to assign appropriate transaction identifiers to ensure the correct classification within the financial statements.
- Systematic controls and front end edits have not been implemented to sufficiently mitigate the risk of Anti Deficiency Act (ADA) violations or a misstatement of financial management reports as evidenced by:
  - NBS does not have system edits to prevent the obligation of funds in excess of allowances, allotments, or appropriations.
  - NBS allows the manual posting of entries which may not comply with the USSGL including inappropriate account combinations which omit the corresponding budgetary entries.

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- The CORE accounting system is a data repository that was not designed to function as an accounting general ledger system. Accordingly, it does not capture all transactions properly and does not facilitate the preparation of timely financial statements. The accounting data in CORE must be downloaded and compiled to facilitate the preparation of adjusting entries. These entries are necessary to accurately reflect the current year activity and balances for financial reporting purposes. Approximately 30 miscellaneous journal vouchers were posted into CORE, each representing multiple accounting transactions with an aggregate value of $9 billion.

I.4 *Financial Statement Preparation*

HHS compiles its financial statements through a multi-step process using a combination of manual and automated procedures. Responsibility segments must manually enter adjusted trial balances or statements into a separate system in order to generate consolidated financial statements and reports. Due to system limitations, HHS records numerous non-standard entries through journal vouchers as well as topside adjustments not entered into the general ledger systems and employs manually intensive procedures using Excel spreadsheets and database queries to prepare the financial statements. These processes increase the risk that errors may occur in the HHS financial statements. The following issues were identified during the financial statement preparation process:

- To prepare financial statements, information must be extracted from the general ledger systems and reviewed by an analyst to determine the following types of non-standard journal vouchers:
    - Correction of beginning balances that were incorrectly impacted by transactions during the year and for accounts that the system did not properly close or inadvertently dropped from the general ledger system.
    - Adjustment of balances to record the impact of reimbursable transactions that the system did not properly record during the year
    - Correction of the system trial balance for journal entries from the prior year that were not recorded in the system.
- During the testing of the supporting spreadsheets, calculations, and journal vouchers used to produce the financial statements we noted the following matters:
    - Calculation errors in the spreadsheet used to support the grant accrual.
    - Numerous journal vouchers for proprietary transaction did not contain the appropriate corresponding budgetary transaction as prescribed in the USSGL.
    - Journal vouchers posted to correct beginning balance errors were not recorded properly.

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- Manual keying errors where debits and credits were inversed and incorrect amounts were posted.
- Lack of standardized methodology that ensures the analysis used to determine adjustments includes the potential impact of subsequently performed adjustments.
- Procedures used to determine the reimbursable adjustments contained numerous deviations from the prescribed methodology resulting in multiple errors.

HHS does not have uniform policies and procedures for the preparation of the financial statements. This results in significant manual "work arounds" and delays in financial reporting. While the errors, unexplained differences, and unsupported entries noted were not material to the HHS financial statements taken as a whole, they serve to illustrate that errors are more likely to occur in an environment that necessitates a time-consuming, manually-intensive financial statement preparation process, as well as the need for additional strengthening of the HHS's financial statement preparation, review, and approval processes.

I.5 *Incomplete and Untimely Completion of Reconciliations*

Since weaknesses currently exist in the financial management systems, management must compensate by implementing and strengthening mitigating controls to ensure that errors and irregularities are detected in a timely manner. A key compensating control is the monthly and quarterly reconciliations that are performed to ensure the balances in the general ledger system are accurate.

Our review of management's reconciliations disclosed a series of weaknesses that impact HHS's ability to report accurate financial information. We found that certain processes were not adequately performed to ensure that differences were properly identified, researched and resolved in a timely manner. The following issues were identified related to the reconciliation process:

- During the first half of the fiscal year, management did not perform key reconciliations due to an inability to obtain information from UFMS and the redirection of resources from these processes to allow for a successful conversion to UFMS. In addition, we noted other reconciliations were not completed within the timeframes established by Departmental policy.
- HHS policy and procedures do not provide thresholds that personnel are required to follow in determining whether a difference has to be investigated. This allows for individual staff to determine amounts that may be inconsistent with the design of these controls.
- The explanations of differences identified by management are incomplete and do not fully explain the business reasons for the outstanding items.

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- Reconciliations were incomplete with differences remaining unreconciled for more than 90 days. While individual items may appear to be immaterial to the Department no analysis is performed by management to determine the aggregate impact of all unreconciled items.

Recommendation

We recommend that management continue to develop and refine its financial reporting systems and processes. Specifically, HHS should:

- Establish appropriate policies, procedures and a protocol to address situations or transactions that require cross-functional involvement in order to ensure interim and year-end financial statements are accurate and complete. This includes policies and procedures to ensure changes to critical systems outputs are appropriately vetted with all users. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting implications.
- Continue to develop its policies and procedures related to the development, documentation, and validation of the Part D accrual process.
- Continue to implement an integrated financial management system for use by Medicare contractors and HHS to promote consistency and reliability in accounting and financial reporting.
- Management should develop appropriate reconciliation procedures between claims incurred to cash drawn from each of the trust funds that would enable the timely identification of potential errors in Medicare Trust Fund draws.
- Fully utilize the built in system functionality designed to perform complete transaction processing and financial reporting in compliance with Federal financial reporting requirements.
- Enhance the documentation related polices and procedures for the preparation of financial statements and ensure compliance through a monitoring process**.**
- Establish appropriate reconciliation policy and procedures which include the following:
    - Thresholds based on the type and purpose of the reconciliation to ensure differences are appropriately identified and researched.
    - Require the clearing of differences with ninety days of identification.
    - Require documentation to be completed which supports the explanation of the difference.

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II. Budgetary Accounting

HHS lacks sufficient controls over its accounting and business processes to ensure budgetary transactions are properly recorded, monitored and reported. Management routinely uses high level analysis to develop adjustments and derive balances for financial reporting purposes. Due to the lack of sufficient controls over the process, management has not mitigated the risk of a misstatement or potential violation of laws and regulations to an acceptable level. The following sections highlight the key issues that were identified with the budgetary process.

II.1 *Undelivered Orders (UDO)*

HHS does not have adequate controls in place to monitor undelivered orders which represent remaining amounts of obligated funds that have not been delivered nor appropriately deobligated. UDO oversight is the key to the status of budgetary resources is accurate.

Management was unable to provide evidence to demonstrate controls existed and operated effectively during the fiscal year. As a result we performed substantive test of details to quantify the potential misstatement due to the lack of controls. Our results revealed a projected error $1.1 billion in errors, including both over and understatements. The following types of errors were detected:

- Grants/Contracts which had expired periods were not closed and deobligated timely
- Obligations were recorded late or not recorded at all
- Deliveries were applied inaccurately to obligations which have been converted from prior systems as a lump sum and not at a document level
- Inaccurate and unsubstantiated postings to the general ledger

II.2 *Recoveries of Prior Year Obligations*

HHS does not have adequate controls in place to capture the recoveries of prior year obligations as required by federal accounting and reporting requirements, which require prior year recoveries to be recorded in a separate general ledger account and reported on the SF-133s and SBR. We noted inconsistent methodologies in use across the Department to derive the prior year recovery amounts.

During our testing we noted:

- One responsibility segment failed to report any recoveries on their financial statements.
- Nine responsibility segments must analyze transactions in other accounts to derive the balance.
- One responsibility segment currently has a waiver from OMB on reporting recoveries until the full implementation of their financial system is complete

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II.3 *Recording of Obligations*

HHS does not have adequate controls to ensure its obligations are recorded appropriately. While the majority of HHS obligations are automatically posted through system interfaces, HHS lacks controls over its manually-processed obligations. During our testing of undelivered orders, we noted several obligating documents that were not recorded into the system. Additionally, we noted that management did not have a sufficient process in place to prevent or detect unrecorded obligations at year end.

Management performed an analysis of unrecorded obligations for all of HHS's operating divisions. Based on our review of this analysis the amount of unrecorded obligations at year end was not material to the fiscal year 2007 financial statements.

II.4 *Budgetary Reimbursable Accounting*

Management manually analyzes revenues and expenses to derive the budgetary account balances for reimbursable activities. This process is prone to error. For year end reporting, HHS posted more than $2.5 billion in adjustments to the SBR to account for these activities. Our review of the journal vouchers and supporting documentation noted keying errors, incorrect application of the USSGL, and inconsistency in the calculations by HHS analysts which went undetected by management.

Recommendation

In order to remove the risks associated with the current budgetary reporting environment, HHS should:

- Implement department wide procedures requiring the periodic review of Undelivered Orders.
- Implement department wide policies and procedures requiring the recording of recoveries in accordance with federal accounting standards.
- Implement a commitment accounting function within the current general ledger system to allow automated reconciliation obligations.
- Implement the projects module of UFMS across the department to ensure obligations are recorded in a timely manner through automated processes.

III. Financial Management Information Systems

Many of the business processes that generate information for the financial statements are supported by HHS information systems. Adequate internal controls over these systems are essential to the confidentiality, integrity, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. As part of our assessment of internal controls, we have conducted general control reviews for systems that are relevant to the financial reporting process. General controls involve the entity-wide

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security programs, access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software, and service continuity. General controls impact the integrity of all applications operating within a single data processing facility and are critical to ensure the reliability, confidentiality, and availability of financial information.

Our testing noted general controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

- Entity-wide security program,
- Access controls (physical and logical),
- Application development and program change controls, and
- Operating systems software, and
- Service continuity.

Of particular concern, we noted the lack of pervasive Information Technology (IT) security standards for areas such as IT security settings on platforms, policies regarding the control and use of passwords, and policies regarding the control over changes to applications whether they be developed in-house or purchased, for HHS at the department level. Our testing consistently noted that management of the various component entities within HHS either had developed their own IT security standards or simply stated that they do not follow HHS standards.

Because of the pervasive nature of general controls, the cumulative effect of these significant deficiencies represents a material weakness in the overall design and operation of internal controls. Detailed descriptions of control weaknesses may be found in SAS70 reports and the management letters issued on information technology general controls and audited applications. The following discusses the summary results by review area.

III.1 *Entity-Wide Security Programs*

These programs are intended to ensure that security threats are identified, risks are assessed, control objectives are appropriately designed and formulated, relevant control techniques are developed and implemented, and managerial oversight is consistently applied to ensure the overall effectiveness of security measures. Security programs typically include formal policies on how and which sensitive duties should be separated to avoid conflicts of interest. Similarly, policies on background checks during the hiring process are usually stipulated. Entity-wide security programs afford management the opportunity to provide appropriate direction and oversight of the design, development, and operation of critical systems controls. Inadequacies in these programs can result in inadequate access controls and software

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change controls affecting mission-critical, systems-based operations. Our procedures identified the following issues:

- **Information System Platform and Database Security Controls:** HHS lacks accepted and used standards for information system platform security settings that are consistent with NIST standards for securing information system platforms and databases.
- **Information System Platform and Database Security Control Monitoring:** HHS lacks processes to monitor security settings continuously to ensure they remain effective.
- **Security Plans:** Security plans for some of the systems have not been updated, finalized, approved, and communicated.
- **Certification & Accreditation:** Required certification and accreditation statements for some of the major financial applications and general support systems have expired or have not been reviewed or updated recently.
- **Security Training:** Relevant security and security awareness training was not provided to all employees and contractors.

III.2 ***Access controls (logical and physical)***

Access controls ensure that critical systems assets are physically safeguarded and that logical access to sensitive application, system utilities, and data is granted only when authorized and appropriate. Access controls over operating systems, network components, and communications software are also closely related. These controls help to ensure that only authorized users and computer processes can access sensitive data in an appropriate manner. Weaknesses in such controls can compromise the integrity of sensitive program data and increase the risk that such data may be inappropriately used and/or disclosed. Our procedures identified the following issues:

- **Access Authorizations**: For some of the systems, the approval of access requests was not, or was inadequately, documented.
- **Access Revalidations**: For some of the systems, the periodic revalidation of user accounts is either not performed or inadequately documented.
- **Password Controls**: The password controls applied to some of the systems do not provide an adequate level of authentication controls.
- **Access Assignments**: Access assignments were excessive for some systems and did not provide an adequate segregation of duties.
- **Access Removal**: For some of the systems, users' access was not terminated, upon termination of their role.

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III.3 *Systems software*

Systems software is a set of computer programs designed to operate and control the processing activities for a variety of applications on computer hardware and related equipment. The systems software helps coordinate the input, processing, output, and data storage associated with all of the applications that are processed on a specific system. Some systems software is designed to change data and programs without leaving an audit trail. Overall, problems in managing routine changes to systems software to ensure an appropriate implementation and related configuration controls were identified. Our procedures identified the following issues:

- **Configuration Controls**: Systems settings for selected databases and operating systems are not optimized to provide a secure computing environment.
- **Patch Management**: The controls over timely and consistent application of system patches are not effective for all of the systems.
- **Change Management**: Change management procedures were insufficient to ensure only properly authorized changes were implemented into some production systems.

III.4 *Application software development and change controls*

A well defined and effectively controlled development and change management process should be in place to ensure that only authorized, tested, approved, and documented new programs, or changes to existing programs, are applied to the production environment. Additionally, the process facilitates that new or changed programs meet the requirements with regards to security and controls; such as providing for programmed integrity controls, audit trails, logging capabilities, etc. Our procedures, which included findings during our SAS70 Reviews of the Division of Financial Operations, the Centers for Information Technology, and the Human Resource Services operation, identified the following issues:

- **Change Controls**: For some applications, there is no formal and consistently applied change control process.
- **Change Management**: Evidence to support that change management procedures and processes were followed was not provided.
- **Access Controls**: Periodic reviews of user access permissions were not conducted and/or not documented. Procedures to approve access assignments and to control terminated and transferred employees were either non-existent or not followed.
- **Application Controls**: Error reports were not properly reviewed and used to correct issues noted and reconciliations of application data were not always performed.

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- **Configuration Controls**: Password controls and system lockouts for incorrect password attempts were not sufficient to provide effective security. Platform security configuration settings were also insufficient to provide effective security.

III.5 *Application Specific Concerns - General Ledger System*

As part of our assessment of internal controls, we have conducted application control reviews for systems that are relevant to the financial reporting process. Application controls involve access controls, data input controls, data processing controls and data output controls. Our testing noted application controls issues in both the design and the operations of key controls. We noted weaknesses in the following review areas:

III.5.1 Access Control

Procedures related to the conversion and entry of data through terminals should be established to deter unauthorized use. Key duties and responsibilities performed within the application should be adequately separated to reduce the risk of errors, waste, or wrongful acts.

- **Access Authorization:** For some users, access to key financial system was not appropriately granted.
- **Password Controls**: The password controls applied to some of key financial systems do not provide an adequate level of authentication controls.
- **Access Assignments**: Access assignments were excessive for some key financial systems and did not provide an adequate segregation of duties, with more than 600 possible segregation of duties issues identified in the G/L system. Assignment conflicts represent instances whereby accesses assigned may have allowed users to perform all phases of transactions without intervention by other users or approvers. For example, creation and approval of transactions from inception of the transaction to payment.
- **Access Removal**: For some of key financial systems, user's access was not terminated, upon termination of their role.

III.5.2 *Data Input*

All authorized source documents should be complete and accurate, properly accounted for, and transmitted in a timely manner for input to the computer system. Input data should be validated and edited to provide reasonable assurance that erroneous data are detected before processing. Procedures should be established for the conversion and entry of data that ensure a separation of duties as well as routine verification of work performed in the input process. Formal procedures should be established

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for data processing to ensure that data is processed completely, accurately, and on time. We noted the following weaknesses:

- **System Interfaces:** For some key financial systems consistent policies and procedures do not exist over these interfaces to ensure that necessary inputs are processed, control logs are monitored and reviewed with issues adequately followed up, and errors held in rejection files during processing are resolved.
- **Configuration Controls**: Application settings are not optimized to provide a controlled processing environment. For example, edits were not properly configured to prevent erroneous input of data.
- **Data Processing Controls:** Procedures were not established for the entry of data to ensure a separation of duties as well as routine verification of work performed during processing. Errors identified during data processing should be promptly investigated, corrected, and resubmitted.
- **Audit Trails:** For some systems, it was not possible to identify the user or users who made modification to key system transactions and standing data. Further, audit trails were generated showing a count of transactions performed in each module by specific users.

III.5.3 *Data Output*

Procedures should exist to report and control errors contained in output. Reports produced outside the normal production cycle (i.e. ad hoc reporting) should be adequately controlled. Output should be balanced to record counts and control totals, and audit trails should be available to facilitate tracing and reconciliation. We noted the following weaknesses:

- **Error Handling Activities**: Procedures do not exist that the Global Error Handler is monitored and that transactions held in error are reviewed and processed timely. Business owners indicated that documentation to evidence the review of transactions in the Global Error Handler was not maintained.
- **Key management reports**: Procedures do not exist to ensure that key management reports are reviewed and maintained

Recommendations

To provide a secure computing environment for critical applications throughout all the operating divisions, HHS should:

- Develop overall HHS platform configuration security standards for all operating platforms and databases, following the guidance issued by NIST, for all components.

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- Ensure the acceptance and implementation of the platform configuration security standards by all components.
- Develop and implement effective tools, policies and procedures to review platform security settings for all components, on a continuing basis.
- Develop an effective and documented patch management process for all critical systems to reduce systems vulnerabilities to a minimum.
- Enhance policies and procedures to ensure that system administrators perform periodic reviews of access authorizations for all applications and that a process exists for communicating terminated employees to administrators for their timely removal.
- Revalidate access rights on a periodic basis to limit systems access to the least privilege required to perform job responsibilities.
- Complete certification and accreditation activities, including the corresponding risk assessments, to limit the residual risk to an acceptable level.
- Maintain system security plans to provide security and controls commensurate with risk changes associated with systems.
- Train all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations.
- Maintain effective program change controls processes for all applications to limit the risk of unauthorized changes to the production systems.

IV. Medicare Claims Processing Controls

Overview

HHS relies on extensive information systems operations at the Centers for Medicare and Medicaid Services Central Office (CMS Central Office) and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts. The internal control structure is inclusive of, but not limited to, automated controls. The internal control structure also includes monitoring controls over claims processing.

Our internal control testing for the audit covered both general and application controls. General controls involve organizational security plans, referred to as entity-wide security plans (EWSP), access controls

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(physical and logical), application software development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems, and combined with application level controls, are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and output of data from HHS application systems.

Our audit included various general controls testing for nine contractors and site visits to six data centers supporting Medicare claims processing. We also reviewed application controls at the CMS Central Office and at Medicare contractors for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems (VIPS) Medicare System (VMS), the Multi-Carrier System (MCS) and the Common Working File (CWF). At CMS Central Office we performed procedures over the Financial Accounting Control System (FACS), Health Plan Management System (HPMS), Medicare Advantage Prescription Drug System (MARx), Healthcare Integrated General Ledger Accounting System (HIGLAS), Medicaid Budget and Expenditure System (MBES), and Children Budget and Expenditure System (CBES).

We also conducted vulnerability reviews of network controls at six data center sites and the CMS Central Office. Further, desktop-based audit procedures were conducted to review the high level management controls regarding direct access to claims data, control over edits within the FISS, MCS and VMS systems, and controls over software supplementing the FISS, MCS and VMS systems used to process Medicare claims. We noted some improvements in each of these 3 areas, which were first identified in FY 2006 or earlier audits, but the progress of these improvements was not sufficient enough to address the concerns expressed below.

During FY 2004, management launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medicare Modernization Act. This evaluation program includes all eight key areas of FISMA: periodic risk assessments; policies and procedures to reduce risk; systems security plans; security awareness training; periodic testing and evaluation of the effectiveness of IT security policies and procedures; remedial activities, processes and reporting for deficiencies; incident detection, reporting and response; and continuity of operations for IT systems. We believe that the evaluations obtained as a result of this effort have served and continue to serve HHS greatly in better understanding the current state of security operations at all Medicare contractors; not just those contractors tested as a result of the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the material weakness conditions, HHS continues its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, HHS continues to request and receive system security plans, risk assessments, contingency plans,

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self-assessments, and test results of contingency plans from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

Efforts to address the findings noted in our review have been and will continue to be challenged by budgetary constraints and the decentralized nature of Medicare operations, the complexity of fee-for-service processing, the modernization of the claims processing applications and the ongoing contractor transition process related to the legislative mandate under MMA to competitively procure claims administration contractors to replace fiscal intermediaries and carriers by 2011. According to HHS officials, the HHS modernization program to centralize data processing and reduce the number of data centers represents a long-term solution to simplify the application software code and change controls needed for more robust security. HHS is also in the process of implementing significant changes to its claims administration contracting environment, which will result in consolidation and reduce the number of contractors and data centers.

IV.1 *Direct Update Access to Medicare Claims Data*

For the direct update access to Medicare claims data control weakness, improvements were noted regarding the number of employees at contractors who had been granted access to directly change claims data, thereby bypassing application controls built into the FISS, MCS and VMS systems. Specifically, the audit showed that fewer employees generally had such access. This progress could be attributable in large measure to further guidance and information that HHS provided to contractors both in a series of briefings, and in writing via joint signature memoranda (JSM) and distributing white papers specifying in detail how to meet the requirement for users of the mainframe ACF2, RACF and Top Secret security packages.

Still, the audit noted significant numbers of contractor employees who had been granted direct access without consistent logging and review. The ability to directly change claims without comprehensive review provides no assurance that changes performed by such employees will result in proper claims payment. We consistently noted employees, particularly those at contractors using the MCS system, who had been granted inappropriate standing update access to Medicare data but who did not require direct access to data and application software programs to perform their job responsibilities. Further, activity was not logged and reviewed.

IV.2 *Control Over Edit Settings in the FISS, VMS and MCS Application Systems*

For controls over edit settings in the FISS, VMS and MCS application systems, management worked diligently during FY 2006 to establish workgroups to determine the proper settings for controlling edits within each of these three applications processing Medicare claims. Additionally, the CMS Central Office issued a JSM to formally establish procedures to report and control changes to edits in these systems.

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During FY 2007, our audit noted general compliance and improvement with the FISS mandated edits (when claims are processed within the common working file software), and the VMS mandated edits. However, our audit noted exceptions at selected contractors. Moreover, we noted that the JSM procedures and workgroup settings for MCS were not correct for numerous edits resulting in incorrect edit setting at contractors.

Additionally, we noted that management could not provide reports to document the volume and nature of claims bypassing the CWF application. Approximately 2,000 edits were not enforced within the FISS application because the edits were redundant in the CWF application. The inability to determine the number of claims bypassing CWF does not allow management to understand the effect of claims not subjected to CWF edits. Thousands of edit controls were built into the Medicare claims processing applications to enforce consistency over claims processing. The ability of claims to bypass application edit controls may result in inconsistent and uncertain claims processing leading to payment inaccuracies.

IV.3 ***Controls Governing the Use of Supplemental Software Used to Process Claims***

We noted a lack of controls with respect to software supplementing the FISS, MCS and VMS systems used to process Medicare claims. The inability of the FISS, MCS and VMS claims processing application systems to efficiently process all Medicare claims types has caused Medicare contractors to develop additional programs to effectively process claims. These additional systems, sometimes referred to as automated adjudication systems (AAS), were developed to automate the handling of claims that could not be processed by the standard claims processing applications without human intervention. AAS programs are developed and used independent of the standard application systems to process valid claims rejected by the standard systems. During FY 2006, management established formal control processes for the use of the AAS, including methods to establish, test, peer review and approve AAS programs prior to their use. Our testing noted issues at numerous contractors regarding compliance with these processes. AAS systems provide a powerful tool to process large volumes of Medicare claims rapidly, without human intervention. The use of such programs without the enforcement of strong controls could again result in inconsistent and uncertain claims processing leading to payment inaccuracies.

IV.4 ***Lack of CMS Oversight***

For the areas of direct update access to Medicare claims data, control over edit settings in the FISS, VMS and MCS application systems, and controls over the use of supplemental software used to process claims into the FISS, VMS and MCS application systems, we observed that often CMS Central Office had issued guidance and requirements to address internal control concerns. In each of these areas, we noted instances where contractors simply did not implement the needed controls although they had been directed to do so. In some cases the contractor staff simply did not appear to understand what was needed, for example the direct access to data instructions are of necessity quite technical. In other cases,

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contractors on the verge of leaving the Medicare program may no longer have the same incentive to comply with requirements. Regardless, HHS lacks sufficient management processes and procedures in place to track compliance with its requirements and to assess the impact of exceptions and findings on the HHS financial statements.

1V.5 *Other Matters*

Of lesser risk, our audit noted the following issues:

IV.5.1 *Logical Access Controls*

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Besides the access control issues described in the "Direct Update Access to Medicare Claims Data" section, we noted that numerous contractors were not consistently recertifying user access to systems to ensure such access was needed for job requirements. We also noted that contractor management was not effectively performing reviews of violations for the FISS, MCS and VMS application systems. These security weaknesses could allow internal users to access and update sensitive systems, program parameters and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed.

We also noted that many contractors had not performed procedures to recertify access granted to employees on an annual basis as required by HHS standards. As a result, we noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites.

IV.5.2 *Systems Software*

Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. We again noted inconsistencies in logical security controls over various platforms at contractor sites. Although contractors have established configuration security standards for platforms such as the mainframe, WINDOWS and UNIX, such standards were not consistently established on these platforms and/or monitored to ensure they remained in effect. Of mention, we did not note significant issues at three of the data center locations we audited which shows progress by HHS compared to prior year audits. Guidance issued by HHS for the implementation of controls, configurations, and design of the mainframe OS/390 and z/OS may have contributed to this improvement.

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Recommendation

During FY 2007, management worked to establish and document consistent controls over the use of direct update access to claims data, control over edits within FISS, MCS and VMS and the use and control of AAS programs. However, the processes to consistently enforce these controls over twenty eight contractor and thirteen data center locations remains challenging. Although, the controls have not been fully implemented, we encourage management to continue their efforts to gain contractor support for full implementation of these controls. Effective management controls over the use of direct update access to claims, changes to edits within the three major Medicare application processing systems and AAS programs is imperative to establish a reasonable range of comfort over the accuracy of Medicare claims processing.

Additionally, we recommend that management should:

- Establish a process to periodically review and test contractor reports of employees with direct update access to Medicare claims data. The testing should include steps to ensure such access is logged and reviewed by contractors.
- Establish ongoing workgroups to review FISS, MCS and VMS edits that should be turned on or off and establish processes to distribute quarterly the results of these reviews to the contractors to allow them to determine their compliance.
- Establish a formal review process to, on a selected and unannounced basis, obtain and review actual in use edit settings for the FISS, VMS and MCS systems running at the contractor sites.
- Use the results of bullet point three above to identify edit settings not in compliance with the recommended edit settings suggested by the workgroups. For edits not matching the workgroup recommendations, match these differences to error trends resulting from contractor claims processed during periods when edits are turned off (use CWFMQA report results). Document the results, including specific matching of error types to contractors from which the errors emanated, and follow-up with contractors. Alternatively, management may wish to research other methods to more efficiently identify and track errors for subsequent review with contractors.
- Establish reports to determine the volume and reason for claims bypassing the CWF application.
- Work with contractors and maintainers of the FISS, MCS, and VMS systems to ensure AAS programs such as SuperOps and SCF maintain complete audit trails and that changes to programs associated with these systems follow the rules outlined in CR 3011 for testing, peer review and approval.
- Continue to enhance processes for the recertification of contractor employee access and the review of violation reports for the FISS, MCS and VMS application systems.

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Significant Deficiencies

I. Inadequate Oversight of Managed Care Organizations

Overview

HHS is responsible for 1) determining which organizations are eligible to contract and participate in the Medicare Managed Care (Part C) and Part D programs, 2) making payments to the participating organizations, and 3) providing oversight over the participating organizations.

Our prior year audits identified weaknesses in HHS internal control surrounding the management procedures to review and process Medicare Part C and Part D payments, and lack of documentation and procedures to determine eligibility of organizations during the initial application review. During our current year audit, we noted significant improvements in those areas. Specifically, management enhanced the procedures used to validate and authorize payments for Medicare Part C and the Part D benefit. Enhancements were made to a number of validation functions including the Beneficiary Payment Validation (BPV), the Plan Payment Validation (PPV), and the monitoring and tracking of payment issues. In addition, management made significant improvements in documentation that evidence their determination of eligibility of organizations during the initial application review.

However, we noted recurring issues with management oversight of the Medicare Advantage Organizations (MAOs). Management's oversight of MAOs is a monitoring control designed to ensure MAOs are in compliance with regulations established within applicable Medicare law, and therefore eligible to participate in the Managed Care program. Our review of the monitoring procedures in place over MAOs noted the following:

I.1 ***Monitoring Review Selection Methodology***

Because of the significant increase in MAOs in the managed care program and limited resources, management developed a risk-based approach for their oversight of the Managed Care organizations. The risk-based approach was used to identify which plans would be within the scope of the review, in addition to what organizational eligibility elements would be reviewed. The following inconsistencies were noted with the newly-developed selection approach:

- Management sporadically provided us with a complete set of formal monitoring policies and procedures used throughout the fiscal year. The inability of HHS to readily provide a comprehensive set of the guidance to be used throughout the fiscal year increases the risk of inappropriate execution of the reviews.

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- Management did not properly document the rationale and sampling approach for the population or universe used for each element selected for review. In addition, management selected an arbitrary percentage for sampling for the PACE organization reviews, with no documentation of the rationale.
- Management has a process in place for the completion of a standard form if additional elements and/or reviews are performed, by a Regional Office Manager. However, we noted instances where management deviated from the risk-based approach and included or excluded elements of the review without documenting the rationale for inclusion or exclusion.

I.2 *Monitoring Review Documentation*

HHS has ten Regional Offices which perform the monitoring reviews. Management issues Standard Operating Procedures and holds training sessions for new releases to the monitoring audit guides.

However, because of a lack of formalized policies and procedures regarding the level of documentation required to evidence the review, management was unable to provide sufficient documentation to evidence the appropriate on going monitoring of managed care organizations by the Regional Offices. The following was noted:

I.2.1 *Evidence of Review*

During the review, the reviewer must identify if organizational requirements are "met" or "not met".

- We noted instances where the reviewer noted that the MAO had "met" the required element; however; documentation supporting the rationale and conclusion were not available.
- We noted significant inconsistencies with how the determination of "met," "met with note," and "not met" was made on different reviews for the same element.
- Documentation available to support the review varied by Regional Office.

I.3 *Corrective Actions*

Upon the completion of the review, management is required to communicate non-compliances identified during the review to the organizations and the organizations are required to submit a corrective action plan. Management is required to evaluate the corrective action plan in order to make a final determination of the plan's eligibility.

- We found instances where findings identified during the review and corrective action plans developed by the MAO in response to the review, were not released and/or approved within the prescribed time frame. In some cases, required corrective action plans were not received at all. In these instances, documentation supporting the ultimate conclusion to continue to allow the organization to participate as a MAOs did not exist.

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- We noted the acceptance of corrective action plans that did not properly identify how the MAO would correct each of the items identified.

I.4 *Oversight Status Tracking*

The Health Plan Management System (HPMS) is used by HHS to monitor the execution and status of managed care organization oversight. This system lies at the core of HHS's management process for MAOs. Inaccurate information within HPMS weakens management ability to monitor the MAOs. We noted the following:

- Management uses a Microsoft Excel spreadsheet and HPMS to monitor the progress of the monitoring reviews, versus one central tracking module. We noted additional reviews were performed that were not tracked within the spreadsheet or HPMS.
- The HPMS monitoring review module was not updated, in accordance with HHS's policy, with the results of review. We noted multiple instances where Regional Offices did not update HPMS with exception items noted during the reviews of the managed care organizations.

Recommendation

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

- Establish policies for Regional Office monitoring of the various organizations (MA, MA-PD, PDP, PACE, RPPO, etc.) that include tailored procedures to address the unique requirements or risks of each organization.
- Ensure that existing policies and procedures for the monitoring of organizations within the Managed Care program are consistently implemented and applied and that the monitoring of these organizations is documented in accordance with appropriate standards and guidelines.
- Develop detailed policies and procedures outlining the minimum documentation requirements that must be maintained as part of the monitoring reviews, in order to appropriately support the review outcome.
- Document the compliance with regulations for the monitoring of specific chapters and/or elements for organizations. For example, PACE organizations are required to be monitored every year for the first three years of acceptance into the program, and every other year thereafter.
- Ensure findings, corrective action plans, and acceptance of the provider's correction action plans are provided, reviewed, and released within the proposed time frames.

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- Ensure that relevant data are updated timely in order to provide the information necessary for adequate management oversight.

II. Lack of Controls over Monitoring of Grant Closeout

One of the largest work streams at HHS is the management of grants, with the award of more than $200 billion in discretionary and mandatory grants each year and over one trillion dollars in open grants under management throughout the year.

II.1 *Grant Closeouts*

The closeout portion of the *HHS Grants Policy Statement* is insufficient as it does not require the respective Grants Management Offices to develop formal and detailed controls to address final grant closeout.

Based on inquiry with grant management personnel, an effort to closeout grants is being made, but the Department has limited authority to ensure grantees comply with HHS grant closeout policy. The compliance actions available (i.e., drawdown restrictions and withholding of future awards) are rarely utilized because there is not a directive in the existing policy to support and encourage the grant offices to use these actions. The Division of Payment Management (DPM) _Grant Closeout Eligibility Report is considered unreliable by the Grants Management Offices and thus is not utilized for grant close-out monitoring.

The DPM report identified more than 25,000 grants with a remaining net obligation balance of $1.5 billion that are potentially eligible for closeout. For 80% of the grants identified as potentially eligible for closeout by management, the grant project period expired more than eighteen months ago. The inability to properly closeout grants has a corresponding effect on funds which have been obligated to settle claims from grantees. To the extent that HHS is able to closeout grants in a timely manner, additional funds could be de-obligated and returned to the US Treasury as required by appropriations law.

II.2 *Grant Documentation Retention*

While HHS has documentation retention policies related to grants that set minimum standards, this policy is not being followed and the systems in place are not sufficient to allow for document retrieval on an as needed basis. This was evidenced by management's inability to provide all requested documentation for 12 out of 105 sample items tested during our audit.

Examples of missing grant documentation include:

- Approved Applications
- Ranks and Approval Lists
- Secondary Review Documentation for grant above $50 thousand

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II.3 *Grant Monitoring*

Management was unable to provide documentation to evidence their ongoing monitoring of open grants. Examples of missing grant documentation are the grant monitoring statements and progress reports.

Financial Status Reports (FSRs or SF-269s) were not submitted in a timely manner and evidence of follow-up by the respective Grants Management Offices (GMO) was not available. The following causes were identified during our testing:

- The grant management automated information systems utilized by HHS do not provide notification (alert) to the Grant Management Specialist (GMS) when an FSR has not been received within the allotted time period.
- Management communicated it does not have sufficient staffing to ensure the FSRs are submitted within the allotted time period.

If the FSR is not received, management is unable to accurately determine if grant funds are being spent in accordance with the approved budget. Management is also unable to tell if financial benchmarks such as cost sharing are being attained by the grant recipient.

In addition, there are no sanctions mentioned in the HHS Grants Management policy that can be imposed on a grantee when they are late in providing an FSR. Repercussions only exist when a grantee is applying for a future award, at which time the grantee must provide the delinquent FSR.

Recommendation

To improve the oversight of grants, better safeguard taxpayer monies and decrease the administrative costs related to grants HHS should:

- Implement a standard document retention system. At a minimum, the system should be organized by unique identifier (grant document number) so that each grant and all of the associated documentation can be retrieved as needed.
- Scan hard-copy documents into their document retention systems, thus reducing the dependence on extensive paper files.
- Assign a GMS to focus solely on monitoring the FSR submission during the course of the project period.
- Develop standardized documentation requirements to ensure all correspondence between a GMS and a grantee is completed consistently and timely. The HHS Grant Policy Statement should be updated to include specific repercussions for not complying with the documentation requirements.

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- Management should implement a systematic function to provide automated alerts to the appropriate GMS when the FSR has not been received by the due date.

III. Lack of Controls over Timely Invoice Payment

HHS lacks standardized policies and procedures for the processing of invoices to ensure proper and timely payment as well as compliance with the Prompt Payment Act (5CFR 1350). During our testing we noted the following:

- The Division of Financial Operations (DFO) accounting technician processing the invoice enters the invoice receipt date in UFMS, using the date of the Paying Office (DFO) receipt date of the invoice rather than the actual invoice receipt date by the receiving (program) office. This methodology is inconsistent with the Prompt Pay Act.
- Not all receiving (program) offices have a requirement to date stamp invoices upon their receipt. While some receiving (program) offices are utilizing date stamps upon receipt of invoices, this process is not performed consistently. Without a date stamp, HHS is unable to ensure that invoices are paid in a timely manner.
- According to the HHS policy, the receiving date should be entered into the UFMS system upon receipt of goods or services by the project officer or their designee. However, during our testing we found instances where entry of receiving date was delayed by up to one month, causing the receiving date to be incorrect. The UFMS system calculates the payment due date based on the later of the goods being received or the receipt of a valid invoice. Payment will not be made until the receiving date is entered into UFMS by the project officers which, if not entered timely, results in the payment due date being inaccurately calculated.

During our testing we noted 19 invoices being paid on average 54 days after the receipt of goods and invoices. In 6 of these instances, HHS failed to pay interest to the vendor as required by the Prompt Payment Act. In addition, in 6 of the 13 invoices where interest was paid it was calculated incorrectly. The lack of controls has resulted in violations of the Prompt Pay Act and the use of tax payer monies for the payment of interest that could have been used for program expenses to benefit the public.

Recommendation

In order to ensure compliance with the Prompt Pay Act and decrease the monies paid on interest that could be used for program expense, management should:

- HHS management should assign a "Designated Agency Office" on all contracts, purchase orders and agreements to receive invoices and date stamp the invoices to ensure consistency and timely payment of invoices. Management should also ensure that vendors are aware of the procedures to send invoices to the Designated Agency Office.

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- Develop stronger polices at the receiving (program) offices to ensure timely entry of goods received. There should also be regular monitoring of these dates involving reconciliation of financial system data to the hard-copy receiving reports.
- HHS should ensure that the training for employees who enter receiving into the financial system is clear as to what the receiving date should be and that receiving officials are aware of the importance of entering receiving information correctly and within the specified time period.

IV. Statement of Social Insurance (SOSI)

The SOSI is a long-term projection of the present value of income to be received from or on behalf of existing and future participants of social insurance programs, the present value of the benefits to be paid to those same individuals, and the difference between the income and benefits.

Starting in FY 2006, the SOSI was required to be presented as part of the basic financial statements rather than as RSSI as previously presented. As such, the process for preparing the SOSI must comply with appropriate financial reporting internal control requirements established by OMB.

HHS has implemented policies, processes, controls and related documentation that will enable them to support the related financial statement assertions. During the current year audit, we noted significant improvements in the areas of change control, access controls, and internal control documentation. However the following control design deficiencies where noted:

- Data are moved within and between spreadsheets by copying the data from cells and pasting the data to new cell locations. Errors from this process could result in significant unintended changes to the SOSI. While the input of data is subjected to secondary validation and review by supervisory actuarial personnel, such manual validation and review processes do not sufficiently mitigate the risk associated with the copying and pasting of data from cell to cell within this complex set of spreadsheets.
- Spreadsheets are named with the same name as the prior version after changes. Further, there are no automated controls to prevent users from inadvertently overwriting changes made by other users. This could result in unintended changes to critical spreadsheets resulting in unreliable outputs.
- Formulae changes are not in all cases independently tested, reviewed and verified. While formulae changes are subjected to secondary validation and review by supervisory actuarial personnel, such manual validation and review processes do not sufficiently mitigate the risk associated with the direct posting of formulae changes into cells by users of this complex set of spreadsheets.

The lack of robust automated controls over spreadsheet changes may result in output that varies significantly from management's intentions.

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Recommendation

We recommend that HHS continue to develop and refine its SOSI financial reporting spreadsheet applications and processes. Specifically, HHS should:

- Implement automated controls to ensure that data moved between and within spreadsheets are moved correctly.
- Implement automated controls to prevent the possibility of overwrite to critical spreadsheet data or formula cells due to insufficient naming convention protocols.
- Implement automated controls to test, review and verify all formulae changes within and between spreadsheets (e.g. spreadsheet change logging capabilities).

* * * * * * * * * * * * *

Internal Control Related to Key Performance Indicators and RSSI

With respect to internal control relevant to data that support reported performance measures, we obtained an understanding of the design of significant internal controls relating to the existence and completeness assertions, as required by OMB Bulletin No. 07-04. Our procedures were not designed to provide assurance on internal control over reported performance measures. Accordingly, we do not provide an opinion on such controls.

We also identified other less significant matters that will be reported to HHS's management in a separate letter.

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

PricewaterhouseCoopers LLP

November 14, 2007

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Report on Compliance and Other Matters

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Report of Independent Auditors on Compliance and Other Matters

To the Secretary of the Department of Health and Human Services and the Inspector General of the Department of Health and Human Services

We have audited the financial statements of the Department of Health and Human Services (HHS) as of and for the year ended September 30, 2007 and the statement of social insurance for the year ended January 1, 2007, and have issued our report dated November 14, 2007. We conducted our audit 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 No. 07-04, *Audit Requirements for Federal Financial Statements.* The management of the HHS is responsible for compliance with laws and regulations.

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of compliance with laws and regulations including laws governing the use of budgetary authority, laws, regulations, and government-wide policies identified in Appendix E of OMB Bulletin No. 07-04 and other laws, noncompliance with which could have a direct and material effect of the determination of financial statement amounts. Under FFMIA, we are required to report whether the HHS financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements.

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

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The Improper Payments Information Act (IPIA) of 2002 requires Federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. HHS has begun to implement the requirements of IPIA, but has not yet completed its implementation of a process to fully estimate improper payments.

The Prompt Payment Act of 1982 requires Federal agencies to pay their bills on a timely basis and to pay interest penalties when payments are made late. During our testing we identified multiple instances of non-compliance with the Prompt Payment Act where interest was not appropriately paid.

In the accompanying Agency Financial Report, HHS has reported violations of the Anti-Deficiency Act (ADA). HHS reported that these violations occurred over a period of several prior fiscal years and the amounts involved were sufficiently small that they would not have been material to any year's financial statements and that management is committed to resolving these issues and complying with all aspects of the ADA.

The HHS OIG determined that HHS did not comply with appropriation statutes and the Federal Acquisition Regulations related to the modification of a contract where the requested services were not allowable under the contracting vehicle, the contract should have gone through a full and open competition, and the contract was incorrectly funded from a prior fiscal year's appropriation.

The results of our tests of HHS's compliance with FFMIA requirements disclosed, as described below, that the HHS is not in substantial compliance with the requirements of FFMIA section 803(a).

In our report on internal control dated November 14, 2007, we reported material weaknesses related to Medicare Claims Processing Controls, Financial Reporting Systems and Processes, Financial Management Information Systems and Budgetary Accounting. We believe these matters taken together; represent substantial non-compliance with FFMIA. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to HHS in our report on internal control dated November 14, 2007.

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

PricewaterhouseCoopers LLP

November 14, 2007

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Department's Response to Audit Reports

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

NOV 15 2007

Mr. Daniel R. Levinson
Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W., Room 5250
Washington, D.C. 20201

Dear Mr. Levinson:

This letter responds to the audit report submitted by the Office of the Inspector General in connection with the Department of Health and Human Services' fiscal year 2007 financial statement audit. We concur with the findings and recommendations presented to us.

We are pleased that, once again, your report reflects an unqualified, or "clean," audit opinion for the Department. Through our joint efforts, the audit was completed on time.

We acknowledge that we have material weaknesses in internal control relating to financial reporting systems and processes, budgetary accounting, financial management information technology systems, and Medicare claims processing. The Department's plan to resolve the financial reporting systems and processes, and budgetary accounting weaknesses is to continue our efforts to improve our financial management processes and to fully utilize the Unified Financial Management System (UFMS) functionality and control capabilities.

In addition, the Department will be formulating entity-wide goals for correcting the information technology weakness. The Centers for Medicare and Medicaid Services will continue efforts to strengthen the controls related to Medicare electronic data processing operations at its contractor sites as well.

I would like to extend my appreciation to you and your staff for the professionalism that was demonstrated in working with us through this challenging year.

Sincerely,

Charles E. Johnson
Assistant Secretary for Resources
and Technology and Chief Financial Officer

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Financial Statements and Notes

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Financial Statements

CONSOLIDATED BALANCE SHEETS
As of September 30, 2007 and 2006
(In Millions)

	2007	2006
Assets (Note 2)		
Intragovernmental		
Fund Balance with Treasury (Note 3)	$ 114,774	$ 159,921
Investments, Net (Note 5)	365,875	341,976
Accounts Receivable, Net (Note 6)	1,164	726
Other (Note 9)	43	132
Total Intragovernmental	481,856	502,755
Accounts Receivable, Net (Note 6)	13,021	3,207
Cash and Other Monetary Assets (Note 4)	129	145
Inventory and Related Property, Net (Note 7)	3,161	2,322
General Property, Plant & Equipment, Net (Note 8)	5,064	4,971
Other (Note 9)	576	509
Total Assets	**$ 503,807**	**$ 513,909**
Stewardship PP&E (Note 29)		
Liabilities (Note 10)		
Intragovernmental		
Accounts Payable	$ 533	$ 620
Accrued Payroll and Benefits	86	88
Other (Note 14)	815	955
Total Intragovernmental	1,434	1,663
Accounts Payable	484	562
Entitlement Benefits Due and Payable (Note 11)	61,470	61,164
Accrued Grant Liability (Note 13)	3,941	3,833
Federal Employee & Veterans' Benefits (Note 12)	8,368	7,532
Accrued Payroll & Benefits	718	804
Other (Note 14)	5,479	2,867
Total Liabilities	**$ 81,894**	**$ 78,425**
Net Position		
Unexpended Appropriations - Earmarked funds	8,887	27,665
Unexpended Appropriations - Other funds	78,830	102,832
Unexpended Appropriations, Total	87,717	130,497
Cumulative Results of Operations - Earmarked funds	332,966	304,465
Cumulative Results of Operations - Other funds	1,230	522
Cumulative Results of Operations, Total	334,196	304,987
Total Net Position	**$ 421,913**	**$ 435,484**
Total Liabilities & Net Position	**$ 503,807**	**$ 513,909**

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

CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2007 and 2006
(In Millions)

Responsibility Segments	2007	2006
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$ 612,411	$ 574,245
Exchange Revenue	(50,304)	(49,847)
CMS Net Cost of Operations	$ 562,107	$ 524,398
Other Segments:		
Administration for Children & Families (ACF)	$ 47,336	$ 47,123
Administration on Aging (AoA)	1,373	1,388
Agency for Healthcare Research & Quality (AHRQ)	131	15
Centers for Disease Control & Prevention (CDC)	8,105	6,555
Food & Drug Administration (FDA)	1,913	1,906
Health Resources & Services Administration (HRSA)	6,897	6,205
Indian Health Service (IHS)	4,250	4,093
National Institutes of Health (NIH)	28,489	28,147
Office of the Secretary (OS)	2,169	2,598
Program Support Center (PSC)	1,414	872
Substance Abuse & Mental Health Services Administration (SAMHSA)	3,320	3,343
Other Segments Gross Cost of Operations	$ 105,397	$ 102,245
Exchange Revenue	(2,905)	(2,706)
Other Segments Net Cost of Operations	$ 102,492	$ 99,539
Net Cost of Operations	**$ 664,599**	**$ 623,937**

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

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2007
(In Millions)

	2007			
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**
Cumulative Results of Operations:				
Beginning Balances	$ 304,465	$ 522	$ -	$ 304,987
Budgetary Financing Sources:				
Appropriations Used	190,742	296,631	-	487,373
Nonexchange Revenue				
Non-exchange Revenue - Tax Revenue	188,219	-	-	188,219
Non-exchange Revenue - Investment Revenue	18,474	-	-	18,474
Non-exchange Revenue - Other	242	36	115	393
Donations and Forfeitures of Cash and Cash Equivalents	44	3	-	47
Transfers-in/out without Reimbursement	(1,920)	911	-	(1,009)
Other budgetary financing sources	(4)	5	-	1
Other Financing Sources (Non-Exchange):				
Donations and forfeitures of property	-	3	-	3
Transfers-in/out without reimbursement (+/-)	(1)	(18)	1	(18)
Imputed financing	26	399	(112)	313
Other (+/-)	-	12	-	12
Total Financing Sources	395,822	297,982	4	693,808
Net Cost of Operations (+/-)	367,321	297,274	4	664,599
Net Change	28,501	708	-	29,209
Cumulative Results of Operations	**$ 332,966**	**$ 1,230**	**$ -**	**$ 334,196**
Unexpended Appropriations				
Beginning Balances	$ 27,665	$ 102,832	$ -	$ 130,497
Budgetary Financing Sources				
Appropriations Received	199,309	274,565	-	473,874
Appropriations transferred in/out	(98)	88	-	(10)
Other Adjustments	(27,247)	(2,024)	-	(29,271)
Appropriations Used	(190,742)	(296,631)	-	(487,373)
Total Budgetary Financing Sources	(18,778)	(24,002)	-	(42,780)
Total Unexpended Appropriations	8,887	78,830	-	87,717
Net Position	**$ 341,853**	**$ 80,060**	**$ -**	**$ 421,913**

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

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2006
(In Millions)

	2006			
	Earmarked Funds	**All Other Funds**	**Eliminations**	**Consolidated Total**
Cumulative Results of Operations:				
Beginning Balances	$ 271,485	$ (1,307)	$ -	$ 270,178
Budgetary Financing Sources:				
Other Adjustments	-	369	-	369
Appropriations Used	173,571	287,273	-	460,844
Nonexchange Revenue				
Non-exchange Revenue - Tax Revenue	180,576	-	-	180,576
Non-exchange Revenue - Investment Revenue	17,227	-	-	17,227
Non-exchange Revenue - Other	311	247	116	674
Donations and Forfeitures of Cash and Cash Equivalents	32	4	-	36
Transfers-in/out without Reimbursement	(2,105)	861	-	(1,244)
Other Financing Sources (Non-Exchange):				
Donations and forfeitures of property	-	4	-	4
Transfers-in/out without reimbursement (+/-)	(1)	(26)	(2)	(29)
Imputed financing	25	406	(118)	313
Other (+/-)	-	(24)	-	(24)
Total Financing Sources	369,636	289,114	(4)	658,746
Net Cost of Operations (+/-)	336,656	287,285	(4)	623,937
Net Change	32,980	1,829	-	34,809
Cumulative Results of Operations	**$ 304,465**	**$ 522**	**$ -**	**$ 304,987**
Unexpended Appropriations				
Beginning Balances	$ 6,877	$ 80,473	$ -	$ 87,350
Budgetary Financing Sources				
Appropriations Received	201,231	323,104	-	524,335
Appropriations transferred in/out	-	(121)	-	(121)
Other Adjustments	(6,872)	(13,351)	-	(20,223)
Appropriations Used	(173,571)	(287,273)	-	(460,844)
Total Budgetary Financing Sources	20,788	22,359	-	43,147
Total Unexpended Appropriations	27,665	102,832	-	130,497
Net Position	**$ 332,130**	**$ 103,354**	**$ -**	**$ 435,484**

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

COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2007 and 2006
(In Millions)

	2007		2006	
	Budgetary	Non-Budgetary Credit Program Financing Accounts	Budgetary	Non-Budgetary Credit Program Financing Accounts
Budgetary Resources:				
Unobligated Balance, Brought Forward, October 1:	$ 67,726	$ 194	$ 18,001	$ 206
Recoveries of Prior Year Unpaid Obligations				
Actual	17,604	-	14,481	-
Budget Authority				
Appropriation	937,162	1	948,366	4
Spending Authority from Offsetting Collections				
Collected	6,104	28	6,741	172
Change in Receivables from Federal sources	650	-	(77)	-
Change in unfilled customer orders				
Advance received	13	-	37	-
Without advance from Federal sources	(1,406)	-	1,903	-
Expenditure Transfers from trust funds				
Actual	3,325	-	3,328	-
Change in Receivables from Trust Funds	290	-	-	-
Subtotal	946,138	29	960,298	176
Nonexpenditure transfers, net, anticipated and actual	(91)	-	59	-
Temporarily not available pursuant to Public Law	(20,607)	-	(34,551)	-
Permanently not available (-)	(29,619)	(29)	(5,847)	-
Total Budgetary Resources	$ 981,151	$ 194	$ 952,441	$ 382
Status of Budgetary Resources:				
Obligations Incurred				
Direct	$ 949,517	$ 49	$ 877,128	$ 4
Reimbursable	7,105	-	7,587	184
Subtotal	956,622	49	884,715	188
Unobligated Balances – Available				
Apportioned	17,155	58	60,075	106
Exempt from apportionment	126	-	73	-
Subtotal	17,281	58	60,148	106
Unobligated Balances - Not Available	7,248	87	7,578	88
Total Status of Budgetary Resources	$ 981,151	$ 194	$ 952,441	$ 382
Change in Obligated Balance:				
Obligated Balance, Net				
Unpaid obligations, brought forward, October 1	$ 142,161	$ 3	$ 123,768	$ -
Uncollected customer payments from Federal sources, brought forward, October 1	(7,327)	-	(5,700)	-
Total unpaid obligated balance, net	134,834	3	118,068	-
Obligations incurred net	956,622	49	884,715	188
Gross outlays	(938,981)	(52)	(851,874)	(185)
Obligated Balance Transferred, Net				
Actual transfers, unpaid obligations	18	-	-	-
Total Unpaid obligated balance transferred, net	18	-	-	-
Recoveries of prior year unpaid obligations, actual	(17,604)	-	(14,481)	-
Change in uncollected customer payments from Federal sources	466	-	1,739	-
Obligated Balance, Net, End of Period				
Unpaid Obligations	142,248	-	142,161	3
Uncollected customer payments from Federal sources	(6,893)	-	(7,327)	-
Total, unpaid obligated balance, net, end of period	135,355	-	134,834	3
Net Outlays				
Gross outlays	938,981	52	851,874	185
Offsetting collections	(9,442)	(28)	(10,338)	(172)
Distributed Offsetting receipts	(257,704)	-	(226,844)	(31)
Net Outlays	**$ 671,835**	**$ 24**	**$ 614,692**	**$ (18)**

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

STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2007 and Prior Base Years
(In Billions)

		Estimates from Prior Years			
	2007	**2006**	**2005** unaudited	**2004** unaudited	**2003** unaudited
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 27 and 28)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	$ 5,975	$ 5,685	$ 5,064	$ 4,820	$ 4,510
SMI Part B	12,112	12,446	11,477	10,505	8,796
SMI Part D	7,285	7,366	7,895	7,545	-
Have attained eligibility age (age 65 and over)					
HI	178	192	162	148	128
SMI Part B	1,648	1,606	1,436	1,310	1,160
SMI Part D	746	750	817	713	-
Those expected to become participants (under age 15)					
HI	4,870	4,767	4,209	4,009	3,773
SMI Part B	4,460	3,562	3,658	3,514	2,817
SMI Part D	2,735	2,134	2,522	2,511	-
All current and future participants:					
HI	11,023	10,644	9,435	8,976	8,411
SMI Part B	18,221	17,613	16,571	15,329	12,773
SMI Part D	10,766	10,250	11,233	10,770	-
Actuarial present value for the 75-year projection period of estimated future cost for or on behalf of: (Notes 27 and 28)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15 – 64)					
HI	15,639	15,633	12,668	12,054	10,028
SMI Part B	12,130	12,433	11,541	10,577	8,845
SMI Part D	7,273	7,338	7,913	7,566	-
Have attained eligibility age (age 65 and over)					
HI	2,558	2,397	2,179	2,168	1,897
SMI Part B	1,834	1,773	1,622	1,475	1,306
SMI Part D	794	792	880	773	-
Those expected to become participants (under age 15)					
HI	5,118	3,904	3,417	3,246	2,653
SMI Part B	4,257	3,407	3,408	3,277	2,622
SMI Part D	2,699	2,121	2,440	2,431	-
All current and future participants:					
HI	23,315	21,934	18,264	17,468	14,577
SMI Part B	18,221	17,613	16,571	15,329	12,773
SMI Part D	10,766	10,250	11,233	10,770	-
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 27 and 28)					
HI	$ (12,292)	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present values for the 75-year projection period of estimated future excess of income (excluding interest) over cost (Notes 27 and 28)					
HI	$ (12,292)	$ (11,290)	$ (8,829)	$ (8,492)	$ (6,166)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust fund assets at start of period					
HI	300	285	268	256	235
SMI Part B	38	23	19	24	34
SMI Part D	1	-	-	-	-
Actuarial present value for the 75-year projection of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over cost (Note 27 and 28)					
HI	$ (11,993)	$ (11,006)	$ (8,561)	$ (8,236)	$ (5,931)
SMI Part B	38	23	19	24	34
SMI Part D	1	-	-	-	-

Note: Totals do not necessarily equal the sums of rounded components.

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

Notes to the Financial Statements
For the Years Ended September 30, 2007 and 2006

Note 1. Summary of Significant Accounting Policies

Reporting Entity

The Department of Health and Human Services (HHS or Department) is a Cabinet-level agency of the Executive Branch of the Federal Government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the Department of Education Organization Act of 1979 (*Public Law 96-88*) was signed into law, providing for a separate Department of Education. HEW officially became HHS on May 4, 1980. The Department is responsible for protecting the health of all Americans and providing essential human services.

Organization and Structure of HHS

The HHS comprises the Office of the Secretary and 11 Operating Divisions (OPDIVs) with diverse missions and programs. The Office of the Secretary and each OPDIV are considered a responsibility segment representing a component that is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products or services. Although it is part of the Office of the Secretary, the Program Support Center reports on its activity separately because its business activities encompass offering services to other OPDIVs and Federal agencies. The Agency for Toxic Substances and Disease Registry is combined with the Centers for Disease Control and Prevention for financial reporting purposes; therefore, these footnotes will refer to them as one responsibility segment. The managers of the responsibility segments report to the entity's top management directly, and the resources and results of operations can be clearly distinguished from those of other responsibility segments of the entity. The 12 responsibility segments are:

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

Basis of Accounting and Presentation

The 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 3515(b), the Chief Financial Officers Act of 1990 (*Public Law 101-576*), as amended by the Government Management Reform Act of 1994, and presented in accordance with the requirements in the Office of Management and Budget (OMB)

Circular No. A-136, *Financial Reporting Requirements.* These statements have been prepared from the Department's financial records using an accrual basis in conformity with accounting principles generally accepted in the United States. 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. These statements are, therefore, different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the HHS' use of budgetary resources.

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

The financial statements consolidate the balances of approximately 160 appropriations and fund accounts, and a number of accounts used for suspense, collection of receipts, and general government functions. Transactions and balances among the HHS OPDIVs have been eliminated in the presentation of the Consolidated Balance Sheets and Statements of Net Cost and of Changes in Net Position. The Combined Statements of Budgetary Resources are presented on a combined basis, therefore intra-HHS and intra-OPDIV transactions and balances have not been eliminated from these statements. Supplemental information is accumulated from the OPDIV reports, regulatory reports, and other sources within the 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 the HHS.

Reconciliation of Net Cost of Operations (Proprietary) to Budget
Effective for FY 2007, OMB Circular No. A-136 changed disclosure requirements for the explanation of the differences between budgetary and financial accounting. The Reconciliation of Net Cost of Operations (Proprietary) to Budget, formerly the Statement of Financing, was transferred from the basic financial statements to a footnote disclosure. The Reconciliation is disclosed in Note 30.

Unified Financial Management System (UFMS)
The HHS continues to streamline and integrate its financial management systems through a phased development of the UFMS. The HHS' financial management goals seek to (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that the HHS resources are used appropriately, efficiently, and effectively. With UFMS, the HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. In FY 2001, the CMS began the Healthcare Integrated General Ledger Accounting System (HIGLAS) project to replace the Medicare contractors' and CMS accounting systems with a single, unified system. As of September 30, 2007, ten Medicare contractors were using HIGLAS. The CDC and the FDA went live with UFMS in April 2005. The ACF, AoA, AHRQ, HRSA, OS, PSC, and the SAMSHA went live in October 2006. The final deployment of UFMS for the IHS occurred in October 2007.

Use of Estimates in Preparing Financial Statements
Preparation of financial statements in accordance with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent liabilities as of the date of the financial statements. Estimates and assumptions also affect the revenues and expenses accrued and reported in the financial statements. Actual results may differ from those estimates.

Entity and Non-Entity Assets
Entity assets are assets that 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 those assets held by the reporting entity but not available for use. An example of a non-entity asset is the interest accrued on overpayments and cost settlements reported by the Medicare contractors.

Entity and non-entity assets are combined into one line on the face of the balance sheet as required by OMB Circular No. A-136.

Fund Balance with Treasury
The HHS maintains its available funds with the Department of the Treasury (Treasury or U.S. Treasury) except for the Medicare Benefit accounts maintained at commercial banks. The Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Cash receipts and disbursements are processed by Treasury, and the HHS' records are reconciled with those of the Treasury on a regular basis.

Investments, Net
Investments consist of Treasury securities including the CMS par value securities that represent the majority of the HHS earmarked funds carried at face value, and other securities carried at amortized cost. Section 1817 for the Hospital Insurance Trust Fund (HI) and Section 1841 for the Supplementary Medical Insurance Trust Fund (SMI) of the Social Security Act require that trust investments not necessary to meet current expenditures be invested in interest-bearing obligations of the U.S. Government, or in obligations guaranteed as to both principal and interest by the U.S. Government.

The FASAB Statement of Federal Financial Accounting Standard (SFFAS), No. 27, *Identifying and Reporting Earmarked Funds*, prescribes certain disclosures concerning earmarked investments. The Federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI trust funds. The cash receipts collected from the public for an earmarked fund are deposited in the U.S. Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI trust funds as evidence of their receipts. The Treasury securities are an asset to the HI and SMI trust funds and a liability to the U.S. Treasury. Because the HI and SMI trust funds and the U.S. Treasury are part of the Federal government, these assets and liabilities offset each other from the standpoint of the Federal government as a whole and are eliminated from presentation in the consolidation of the U.S. Government-wide financial statements.

The Treasury securities provide the HI and SMI trust funds with authority to draw upon the U.S. Treasury to make future benefit payments or other expenditures. When the trust funds require redemption of these securities to make expenditures, the government finances the expenditures out of accumulated cash balances, by raising taxes, by raising the Federal match of SMI premiums or other receipts, by borrowing from the public or repaying less debt, or by curtailing other expenditures. This is the same way that the government finances all expenditures.

No provision is made for unrealized gains or losses on these securities since it is the Department's intent to hold investments to maturity. Interest income is compounded semiannually in June and December.

Accounts Receivable, Net

Accounts receivable consist of the amounts owed to the HHS by other Federal agencies and the public as the result of the provision of goods and services. Intragovernmental accounts receivable arise generally from the provision of reimbursable work to other Federal agencies and no allowance for uncollectible accounts is established as they are considered to be fully collectible. Accounts receivable also include interest due to the HHS that is directly attributable to delinquent accounts receivable.

Accounts receivable from the public are primarily composed of provider and beneficiary overpayments, Medicare Secondary Payer overpayments, Medicare Premiums, and Medicaid Audit Disallowances. They are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is determined based on past collection experience and an analysis of outstanding balances.

Direct Loans and Loan Guarantee Receivables and Liabilities

Direct Loans:

The Health Care Infrastructure Improvement Program was enacted into law as part of the Medicare Modernization Act of 2003. This loan program provides loans to hospitals or entities that are engaged in research in the causes, prevention, and treatment of cancer; and are designated as cancer centers by the National Cancer Institute, or are designated by the State legislature as the official cancer institute of the State, and such designation by the State legislature occurred prior to December 8, 2003, for payment of the capital costs of eligible projects. The HHS reasonably expects any loans made under this program to be forgiven as it is anticipated that the borrowers will meet the requirements for forgiveness.

Loan Guarantees:

The HHS administers guaranteed loan programs for the Health Center and the Health Education Assistance Loans (HEAL) programs. Loans receivable represent defaulted guaranteed loans, which have been paid to lenders under this program. Loans receivable also include interest due to the HHS on the defaulted loans. The loans guarantee liabilities are valued at the present value of the cash outflows from the HHS less the present value of related inflows.

As required under the Federal Credit Reform Act (FCRA) of 1990, for loan guarantees committed on or after October 1, 1991, guaranteed loans are reduced by an allowance for subsidy representing the present value of the amounts not expected to be recovered and thus having to be subsidized by the government for loan guarantees. The FCRA also requires that the subsidy cost estimate be based on the net present

value of the specified cash flows discounted at the interest rate of marketable Treasury securities of similar maturities. The liability for loan guarantees committed on or after October 1, 1991, is reported at present value.

For loan guarantees committed prior to October 1, 1991, loan guarantee principal and interest receivable are reduced by an allowance for estimated uncollectible amounts. The allowance is estimated based on past experience and an analysis of outstanding balances. The liability for loan guarantees committed prior to October 1, 1991, is established based upon an average default rate. The liability is adjusted each year for the change in default rates.

Advances to Grantees/Accrued Grant Liability

The HHS awards grants to various grantees and provides advance payments to grantees to meet their cash needs to carry out their programs. Advance payments are recorded as "Advances to Grantees" and are liquidated upon grantees' reporting expenditures. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the "Advances to Grantees" account. An accrued grant liability occurs when the accrued grant expenses exceed the outstanding advances to grantees, resulting in a negative balance in the "Advances to Grantees" account. The HHS grants are classified into two categories: "Grants Not Subject to Grant Expense Accrual" and "Grants Subject to Grant Expense Accrual." Progress payments on work in process are not included in grants.

Grants Not Subject to Grant Expense Accrual: These grants represent formula grants (also referred to as "block grants") under which grantees provide a variety of services or payments to individuals and local agencies. Expenses are recorded as the grantees draw funds. These grants are funded on an allocation basis determined by budgets and agreements approved by the sponsoring OPDIV as opposed to a reimbursable basis. Therefore, they are not subject to grant expense accrual.

Grants Subject to Grant Expense Accrual: For grants subject to grant expense accrual, commonly referred to as "non-block grants," grantees draw funds (recorded as Advances to Grantees) based on their estimated cash needs. As grantees report their actual disbursements (quarterly), the amounts are recorded as expenses, and their advance balances are reduced. At year-end, the OPDIVs report both actual payments made through the fourth quarter and an unreported grant expenditures estimate for the fourth quarter based on historical spending patterns of the grantees. The year-end accrual estimate equals the estimate of fourth quarter disbursements plus an average of two weeks annual expenditures for expenses incurred prior to the cash being drawn down.

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

Inventory and Related Property, Net

Inventory and Related Property primarily consist of Inventory Held for Sale, Operating Materials and Supplies, and Stockpile Materials.

Inventory Held for Sale consists of small equipment and supplies held by the Service and Supply Fund for sale to HHS components and other Federal entities. Inventories held for sale are valued at historical cost using the weighted average valuation method for PSC inventories and using the moving average valuation method for the NIH inventories.

Operating Materials and Supplies consist of pharmaceuticals, biological products, and other medical supplies used in providing medical services and conducting medical research. Operating materials and supplies are recorded as assets when purchased and are expensed when they are consumed. Operating materials and supplies are valued at historical cost.

Stockpile Materials are materials held in reserve to respond to local and national emergencies. In addition, the CDC maintain a stockpile of vaccines to meet unanticipated needs in the case of a national emergency. As required by the Project BioShield Act of 2004, the Department of Homeland Security transferred Strategic National Stockpile materials to the HHS in FY 2004. The Strategic National Stockpile materials are not available for sale and are valued at historical cost using the FIFO cost flow assumption and the CDC's vaccine stockpile is valued at historical cost.

General Property, Plant and Equipment, Net

General Property, Plant and Equipment (PP&E) consist of buildings, structures, and facilities used for general operations; land acquired for general operating purposes; equipment; assets under capital lease; leasehold improvements; construction-in-progress; and internal use software. The basis for recording purchased PP&E is full cost, net of accumulated depreciation including all costs incurred to bring the PP&E to a form and location suitable for its intended use. The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. The cost of PP&E acquired through donation is the estimated fair market value when acquired. The cost of PP&E transferred from other Federal entities is the net book value of the transferring entity. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of two years or more are capitalized, except for internal use software discussed below.

The PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

The SFFAS No. 10, *Accounting for Internal Use Software,* requires that the capitalization of internally developed, contractor-developed and commercial off-the-shelf (COTS) software begin in the software development phase. In FY 2004, the HHS incurred development costs for UFMS, a COTS software package, and began capitalizing the cost. The estimated useful life for internal use software was determined to be five to ten years for amortization purposes. The HHS began amortization when the internal use software was placed in use. Capitalized costs include all direct and indirect costs. In FY 2005, the CMS began amortizing HIGLAS over ten years using the straight-line method in accordance with the HHS policy for UFMS. In addition, the CMS has other capitalized internal use software that is currently being amortized over a useful life of five years.

The capitalization threshold for internal use software costs for appropriated fund accounts is $1 million and the capitalization threshold for revolving funds is $500 thousand. Costs below the threshold levels

are expensed. The software is depreciated for a period of time consistent with the estimated useful life used for planning and acquisition purposes.

Stewardship Property, Plant & Equipment
Stewardship PP&E consist of heritage assets and stewardship land whose physical properties resemble those of general PP&E that are traditionally capitalized in financial statements. Based on SFFAS No. 29, *Heritage Assets and Stewardship Land*, and due to the difficulty in valuing these assets, the HHS does not report a related amount on the balance sheet. This standard requires that the balance sheet reference a note that discloses information but not an amount for Stewardship PP&E.

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 the HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing Federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare Health Insurance Trust Fund, since liabilities are only those items that are present obligations of the Government. The Department's liabilities are classified as covered by budgetary resources or not covered by budgetary resources.

Liabilities Covered by Budgetary Resources: Available budgetary resources include: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of expired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities Not Covered by Budgetary Resources: Sometimes funding has not yet been made available through Congressional appropriations or current earnings. The major liabilities in this category include employee annual leave earned but not taken, amounts billed by the Department of Labor (DOL) for Federal Employees' Compensation Act (FECA) disability payments, and portions of the Entitlement Benefits Due and Payable liability (discussed below) for which no obligations have been incurred. Also included in this category is the actuarial FECA liability determined by DOL but not yet billed. For HHS revolving funds, all liabilities are funded as they occur.

Accounts Payable
Accounts Payable primarily consist of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

Accrued Payroll and Benefits
Accrued Payroll and Benefits consist of salaries, wages, leave and benefits earned by employees, but not disbursed as of September 30. Liability for annual and other vested compensatory leave is accrued when 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 this leave will be funded from future appropriations when it is actually

taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consists of the HHS FECA liability.

Entitlement Benefits Due and Payable
Entitlement Benefits Due and Payable primarily represent the liability for Medicare and Medicaid for medical services incurred but not reported (IBNR) as of the balance sheet date.

Medicare
The Medicare liability is developed by the Office of the Actuary of the Centers for Medicare & Medicaid Services and includes (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of claims that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

Medicaid
The Medicaid estimate represents the net Federal share of expenses incurred by the States but not yet reported to CMS. The September 2007 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Federal Employee and Veterans' Benefits
Most HHS employees participate in either 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 FERS. For employees covered under FERS, the Department contributes the employer's matching share for Social Security and Medicare Insurance. A primary feature of FERS is that it offers a Thrift Savings Plan into which the Department automatically contributes one percent of employee pay and matches employee contributions up to an additional four percent of pay.

The U.S. Office of Personnel Management is the administering agency for both of these benefit plans and, thus, reports CSRS or FERS assets, accumulated plan benefits, or unfunded liabilities applicable to Federal employees. Therefore, the HHS does not recognize any liability on its balance sheet for pensions, other retirement benefits, and other post-employment benefits with the exception of Commissioned Corps (see below). The HHS does, however, recognize an expense in the Consolidated Statements of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statements of Changes in Net Position.

The HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System, a defined noncontributory benefit plan, for its active duty officers and retiree annuitants or survivors. The plan does not have accumulated assets, and funding is provided entirely on a pay-as-you-go basis by Congressional appropriations. The HHS records the actuarial liability based on the present value of accumulated pension plan benefits and the post-retirement health benefits.

The liability for Federal employee and veterans' benefits also includes a liability for actual and estimated future payments for workers' compensation pursuant to the Federal Employees Compensation Act (FECA). The FECA provides income and medical cost protection to (1) Federal employees who were injured on the job or who have sustained a work-related occupational disease and (2) beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by the Department of Labor (DOL), which pays valid claims and subsequently bills the employing Federal agency. The FECA liability consists of two components: the (1) actual claims paid by DOL but not yet disbursed, and (2) estimated liability for future benefit payments as a result of past events, such as death, disability, and medical costs.

Revenue and Financing Sources

The Department receives the majority of funding needed to support its programs through Congressional appropriation and through reimbursement for the provision of goods or services to other Federal agencies. The United States Constitution prescribes that no money may be expended by a Federal agency unless and until funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by the Department. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statements of Changes in Net Position.

Appropriations. The Department 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).

Exchange and Non-Exchange Revenue. The HHS classifies revenues as either exchange or non-exchange. Exchange revenues are recognized when earned, i.e., when goods have been delivered or services have been rendered. These revenues reduce the cost of operations borne by the taxpayer.

Non-exchange revenues result 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 revenues are not considered to reduce the cost of the Department's operations and are reported in the Statements of Changes in Net Position.

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employee wages and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the General Fund of the Treasury. The Social Security Act requires the transfer of these contributions from the General Fund of the Treasury to the HI trust fund based on the amount of wages certified by the Social Security Administration (SSA) from SSA records of wages established and maintained by the SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers and self-employed individuals to the Internal Revenue Service as the basis for conducting quarterly certification of regular wages.

With minor exceptions, all receipts of revenues by Federal agencies are processed through the Treasury's central accounting system. Regardless of whether they derive from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate departmental use are deposited in the general or special funds of the Treasury. Amounts not retained for use by the HHS are reported as transfers to other government agencies on the HHS Statements of Changes in Net Position.

Imputed Financing Sources. In certain instances, operating costs of the HHS are paid out of funds appropriated to other Federal agencies. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management, and certain legal judgments against the HHS are paid from the Judgment Fund maintained by the Treasury. When costs that are identifiable to the HHS and directly attributable to the Department's operations are paid by other agencies, the Department recognizes these amounts as imputed costs on the Statements of Net Cost and as an imputed financing source on the Consolidated Statements of Changes in Net Position.

Other Financing Sources. Medicare's HI program, or Medicare Part A, is financed through the HI trust fund, whose revenues come primarily from the Medicare portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and under the Self-Employment Contribution Act (SECA). Contribution rates are discussed under *Exchange and Non-Exchange Revenue*. Medicare's Supplemental Medical Insurance (SMI) program, or Medicare Part B, is financed primarily by general fund appropriations (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries.

Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to the Department. The uncertainty should ultimately 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 No. 5, *Accounting for Liabilities of the Federal Government,* as amended by SFFAS No. 12, *Recognition of Contingent Liabilities from Litigation*, contain the criteria for recognition and disclosure of contingent liabilities. 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 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.

Parent/Child Reporting

The HHS is a party to allocation transfers with other federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one department of its authority to obligate budget authority and outlay funds to another department. A separate fund account (allocation account) is created in the U.S. Treasury as a subset of the parent fund account for tracking and reporting purposes. All allocation transfers of balances are credited to this account, and subsequent obligations and outlays incurred by the child entity are charged to this allocation account as

they execute the delegated activity on behalf of the parent entity. Generally, all financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived.

Exceptions to this general rule affecting the HHS include Treasury-Managed Trust Funds: Federal Supplementary Medical Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, the Vaccine Injury Compensation Program Trust Fund and the Healthcare Fraud and Abuse Control Account, for which the HHS is the child in the allocation transfer but, per OMB guidance, will report all activity relative to these allocation transfers in the HHS financial statements.

In addition to these funds, the HHS allocates funds, as the parent, to the Department of the Interior, Bureau of Indian Affairs. The HHS receives allocation transfers, as the child, from the Environmental Protection Agency and the Departments of Homeland Security, Justice and State.

Intragovernmental Relationships and Transactions

In the course of its operations, the HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are the SSA and the Department of the Treasury. The SSA determines eligibility for Medicare programs and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Similarly, Medicare Part D is also primarily financed by the General Fund of the Treasury.

Earmarked Funds

SFFAS No. 27, *Identifying and Reporting Earmarked Funds,* defines earmarked funds and requires that they be shown separately from all other funds on the Statement of Changes in Net Position, as well as in the Net Position section of the Balance Sheet. Earmarked funds are defined as those financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time; are required by statute to be used for designated activities, benefits or purposes; and must be accounted for separately from the Government's general revenues. "Fund" in this statement's definition of earmarked funds refers to a "fiscal and accounting entity with a self-balancing set of accounts recording cash and other financial resources, together with all related liabilities and residual equities or balances, and changes therein, which are segregated for the purpose of carrying on specific activities or attaining certain objectives in accordance with special regulations, restrictions, or limitations."

Whether the appropriation is provided by authorizing legislation or annual appropriations acts, the cumulative results of operations arising from earmarked funds are reserved or restricted to the designated activity, benefit or purpose. The standard also requires that condensed information on assets, liabilities and costs for earmarked funds be disclosed. An earmarked fund may be classified in the unified budget as a trust, special or public enterprise fund. Examples of the HHS earmarked funds include the HI trust fund that is used to process claims associated with Part A benefits and the SMI trust fund that is used to process claims associated with Part B and Part D benefits.

Medicare Hospital Insurance (HI) Trust Fund – Part A
Section 1817 of the Social Security Act established the Medicare Hospital Insurance Trust Fund. Medicare contractors are paid by the HHS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The HHS payments to Medicare Advantage plans (previously known as Managed Care plans) are also charged to this fund. The financial statements include the HI trust fund activities administered by the Department of Treasury. This 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 FICA and SECA. Employee 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 General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance (SMI) Trust Fund – Part B
Section 1841 of the Social Security Act established the Supplementary Medical Insurance Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end-stage renal disease treatment (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The HHS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

The SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Prescription Drug Benefit – Part D
The Medicare Prescription Drug Benefit – Part D, established by the Medicare Modernization Act (MMA) of 2003, became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through

the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources. Medicare also reimburses States who have paid prescription drug costs for dual eligibles who have had difficulty accessing Part D benefits.

The Part D is considered part of the SMI trust fund and is reported in the Medicare column of financial statements where required.

Medicare and Medicaid Integrity Program

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, *Public Law No. 104-191, § 202*) established the Medicare Integrity Program at section 1893 of the Social Security Act, and codified Medicare program integrity activities previously known as "payment safeguards." 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." Through the Medicare Integrity program, the CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the Deficit Reduction Act of 2005 (DRA, *Public Law No. 109-171. § 6034*), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the Federal government's first effort to directly review and audit Medicaid providers, tasks that were formerly performed solely by States. Under the Medicaid Integrity Program, which is still in the implementation phase, CMS will contract with eligible entities to perform, with respect to Medicaid providers, activities generally similar to those currently performed by Medicare Integrity Program contactors with respect to Medicare providers.

Medicaid

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the CMS' share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by the CMS for the difference between approved expenses reported for the period and grant awards previously issued. Medicaid is financed by general funds and is not classified as "earmarked."

The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The Grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to fund SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between the approved expenses reported for the period and the grant awards previously issued.

Statement of Social Insurance

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

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under current law. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care cost, wages, the gross domestic product (GDP), the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The assumptions underlying the SOSI actuarial projections, and the projections themselves, are drawn from the Social Security and Medicare Trustees Reports for 2007. 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 additional information on the SOSI of actuarial present values of estimated future income (excluding interest) less expenditures plus assets at the start of the period is presented for purposes of additional analysis and is not a required part of the financial statements.

Note 2. Non-Entity Assets

Non-entity assets at September 30, 2007 and 2006, consisted of the following:

(In Millions)	2007	2006
Intragovernmental:		
Fund Balance with Treasury	$ 22	$ 26
Total Intragovernmental	22	26
Accounts receivable	15	14
Total Non-Entity Assets	37	40
Total Entity Assets	503,770	513,869
Total Assets	$ 503,807	$ 513,909

The $22 million non-entity asset Fund Balance with Treasury primarily consists of Federal tax refunds collected by the Internal Revenue Service for delinquent child support payments that were transferred to ACF for distribution to the States and also includes $9 million in NIH collections of royalties from licenses for which a portion is paid to inventors under the Federal Technology Transfer Act. The $15 million net accounts receivable primarily represents CMS' receivables for interest and penalties.

Note 3. Fund Balance with Treasury

The Fund Balance with Treasury (FBWT) and the status of the fund balance as of September 30, 2007 and 2006, are listed below by fund type.

(In Millions)	2007	2006
Fund Balance with Treasury		
Trust Funds	$ 9,047	$ 28,985
Revolving Funds	5,613	896
Appropriated Funds	99,225	129,292
Other Funds	889	748
Total	$ 114,774	$159,921

Status of Fund Balance with Treasury		
Unobligated Balance	2007	2006
Available	$ 17,339	$ 60,254
Unavailable	7,335	7,666
Obligated Balance not yet Disbursed	135,355	134,837
Non-Budgetary FBWT	(45,255)	(42,836)
Total	$ 114,774	$ 159,921

Other Funds include balances in deposit, suspense, clearing, and related non-spending accounts. The Unobligated Balance includes $2.2 billion for both September 30, 2007 and 2006, which is restricted for future use and is not apportioned for current use. The $2.2 billion reported for September 30, 2007, includes restricted amounts for the ACF Contingency Fund for State Welfare Programs, the CMS Program Management and State Grants and Demonstrations, the NIH Royalties owed to Inventors, the HRSA Federal Interest Subsidies for Medical Facilities Guarantee and Loan Fund, the FDA Imprest Fund and the PSC Service and Supply Funds.

The Non-Budgetary FBWT negative balances reported for September 30, 2007 and 2006, are primarily due to CMS Medicare trust funds temporarily precluded from obligation.

Note 4. Cash and Other Monetary Assets

Cash and Other Monetary Assets consist primarily of the time account balances at the Medicare contractors' commercial banks. The HHS uses the "Checks Paid Letter-of-Credit" method for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against Medicare Benefits Accounts maintained at commercial banks. To compensate the commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest bearing time accounts. The interest foregone by HHS on these time accounts is used to reimburse the commercial banks for the service. The account balances as of September 30, 2007 and 2006, were $129 million and $145 million, respectively.

Note 5. Investments, Net

The HHS' investments as of September 30, 2007 and 2006, are summarized below:

	2007			
(In Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 41	$ -	$ 41	$ 41
Non-Marketable: Par Value	358,625	-	358,625	358,625
Non-Marketable: Market-based	2,629	(3)	2,626	2,626
Subtotal	361,295	(3)	361,292	361,292
Accrued Interest	4,583	-	4,583	4,583
Total, Intragovernmental	$ 365,878	$ (3)	$365,875	$ 365,875

	2006			
(In Millions)	Cost	Unamortized (Premium) Discount	Investments, Net	Market Value Disclosure
Intragovernmental Securities				
Marketable	$ 29	$ -	$ 29	$ 29
Non-Marketable: Par Value	335,247	-	335,247	335,247
Non-Marketable: Market-based	2,383	7	2,390	2,390
Subtotal	337,659	7	337,666	337,666
Accrued Interest	4,310	-	4,310	4,310
Total, Intragovernmental	$ 341,969	$ 7	$341,976	$ 341,976

The HHS invests entity trust fund balances in excess of current needs in U.S. Treasury securities. The Department of Treasury acts as the fiscal agent for the U.S. Government's investments in securities. The HHS securities purchased and redeemed include Marketable, Non-Marketable (Par Value), and Non-Marketable Market-based (MK) securities. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The Medicare bonds interest rates ranged from 3.50 percent to 7.25 percent from October 1, 2006, to September 30, 2007, and 3.50 percent to 7.375 percent from October 1, 2005, to September 30, 2006. The One Day Certificates are short-term and paid between 4.50 percent and 4.75 percent from

October 1, 2006, to September 30, 2007 and 4.75 to 5.25 percent from October 1, 2005, to September 30, 2006.

The HHS invests in One Day Certificates, Market-Based Notes and Market-Based Bills. The MK securities purchased by the HHS mirror marketable securities terms that are not traded on any securities exchange; these include Non-Marketable, MK, and One Day Certificates. The MKs are purchased by HRSA's Vaccine Injury Compensation Program (VICP) trust fund. Discounts on Market-Based Bills are amortized on a straight-line basis, and discounts and premiums on Market-Based Notes are amortized on an effective interest basis. Currently, securities held by the VICP will mature in fiscal years 2008 through 2012. The Market-Based Notes paid from 3.00 percent to 5.50 percent from October 1, 2006, to September 30, 2007, and from 3.00 percent to 6.25 percent from October 1, 2005, to September 30, 2006. One Day Certificates paid from 4.58 percent to 5.34 percent from October 1, 2006, to September 30, 2007.

Marketable securities purchased by the NIH gift funds are recorded at cost based on market terms and are invested in interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

Note 6. Accounts Receivable, Net

The HHS' accounts receivable as of September 30, 2007 and 2006, are summarized below:

	2007							
(In Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 1,621	$ -	$ -	$ 1,621	$ -	$ 1,621	$ (457)	$ 1,164
Non-Entity	-	-	-	-	-	-	-	-
Total	$ 1,621	$ -	$ -	$ 1,621	$ -	$ 1,621	$ (457)	$ 1,164
With the Public								
Entity								
Medicare	$ 13,827	$ -	$ -	$ 13,827	$(2,483)	$ 11,344	$ -	$ 11,344
Other	1,886	2	1	1,889	(227)	1,662	-	1,662
Non-Entity	13	49	-	62	(47)	15	-	15
Total	$ 15,726	$ 51	$ 1	$ 15,778	$(2,757)	$ 13,021	$ -	$ 13,021

	2006							
(In Millions)	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable, Gross	Allowance	Net OPDIV Receivables Consol.	Inter-OPDIV Eliminations	Net HHS Receivables Consol.
Intragovernmental								
Entity	$ 978	$ -	$ -	$ 978	$ -	$ 978	$(252)	$ 726
Non-Entity	-	-	-	-	-	-	-	-
Total	$ 978	$ -	$ -	$ 978	$ -	$ 978	$(252)	$ 726
With the Public								
Entity								
Medicare	$4,784	$ -	$ -	$4,784	$(1,919)	$2,865	$ -	$2,865
Other	590	2	1	593	(265)	328	-	328
Non-Entity	9	43	-	52	(38)	14	-	14
Total	$5,383	$45	$ 1	$5,429	$(2,222)	$3,207	$ -	$3,207

The Hospital Insurance (HI) Trust Fund accrues a receivable from the Railroad Retirement Board (RRB) for amounts transferred through a financial interchange between the HI Trust Fund and the RRB. The transfer is intended to place the HI trust fund in the same position it would have been had railroad employment been covered by the Federal Insurance Contributions Act. Of the Intragovernmental Accounts Receivable, Net, as of September 30, 2007 and 2006, $484 million and $473 million were owed by the RRB, respectively.

Medicare Secondary Payer (MSP) receivables are composed of paid claims in which Medicare should have been the secondary payer rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount.

For Medicare receivables, the HHS calculates the allowance for uncollectible accounts receivable based on the collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the preceding five years. The Medicaid accounts receivable has been recorded at a net realizable amount based on historic analysis of actual recoveries and the rate of disallowances found in favor of the States.

Note 7. Inventory and Related Property, Net

The HHS' inventory and related property, net, at September 30, 2007 and 2006, are summarized below:

(In Millions)	2007	2006
Inventory Held for Sale:		
Inventory Held for Current Sale	$ 13	$ 19
Total Inventory Held for Sale	13	19
Operating Materials and Supplies:		
Operating Materials and Supplies Held for Use	4	4
Total Operating Materials and Supplies	4	4
Stockpile Materials:		
Stockpile Materials Held for Emergency or Contingency	3,144	2,299
Total Stockpile Materials	3,144	2,299
Inventory and Related Property, Gross	3,161	2,322
Inventory and Related Property, Net	$ 3,161	$ 2,322

Note 8. General Property, Plant and Equipment, Net

Major categories of the HHS General Property, Plant and Equipment (PP&E) at September 30, 2007 and 2006, are listed below:

			2007		
(In Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 50	$ -	$ 50
Construction in Progress	-	-	737	-	737
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,419	(1,574)	2,845
Equipment	Straight Line	3-20 Yrs	1,140	(695)	445
Internal Use Software	Straight Line	5-10 Yrs	1,116	(262)	854
Assets Under Capital Lease	Straight Line	1-20 Yrs	140	(42)	98
Leasehold Improvements	Straight Line	*Life of Lease	43	(8)	35
Totals			$7,645	$ (2,581)	$ 5,064

*7 to 15 years or the life of the lease.

			2006		
(In Millions)	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 48	$ -	$ 48
Construction in Progress	-	-	718	-	718
Buildings, Facilities & Other Structures	Straight Line	5-50 Yrs	4,179	(1,458)	2,721
Equipment	Straight Line	3-20 Yrs	1,281	(620)	661
Internal Use Software	Straight Line	5-10 Yrs	863	(179)	684
Assets Under Capital Lease	Straight Line	1-20 Yrs	41	(38)	103
Leasehold Improvements	Straight Line	*Life of Lease	43	(7)	36
Totals			$7,273	$(2,302)	$ 4,971

*7 to 15 years or the life of the lease.

Note 9. Other Assets

Other assets as of September 30, 2007 and 2006, are comprised of the following, all of which are considered entity assets:

(In Millions)	2007	2006
Intragovernmental		
Advances to Other Federal Entities	$ 438	$ 499
Other		1
OPDIV Combined, Intragovernmental	438	500
Intra-OPDIV Eliminations	(392)	(365)
OPDIV Consolidated, Intragovernmental	46	135
Inter-OPDIV Eliminations	(3)	(3)
HHS Consolidated, Intragovernmental	$ 43	$ 132
With the Public		
Prepayments and Deferred Charges	$ 1	$ -
Travel Advances & Emergency Employee Salary Advances	12	139
Other	563	370
HHS Consolidated, With the Public	$ 576	$ 509

Advances to other Federal entities is largely comprised of advances from the NIH to the NIH Service and Supply Fund and the Management Fund for financing the NIH Business System and the NIH Clinical Center, as well as advances from the CDC and the OS to the Department of Veterans Affairs for Strategic National Stockpile items.

As of September 30, 2007, the CMS had $161 million ($124 million in FY 2006) in Other Assets representing advances made to various contractors and vendors. The HRSA has Health Education Assistance Loan programs from which the net loan receivable comprises a large portion of Other Assets with the Public.

Note 10. Liabilities Not Covered by Budgetary Resources

The HHS' liabilities not covered by budgetary resources at September 30, 2007 and 2006 are summarized below:

(In Millions)	2007	2006
Intragovernmental		
Accrued Payroll and Benefits	$ 29	$ 27
Other (Note 14)	613	526
Total Intragovernmental	642	553
Federal Employees and Veterans' Benefits (Note 12)	8,368	7,532
Accrued Payroll and Benefits	392	458
Other (Note 14)	4,371	1,889
Total Liabilities Not Covered by Budgetary Resources	13,773	10,432
Total Liabilities Covered by Budgetary Resources	68,121	67,993
Total Liabilities	$ 81,894	$ 78,425

Note 11. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represent benefits due and payable to the public at year-end from entitlement programs enacted by law. The Medicare and Medicaid programs are the largest entitlement programs in the HHS and comprise all of the HHS Entitlement Benefits Due and Payable.

Entitlement Benefits Due and Payable at September 30, 2007 and 2006, are summarized in the following schedule:

	2007			2006		
(In Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Medicare	$ 41,604	$ -	$ 41,604	$ 40,824	$ -	$40,824
Medicaid	19,414	-	19,414	19,182	-	19,182
Other	452	-	452	1,158	-	1,158
Totals	$ 61,470	$ -	$ 61,470	$ 61,164	$ -	$61,164

Medicare benefits payable consists of a $35,063 million estimate ($36,628 million in FY 2006) by CMS Office of the Actuary of Medicare services incurred but not paid as of September 30, 2007.

Medicare Advantage and Prescription Drug Program benefits payable consist of a $2,653 million estimate ($1,683 million in FY 2006) for amounts owed to plans relating to risk and other payment related adjustments in addition to $982 million owed to plans after the completion of the Prescription Drug Payment reconciliation.

The Retiree Drug Subsidy (RDS) consists of a $2,906 million estimate ($2,377 million in FY 2006) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2007. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

During FY 2006, CMS implemented the State to Plan Reconciliation Demonstration project under the authority of Section 402 of the Social Security Amendments of 1967 in order to ensure appropriate care continuation for dual eligibles and other low-income subsidy entitled beneficiaries. As of September 30, 2006, the liability of $136 million relating to the demonstration project represents estimated amounts to be paid to States for costs incurred in assisting dual eligible beneficiaries to transition to the Medicare Part D Prescription Drug Benefit. As of September 30, 2007, no liability exists because the project was completed during FY 2007.

Undocumented aliens consist of a $163 million estimate ($170 million in FY 2006) of emergency health services furnished by providers to eligible aliens but not paid as of September 30. As part of the MMA, Section 1011, Congress mandated HHS directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act related to undocumented aliens.

Medicaid benefits payable of $19,414 million ($19,182 million in FY 2006) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2007. An estimated SCHIP benefits payable of $289 million has been recorded ($284 million in FY 2006) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2007.

A liability reported at September 30, 2006, for Katrina relief waivers of $704 million which consisted of $543 million in actual services rendered but not paid plus a $161 million estimate for services incurred but not paid by eligible States with respect to evacuees who did not have other coverage for assistance through insurance under title XIX of the Social Security Act does not exist as of September 30, 2007. Services were rendered by September 30, 2006, and the payments were made during FY 2007. CMS has this authority under an approved Multi-State Section 1115 Demonstration Project of Public Law 109-171, Subtitle C.

Note 12. Federal Employee and Veterans' Benefits

The HHS' Federal Employee and Veterans' Benefits at September 30, 2007 and 2006, are summarized below. These liabilities are not covered by budgetary resources.

(In Millions)	2007	2006
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 7,575	$ 6,583
PHS Commissioned Corp Post-retirement Health Benefits	516	680
Workers' Compensation Benefits (Actuarial FECA Liability)	277	269
Total, Federal Employee and Veterans' Benefits	$ 8,368	$ 7,532

Public Health Service (PHS) Commissioned Corps: The HHS administers the PHS Commissioned Corps Retirement System for approximately 5,913 active duty officers and 5,441 retiree annuitants and survivors. Authorized by *Public Law 78-410,* it is a defined noncontributory benefit plan. At September 30, 2007, the actuarial present value of accumulated plan pension benefits was $7,575 million, of which $578 million was not vested, and the liability for medical benefits was actuarially determined to be $697 million.

Significant assumptions used by the actuary in its reports on the pension and medical programs as of September 30, 2007, were as follows:

Interest on Federal securities	6.00 percent
Annual basic pay scale increase	3.75 percent
Annual inflation	3.00 percent

Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system. The HHS applies the aggregate entry age normal actuarial cost method to both programs to determine its liabilities.

The following shows key valuation results as of September 30, 2007 and 2006, in conformance with the actuarial reporting standards set forth in the Statement of Federal Financial Accounting Standards No. 5, *Accounting for Liabilities of the Federal Government*.

(In Millions)	2007	2006
SFFAS 5 Expense		
(a) Normal Cost	$ 153	$ 156
(b) Interest Cost	443	425
(c) Ongoing Cost (a & b)	596	581
(d) Prior Service Cost & (Gains)/Losses	533	34
(e) Total Expense	$ 1,129	$ 615

Workers' Compensation Benefits: The actuarial liability for future workers' compensation benefits include the expected liability for death, disability, medical, and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims.

The liability utilizes historical benefit payment patterns to predict the ultimate payment related to a period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the OMB's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in FY 2007 and 2006 appear below.

FY 2007	FY 2006
4.930% in Year 1	5.170% in Year 1
5.078% in Year 2 and thereafter	5.313% in Year 2 and thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (cost of living adjustments (COLAs)) and medical inflation factors (consumer price index medical (CPIMs)) are applied to the calculations for projected future benefits. These factors are also used to adjust historical payments to current year dollars. The anticipated percentages for COLAs and CPIMs used in projections are:

FY	COLA	CPIM
2007	3.13%	4.01%
2008	2.40%	4.01%
2009	2.40%	4.01%
2010	2.43%	4.09%
2011+	2.30%	3.94%

Note 13. Accrued Grant Liability

Grant advances are liquidated upon the grantees' reporting of expenditures on the quarterly Federal Cash Transaction Report (SF-272). In many cases, the HHS receives these reports several months after the grantees incur the expense. To avoid understating grant expenses, the HHS developed departmental procedures to estimate and accrue amounts due grantees for their unreported expenses through September 30.

At September 30, the OPDIVs record the liability based on the estimated accrual for unreported grantees' expenses. If the amount of the collective OPDIV advances outstanding exceeds the amount of the collective estimated expenses, HHS reports the difference as "Advances to Grantees." If the amount of the estimated expenses exceeds the amount of the collective advances outstanding, the HHS reports the difference as "Accrued Grant Liability."

The HHS' net grant advances (liability) at September 30, 2007 and 2006, are summarized below:

(In Millions)	2007	2006
Grant Advances Outstanding (before year-end grant accrual)	$15,528	$15,590
Estimated Accrual for Amounts Due to Grantees	(19,469)	(19,423)
Net Grant Liability	$ (3,941)	$ (3,833)

Note 14. Other Liabilities

The HHS' other liabilities at September 30, 2007 and 2006 are summarized below:

2007	Intragovernmental			With the Public		
(In Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ 477	$ -	$ 477	$ 59	$ -	$ 59
Deferred Revenue	410	-	410	555	-	555
Contingent Liabilities (Note 20)	-	-	-	5	4,111	4,116
Capital Lease Liability (Note 15)	-	80	80	27	5	32
Custodial Liabilities	-	480	480	-	(15)	(15)
Vaccine Injury Compensation Program	-	-	-	-	221	221
Environmental and Disposal Costs	-	-	-	4	33	37
Other	60	53	113	458	16	474
Combined OPDIV Totals	947	613	1,560	1,108	4,371	5,479
Intra-OPDIV Eliminations	(392)	-	(392)	-	-	-
Consolidated OPDIV Totals	555	613	1,168	1,108	4,371	5,479
Inter-OPDIV Eliminations	(353)	-	(353)	-	-	-
Consolidated HHS Totals	$ 202	$ 613	$ 815	$ 1,108	$ 4,371	$ 5,479

2006	Intragovernmental			With the Public		
(In Millions)	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Advances from Others	$ -	$ -	$ -	$ -	$ -	$ -
Deferred Revenue	480	-	480	746	-	746
Contingent Liabilities (Note 20)	-	34	34	-	1,601	1,601
Capital Lease Liability (Note 15)	-	83	83	27	9	36
Custodial Liabilities	-	409	409	-	10	10
Vaccine Injury Compensation Program	-	-	-	-	221	221
Environmental and Disposal Costs	-	-	-	1	36	37
Other	471	-	471	204	12	216
Combined OPDIV Totals	951	526	1,477	978	1,889	2,867
Intra-OPDIV Eliminations	(365)	-	(365)	-	-	-
Consolidated OPDIV Totals	586	526	1,112	978	1,889	2,867
Inter-OPDIV Eliminations	(157)	-	(157)	-	-	-
Consolidated HHS Totals	$ 429	$ 526	$ 955	$ 978	$ 1,889	$ 2,867

The majority of the other liabilities include Deferred Revenue, Custodial Liabilities, Contingent Liabilities, the Vaccine Injury Compensation Program, and Other Intragovernmental Liabilities.

Deferred Revenue:

The CMS receives premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting

period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill. The CMS accounts for $329 million of the deferred revenue with the public.

The IHS accounts for $137 million of the intragovernmental deferred revenue for construction-in-process projects primarily under the Contribution Indian Health Facilities fund, and $173 million of the deferred revenue with the public for the Tribal Buybacks. The SAMHSA accounts for $160 million intragovernmental deferred revenue for interagency agreements with another Federal agency to award and administer the Drug Free Communities program grants. The Vaccine Injury Compensation Program administered by the HRSA accounts for $90 million in intragovernmental deferred revenue arising from the provision of goods and services by the program. The NIH accounts for $46 million deferred revenue with the public for unearned Cooperative Research and Development Agreement (CRADA) revenue. The AHRQ accounts for $23 million of intragovernmental deferred revenue for Public Health Service Evaluations.

Other Intragovernmental Liabilities:
Other Intragovernmental Liabilities of $815 million are primarily comprised of $530 million which CMS owes to other Federal entities, primarily to the Department of the Treasury ($480 million at September 30, 2007). The CMS' payable to Treasury is a result of the receivables from the beneficiaries and Medicare contractors. The CMS owes other Federal entities $50 million for services performed through interagency agreements.

Environmental and Disposal Costs:
The Comprehensive Environmental Response Compensation and Liability Act, the Comprehensive Environmental Cleanup and Responsibility Act, the Superfund Amendments and Reauthorization Act of 1986, and the Conservation Recovery Act of 1976 are several laws and regulations which require the HHS to remove, contain, and/or dispose of hazardous waste. Environmental and disposal costs are the costs of removing, containing, and/or disposing of (1) hazardous waste from property, and/or (2) material and/or property that consist of hazardous waste at a permanent or temporary closure or shutdown of associated property, plant, or equipment. The majority of the environmental and disposal costs consist of the IHS liabilities associated with surveying, testing, and remediating contaminated sites and the NIH ground water remediation project in accordance with applicable laws and regulations.

Note 15. Leases
Capital Leases:
The HHS has entered into various capital leases with Native American and Alaskan Native tribes and with the General Services Administration (GSA) for office and warehouse space. Lease terms vary from 1 to 20 years. Capitalized assets acquired under capital lease agreements and the related liabilities are reported at the present value of the minimum lease payments. Assets under Capital Lease amounts are reported in Note 8, General Property, Plant and Equipment.

Operating Leases:
The HHS has commitments under various operating leases with private entities and GSA for offices, laboratory space, and land. Leases with private entities have initial or remaining noncancelable lease

terms from 1 to 20 years. The GSA leases in general are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

A Summary of Net Assets under Capital Lease and Future Minimum Lease Payments at September 30, 2007 and 2006, is presented in the schedules that follow:

(In Millions)	2007	2006
Summary of Net Assets Under Capital Lease		
Land and Building	$ 139	$ 140
Machinery and Equipment	1	1
Subtotal	$ 140	$ 141
Accumulated Amortization	(42)	(38)
Assets Under Capital Lease	$ 98	$ 103

(In Millions)	2007		2006	
Future Minimum Lease Payments	Capital Leases	Operating Lease	Capital Leases	Operating Lease
Year 1	$ 13	$ 341	$ 12	$ 319
Year 2	13	349	12	333
Year 3	13	325	13	333
Year 4	11	313	13	285
Year 5	11	290	11	253
Later Years	127	1,069	137	859
Total Minimum Lease Payments	$ 188	$ 2,687	$ 198	$ 2,382
Imputed Interest	(76)		(79)	
Total Capital Lease Liability	$ 112		$ 119	

Note 16. Consolidated Gross Cost and Earned Revenue by Budget Function Classification

Intragovernmental transactions are between Federal entities meaning both the buyer and seller are Federal. Exchange revenue with the public is a transaction when the buyer of the goods or services is a non-Federal entity and the seller is Federal.

If a Federal entity purchases goods or services from another Federal entity and sells them to the public, the exchange revenue would be classified as "with the public" but the related costs would be classified as "intragovernmental." The purpose of the classifications is to enable the Federal Government to provide consolidated financial statements, and not to match public and intragovernmental revenue with costs that are incurred to produce public and intragovernmental revenue.

The HHS' consolidated gross cost and exchange revenue by budget functional classification for the years ended September 30, 2007 and 2006, are summarized below:

	2007							2006
(In Millions)	Education Training and Social Services	Health	Medicare	Income Security	OPDIV Combined Totals	Intra-HHS Eliminations	HHS Consolidated Totals	HHS Consolidated Totals
Intragovernmental								
Gross Cost	$ 135	$ 4,261	$ 612	$ 33	$ 5,041	$ (1,553)	$ 3,488	$ 3,320
Earned Revenue	(9)	(2,880)	(7)	(11)	(2,907)	1,557	(1,350)	(1,101)
Net Cost, Intragovernmental	$ 126	$ 1,381	$ 605	$ 22	$ 2,134	$ 4	$ 2,138	$ 2,219
With the Public								
Gross Cost	$ 12,858	$248,560	$417,205	$35,697	$ 714,320	$ -	$ 714,320	$ 673,170
Earned Revenue	-	(1,599)	(50,259)	(1)	(51,859)	-	(51,859)	(51,452)
Net Cost, With the Public	$ 12,858	$246,961	$366,946	$35,696	$ 662,461	$ -	$ 662,461	$ 621,718
Totals								
Gross Cost	$ 12,993	$252,821	$417,817	$35,730	$ 719,361	$ (1,553)	$ 717,808	$ 676,490
Earned Revenue	(9)	(4,479)	(50,266)	(12)	(54,766)	1,557	(53,209)	(52,553)
Net Cost of Operations	$ 12,984	$248,342	$367,551	$35,718	$ 664,595	$ 4	$ 664,599	$ 623,937

Note 17. Exchange Revenue

The HHS recognizes its revenue from exchange transactions when goods and services are provided. Total exchange revenue was $53 billion and $53 billion through September 30, 2007 and 2006, respectively. The HHS exchange revenue primarily consists of Medicare premiums collected from beneficiaries.

Premiums collected are used to finance Supplemental Medical Insurance (SMI) benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal Government through the General Fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

The HHS pricing policy for the reimbursable agreements is to recover full cost and to incur no profit or loss. In addition to revenues related to reimbursable agreements, the HHS collects various user fees to offset the cost of its programs. Certain fees charged by the HHS are based on an amount set by law or regulation and may not represent full cost.

Note 18. Custodial Activity

The ACF receives monies from the Internal Revenue Service for outlay to the States for child support. These monies represent delinquent child support payments withheld from Federal tax refunds. Receipts are transferred to the HHS appropriation 75X6234 to cover outlays. During FY 2007, receipts amounted to $1,682 million ($1,571 million for FY 2006) and outlays amounted to $1,682 million ($1,556 million for FY 2006).

The FDA custodial activity involves collections of civil monetary penalties (CMP) assessed by the Department of Justice on behalf of FDA. Penalties are assessed for violations in areas such as illegally manufactured, marketed, and distributed animal feeds and drug products. Total CMP collections in FY 2007 were $10 million ($24.8 million for FY 2006). The CMP collections are immediately forwarded to the Department of the Treasury and cannot be used for FDA operations.

The CDC custodial activity consists of collections of interest on outstanding receivables and funds received from debts in collection status. Total custodial liabilities for FY 2007 and FY 2006 were $4.3 million and $3.6 million, respectively. CDC custodial collections are also forwarded to the Department of the Treasury and cannot be used for CDC operations.

Note 19. Federal Matching Contribution

The monthly SMI premium per beneficiary was $88.50 from October 2006 through December 2006 and $93.50 from January 2007 through September 2007. Premiums collected from beneficiaries totaled $45.7 billion in FY 2007 ($41.6 billion in FY 2006) and were matched by $137.8 billion ($129.1 billion in FY 2006) contribution from the Federal Government.

Note 20. Contingencies

Contingent Liabilities:

The 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. Management, in consultation with legal counsel, has determined that it is reasonably possible that certain claims may result in an adverse outcome to the Department. The HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined.

The Medicaid amount for $1,702 million consists of Medicaid audit and program disallowances of $463 million and $1,239 million, respectively, for reimbursement of State plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. The CMS will be required to pay these amounts if the appeals are decided in the 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. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid & State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations.

The monetary effect of these reviews is not known until a final decision is determined and rendered by the CMSO Director. The outcome of these reviews is that CMS could be owed funds.

As of September 30, 2007, CMS recorded $1,742 million for a contingent liability for asserted and unasserted claims that could be owed to States arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. In FY 2006, CMS believed this contingent liability to be reasonably possible and disclosed it in the footnotes. On September 24, 2007, one state asserted a claim in a civil action brought in federal district court. The agency intends to defend against this claim. Because appropriation law requires Congress to authorize the transfer of funds out of the Medicare trust funds into an appropriation account, the Medicare trust funds cannot reimburse the Health Program accounts in the general fund of the Treasury absent Congressional authorization. The CMS does not intend to seek such Congressional authorization and there will be no transactions recorded between the trust funds and the Health Programs' accounts in the general fund.

The CMS has accrued $667 million as of September 30, 2007, for a contingent liability to providers for previous years' disputed cost report adjustments for disproportionate share hospitals.

Vaccine Injury Compensation Program (VICP):
The VICP is administered by HRSA and provides compensation for vaccine-related injury or death. The $221 million VICP liability represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 2007.

Appeals at the Provider Reimbursement Review Board:
Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2006, there were 5,886 PRRB cases (5,737 in FY 2005) under appeal. A total of 2,901 new cases (2,422 in FY 2006) were filed in FY 2007. The PRRB rendered decisions on 119 cases (85 in FY 2006) in FY 2007 and 2,024 additional cases (2,188 in FY 2006) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to an appeal hearing. Since data is available for only the 119 cases that were decided in FY 2007, a reasonable liability estimate cannot be projected for the value of the 6,644 cases (5,886 in FY 2006) remaining on appeal as of September 30, 2007. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

Obligations Related to Cancelled Appropriations:
Payments may be required of up to one percent of current year appropriations for valid obligations incurred against prior year appropriations that have been cancelled pursuant to the National Defense Authorization Act of FY 1991 (*Public Law 101-150*). The total payments related to cancelled appropriations are estimated at $1,358 million and $1,009 million as of September 30, 2007 and 2006, respectively.

Note 21. Apportionment Categories of Obligations Incurred
Obligations incurred by apportionment categories at September 30, 2007 and 2006, are summarized below:

(In Millions)	2007 Direct	2007 Reimbursable	2007 Totals
Category A (Distributed by Quarter)	$ 136,544	$ 6,913	$ 143,457
Category B (Restricted and Distributed by Activity)	411,939	192	412,131
Exempt from Apportionment	401,083	-	401,083
Total Obligations Incurred	$ 949,566	$ 7,105	$ 956,671

(In Millions)	2006 Direct	2006 Reimbursable	2006 Totals
Category A (Distributed by Quarter)	$ 125,641	$ 7,340	$ 132,981
Category B (Restricted and Distributed by Activity)	388,707	431	389,138
Exempt from Apportionment	362,784	-	362,784
Total Obligations Incurred	$ 877,132	$ 7,771	$ 884,903

Obligations incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the OMB Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133.

Note 22. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances consist of appropriated funds, revolving funds, management funds, trust funds, Cooperative Research and Development Agreement (CRADA) funds and royalty funds. The annual appropriations are available for sponsoring and conducting medical research and are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. The revolving and management funds are available for centralized research support services and administrative activities of the NIH. Revolving funds are no-year funds available until expended. The NIH management fund is available for two fiscal years. The trust funds consist of the Conditional, Unconditional, and Patient Emergency Funds and are also available until expended. The Patient Emergency Fund is intended solely for the benefit of patients. The Unconditional Gift Fund is available for any authorized purpose in the performance of NIH functions. The Conditional Gift Fund is restricted to a specific purpose determined by the donor. The NIH is not authorized to spend the funds to support functions not encompassed within the terms of the conditions. However, for conditional monetary gifts, upon completion of the stipulated conditions, or circumstances rendering completion of the conditions impossible, any remaining unobligated conditional funds are transferred to the Unconditional Gift Fund for the support of any other objectives of the recipient organization. The funds received for CRADA are available for the performance of the contractual agreement, and are available for the term of the agreement. The Royalty funds are available for obligations for two fiscal years after the fiscal year in which the funds are received and are available for a variety of purposes, such as rewards to scientific, engineering, and technical employees of the laboratory, to educate and train employees and to pay expenses incidental to the administration of intellectual property by the entity.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statements 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 reported as "Temporarily Not Available Pursuant to Public Law" in the Statements of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of $313,882 million as of September 30, 2007 ($292,426 million in FY 2006), are included in Investments on the Balance Sheet.

The FDA received $168 million in funding in FY 2002, to remain available until expended, to support counter-terrorism projects that recognize the important role FDA plays in protecting the public health. The attacks of September 11, 2001 and subsequent national events resulted in an accelerated and intensified need for attention to activities related to counter-terrorism. The amount obligated for counter-terrorism projects through FY 2007 was approximately $167.7 million.

Note 23. Explanation of Differences between the Statement of Budgetary Resources (SBR) and the Budget of the United States Government

The FY 2009 *President's Budget*, with actual amounts for FY 2007, has not yet been published, and, therefore, no comparisons can be made between FY 2007 amounts presented in the SBR with amounts reported in the "Actual" column of the *President's Budget*. The FY 2009 *President's Budget* is expected to be released in February 2008, and may be obtained from the Office of Management and Budget website http://www.whitehouse.gov/omb/budget or the Government Printing Office.

The *Budget of the United States Government, FY 2008 – Appendix* was used as the reference for the HHS total budgetary resources amount. Information in the "Federal Programs by Agency and Account" in the FY 2008 Analytical Perspectives volume of the *Budget of the United States Government* was used as the reference for the net outlays (less offsetting receipts) amount in the following reconciliation of the SBR to the *President's Budget* for FY 2006:

	2006			
(In Millions)	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$952,823	$884,903	$226,875	$841,549
Unobligated Balances – Not Available	(5,078)	-	-	-
Other	7	275	(84)	(89)
Budget of the U.S. Government	$947,752	$885,178	$226,791	$841,460

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the SBR and not in the *President's Budget* is the budgetary resources that were not available. The "Unobligated Balances – Not Available" line in the above schedule includes expired authority, recoveries, and other amounts included in the SBR that are not included in the *President's Budget*. The "Other" adjustments in Obligations Incurred primarily consist of NIH's $179 million obligations in expired accounts and $28 million of Gift Fund obligations not included in the *President's Budget*.

Note 24. Permanent Indefinite Appropriations

The HHS permanent indefinite appropriations are open-ended; that is, 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.

The list below includes the Treasury Fund Symbols that meet the criteria stated above and are considered permanent indefinite appropriations. The list also includes the period of availability (fiscal year or no-year) and the titles of the accounts.

75 0170 (fiscal year) HHS Accrual Contribution to the Uniformed Services Retiree Health Care Fund, Office of the Assistant Secretary for Health
75 0340 (fiscal year) Health Education Assistance Loans Program
75X0350 (no year) Health Centers Loan Program, HRSA
75X0513 (no year) Payments for Credits Against Health Care Contributions
75X0585 (no year) Taxation on Old-Age, Survivors, and Disability Insurance Benefits
75 1552 (fiscal year) Temporary Assistance for Needy Families
75 1553 (fiscal year) Children's Research and Technical Assistance
75X1553 (no year) Children's Research and Technical Assistance
75X4305 (no year) Health Prof. Grad. Student Loan Insurance Fund, Liquidating Account
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8247 (no year) FDA Unconditional Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8249 (no year) Unconditional Gift Fund, HRSA
75X8250 (no year) Gifts and Donations, CDC
75X8253 (no year) NIH Conditional Gift Fund
75X8254 (no year) Conditional Gift Fund, HRSA
75X8307 (no year) Transitional Drug Assistance, CMS
75X8308 (no year) Medicare Prescription Drug Account, CMS
75X8510 (no year) Administration on Aging Gift Fund
75X8511 (no year) Indian Health Service Gift Fund
75X8512 (no year) AHRQ Gift Fund
75X8513 (no year) SAMHSA Gift Fund
75X8514 (no year) OS Gift Fund
75X8888 (no year) Patients Benefit Fund, NIH
75X8889 (no year) Patients Benefit Fund, HRSA
75-20X8004 (no year) Federal Supplementary Medical Insurance Trust Fund, CMS
75-20X8005 (no year) Federal Hospital Insurance Trust Fund, CMS
75-20X8175 (no year) Vaccine Injury Compensation Trust Fund, HRSA

Note 25. Undelivered Orders at the End of the Period

The HHS reported $74,436 million of budgetary resources obligated for undelivered orders as of September 30, 2007, and $76,429 million as of September 30, 2006.

Note 26. Earmarked Funds

Medicare is the largest earmarked fund group managed by the Department; therefore, Medicare financial data is presented in a separate column in the schedule below.

The HHS has designated as earmarked funds the HI and SMI trust funds, which also include the Payments to the Health Care Trust Funds appropriation and the Health Care Fraud and Abuse Control Account. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI trust funds.

The Medicare programs include: (a) Medicare HI Trust Fund, (b) Medicare SMI Trust Fund, (c) Medicare Prescription Drug Benefit – Part D, and (d) Medicare/Medicaid Integrity Program (MIP).

The Social Security Act provides for payments to the HI and SMI trust funds: HI (for the Uninsured and Federal Uninsured payments) and SMI (appropriated funds to provide for Federal matching of SMI premium collections). The Medicare Modernization Act of 2003 prescribes that funds covering the Medicare Prescription Drug Benefit, retiree drug coverage reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to SMI. A transfer of general funds to the HI Trust Fund is made in amounts equal to Self-Employment Contribution Act tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance beneficiaries.

There were no legislative changes that significantly changed the purpose of or redirected a significant portion of an earmarked fund during this reporting period.

Earmarked Funds (In Millions)	Earmarked Funds		Eliminations	Earmarked Funds Total
	Medicare	Others		
Balance Sheet as of September 30, 2007				
Assets				
Fund balance with Treasury	$ 8,793	$ 679	$ -	$ 9,472
Investments	363,195	2,680	-	365,875
Other Assets	65,614	24	(53,206)	12,432
Total Assets	$ 437,602	$ 3,383	$ (53,206)	$387,779
Entitlement Benefits Due and Payable	$ 41,604	$ -	$ -	$ 41,604
Other Liabilities	57,089	439	(53,206)	4,322
Total Liabilities	$ 98,693	$ 439	$ (53,206)	$ 45,926
Unexpended Appropriations	$ 8,978	$ (91)	$ -	$ 8,887
Cumulative Results of Operations	329,931	3,035	-	332,966
Total Liabilities and Net Position	$ 437,602	$ 3,383	$ (53,206)	$387,779
Statement of Net Cost For the Period Ended September 30, 2007				
Gross Program Costs	$ 417,817	$ 380	$ -	$ 418,197
Earned Revenues	(50,266)	(610)	-	(50,876)
Net Cost of Operations	$ 367,551	$ (230)	$ -	$ 367,321
Statement of Changes in Net Position For the Period Ended September 30, 2007				
Net Position Beginning of Period	$ 329,511	$ 2,619	$ -	$ 332,130
Non-Exchange Revenue	206,598	337	-	206,935
Other Financing Sources	170,351	(242)	-	170,109
Net Cost of Operations	(367,551)	230	-	(367,321)
Change in Net Position	$ 9,398	$ 325	$ -	$ 9,723
Net Position End of Period	$ 338,909	$ 2,944	$ -	$ 341,853

Earmarked Funds (In Millions)	Earmarked Funds		Eliminations	Earmarked Funds Total
	Medicare	Other		
Balance Sheet as of September 30, 2006				
Assets				
Fund balance with Treasury	$ 28,726	$ 820	$ -	$ 29,546
Investments	339,545	2,431	-	341,976
Other Assets	46,484	42	(42,637)	3,889
Total Assets	$ 414,755	$ 3,293	$ (42,637)	$375,411
Entitlement Benefits Due and Payable	$ 40,824	$ -	$ -	$ 40,824
Other Liabilities	44,420	674	(42,637)	2,457
Total Liabilities	$ 85,244	$ 674	$ (42,637)	$ 43,281
Unexpended Appropriations	$ 27,658	$ 7	$ -	$ 27,665
Cumulative Results of Operations	301,853	2,612	-	304,465
Total Liabilities and Net Position	$ 414,755	$ 3,293	$(42,637)	$375,411
Statement of Net Cost For the Period Ended September 30, 2006				
Gross Program Costs	$ 386,924	$ 199	$ -	$387,123
Earned Revenues	(49,955)	(512)	-	(50,467)
Net Cost of Operations	$ 336,969	$ (313)	$ -	$336,656
Statement of Changes in Net Position For the Period Ended September 30, 2006				
Net Position Beginning of Period	$ 276,020	$ 2,342	$ -	$278,362
Non-Exchange Revenue	197,843	155	116	198,114
Other Financing Sources	192,617	(191)	(116)	192,310
Net Cost of Operations	(336,969)	313	-	(336,656)
Change in Net Position	$ 53,491	277	-	53,768
Net Position End of Period	$ 329,511	$ 2,619	$ -	$332,130

The list below includes the Treasury fund symbols that are "Other Earmarked Funds":

75X8510 (no year) Administration on Aging Gift Fund
75X8512 (no year) Agency for Healthcare Research and Quality Gift Fund
75X0943 (no year) Disease Control, Research, & Training, CDC (partial – user fee portion only)
75 0943 (fiscal year) Disease Control, Research, & Training, CDC (partial – multi-year royalties)
75X5146 (no year) Cooperative Research and Development Agreements, CDC
75X8250 (no year) Gifts and Donations, CDC
20X8145 (no year) Allocation Transfer from EPA Hazardous Superfund, CDC
75X5148 (no year) Cooperative Research and Development Agreements, FDA
75X8247 (no year) Food and Drug Administration Unconditional Gift Fund
75X0600 (no year) User Fee Act(s), FDA
75X4309 (no year) Revolving Fund for Certification and Other Services, FDA

75X8249 (no year) Unconditional Gift Fund, HRSA
75X8254 (no year) Conditional Gift Fund, HRSA
75X8889 (no year) Patients Benefit Fund, HRSA
20X8175 (no year) Vaccine Injury Compensation Trust Fund, HRSA
75X5071 (no year) Operation and Maintenance of Quarters, IHS
75X8073 (no year) Contributions, Indian Health Facilities, IHS
75X8511 (no year) IHS Gift Fund
75X8248 (no year) NIH Unconditional Gift Fund
75X8253 (no year) NIH Conditional Gift Fund
75X8393 (no year) Health Care Fraud and Abuse Control Accounts, CMS
75X8888 (no year) Patients Benefit Fund, NIH
75X5145 (no year) Cooperative Research and Development Agreements, NIH
75 3966 (fiscal year) Royalties, NIH
75X8513 (no year) SAMHSA Gift Fund
75X8514 (no year) Office of the Secretary Gift Fund

Note 27. Statement of Social Insurance Disclosures

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions.

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 as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from State governments are also 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, or those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both. Since the projection period consists of 75 years, the period covers virtually all of the current participants' working and retirement years.

The SOSI sets forth, for each of these three groups, the projected actuarial present value of all future HI (Part A) and SMI (Parts B and D) expenditures and all future non-interest income for the next 75 years. The SOSI also presents the net present value of future net cash flows for each fund, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The existence of a large actuarial deficit for the HI trust fund indicates that, under these assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its financing mechanism.

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

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

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under current law. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care cost, wages and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included in the Table 1 below. The assumptions underlying the 2007 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2007. 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.

Table 1: Significant Assumption and Summary Measures Used for the Statement of Social Insurance 2007

					Annual percentage change in.						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2007	2.04	1,075,000	839.8	2.7	4.6	1.9	2.6	6.4	6.2	0.1	2.9
2010	2.03	1,000,000	825.3	1.4	4.2	2.8	2.6	5.0	4.6	8.6	2.8
2020	2.02	950,000	764.5	1.0	3.8	2.8	2.1	4.5	4.7	7.6	2.9
2030	2.00	900,000	705.4	1.1	3.9	2.8	2.0	5.8	5.6	5.5	2.9
2040	2.00	900,000	652.8	1.1	3.9	2.8	2.0	5.8	5.4	5.2	2.9
2050	2.00	900,000	606.6	1.1	3.9	2.8	2.0	4.9	4.8	4.9	2.9
2060	2.00	900,000	565.7	1.1	3.9	2.8	1.9	4.7	4.8	4.6	2.9
2070	2.00	900,000	529.3	1.1	3.9	2.8	1.9	4.6	4.5	4.4	2.9
2080	2.00	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

[1]Average number of children per woman.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4]Difference between percentage increases in wages and the CPI.

[5]Average annual wage in covered employment.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

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

The ultimate values of the above-specified assumptions used in determining the estimates for each of the five years presented in the Statement of Social Insurance are listed within table 2 below. They are based on the intermediate assumptions of the respective Medicare Trustee Reports.

Table 2: Significant Ultimate Assumptions used for the Statement of Social Insurance, FY 2007 – 2003

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2007	2.00	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
2006	2.00	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
2005	1.95	900,000	495.5	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0
2004	1.95	900,000	497.2	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0
2003	1.95	900,000	447.9	1.1	4.1	3.0	1.8	5.3	5.1	—	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate assumption is reached by the 20th year of each projection period.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[4]Difference between percentage increases in wages and the CPI. The ultimate assumption is reached within the first 10 years of the projection period.

[5]Average annual wage in covered employment. The ultimate assumption is reached within the first 10 years of the projection period.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of the projection period.

Part D Projections
In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is new (having begun operations in January 2006), with very little actual program data currently available. The actual 2006 and 2007 bid submissions by the private plans offering this coverage, together with preliminary data on beneficiary enrollment, has been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Hospice Benefits Mis-Posting
Beginning in May 2005, expenditures for certain Part A hospice benefits were posted to the Part B account of the SMI trust fund, rather than from the HI trust fund. Correction of this mis-posting will increase Part A expenditures and reduce Part B expenditures in 2008 and later years, compared to the projections shown in the 2007 Medicare Trustees Report. It will also result in adjustments to the HI and SMI trust funds to account for the misallocated hospice expenditures during fiscal years 2005 through 2007. The present values displayed in the Statement of Social Insurance have been revised to include the estimated impact of correcting this mis-posting. The impact on the Part A and Part B expenditure projections presented in the Statement of Social Insurance is roughly $465 billion over the entire 75-year period, equivalent to a 2.0-percent increase for Part A and a 2.5-percent decrease for Part B. However, the change in Part A expenditures also resulted in a very slight change to the discount rates used to calculate all of the present values in the SOSI, thereby contributing to a further minor change in the present value amounts for Parts A, B, and D relative to the original Trustees Report projections.

Note 28. SMI Part B Physician Update Factor
The projected Part B expenditure growth reflected in the accompanying SOSI is significantly reduced as a result of the structure of physician payment updates under current law. In the absence of legislation, this structure would result in multiple years of significant reductions in physician payments, totaling an estimated 41 percent over the next 9 years. Reductions of this magnitude are very unlikely to occur fully. For example, Congress has overridden scheduled negative updates for each of the last 5 years. However, since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. Consequently, the projected actuarial present values of Part B expenditure shown in the accompanying SOSI are likely to be understated.

The potential magnitude of the understatement of Part B expenditures due to the physician payment mechanism can be illustrated using two hypothetical examples of changes to current law. These examples were developed by management for illustrative purposes only; the calculations have not been audited; 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 on physician payments under Medicare and of the broad range of uncertainty associated with such impacts.

Under current law, the projected 75-year present value of future Part B expenditures is $18.2 trillion. An alternate scenario indicates that if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to

$22.6 trillion. Similarly, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $25.4 trillion.

The extent to which actual future Part B costs could exceed the projected current-law amounts due to physician payments depends on both the level of physician payment updates that might be legislated and on whether Congress would pass further provisions to help offset such costs (as it did, for example in the Deficit Reduction Act in 2006). As noted, these examples only reflect hypothetical changes to physician payments.

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

Note 29. Stewardship Property, Plant & Equipment

The HHS assets, regardless of their status, are used to support the day-to-day operations of providing healthcare to American Indians and Alaskan Natives in remote areas of the country where no other facilities exist. For stewardship reporting purposes, the HHS identifies two types of assets: Heritage and Indian Trust Lands.

Heritage assets are historically, architecturally, or culturally significant. This category includes:

- Buildings Located in a Historic District or Included with a National Landmark
- Buildings Determined to be Historic in Nature
- Building Submitted to Tribal Historic Preservation or State Historic Preservation Offices for Determination
- Buildings Having Some Potential Historic Significance

Indian Trust lands are those lands that do not meet the definition of Stewardship land (i.e., land other than that acquired for or used in connection with general (capitalized) PP&E) but have always been held by the U.S. Government as separate and distinct because of the Government's long-term trust responsibility. Indian Health Service has built health care facilities on Indian land held in Trust by the U.S. Government. 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.

Currently, the HHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. The IHS is developing new procedures to strengthen its stewardship over real property accounting and reporting. The Required Supplementary Information (RSI) provides additional information for Stewardship PP&E.

Note 30. Reconciliation of Net Cost of Operations (Proprietary) to Budget (In Millions)

	2007	2006
RESOURCES USED TO FINANCE ACTIVITIES		
Budgetary Resources Obligated		
Obligations Incurred	$ 956,671	$ 884,903
Spending Authority from Offsetting Collections and Recoveries	(26,608)	(26,585)
Obligations Net of Offsetting Collections and Recoveries	930,063	858,318
Offsetting Receipts	(257,704)	(226,875)
Net Obligations	672,359	631,443
Other Resources		
Net Non-Budgetary Resources Used to Finance Activities	310	264
Total Resources Used to Finance Activities	672,669	631,707
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS		
Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	980	(4,249)
Resources That Fund Expenses Recognized in Prior Periods	1	15,278
Budgetary Offsetting Collections and Receipts That Do Not Affect Net Cost of Operations:		
Credit Program Collections That Increase Liabilities for Loans Guarantees or Allowances for Subsidy	28	90
Other	(234)	(242)
Resources That Finance the Acquisition of Assets or Liquidations of Liabilities	1,262	1,296
Other Resources or Adjustments to Net Obligated Resources That Do Not Affect Net Cost of Operations	373	(3,352)
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	2,410	8,821
Total Resources Used to Finance the Net Cost of Operations	670,259	622,886
COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD		
Components Requiring or Generating Resources in Future Period	(6,913)	(7)
Components Not Requiring or Generating Resources	1,253	1,058
Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	(5,660)	1,051
NET COST OF OPERATIONS	**$ 664,599**	**$ 623,937**

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Required Supplementary Stewardship Information

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Investment in Human Capital
For the Year Ended September 30, 2007
(In Millions)

RESPONSIBILITY SEGMENT PROGRAM	2007	2006	2005	2004	2003
ACF					
Administration on Developmental Disabilities	$ 8	$ 7	$ 8	$ 9	$ 10
NIH					
Research Training and Career Development	1,756	1,747	1,699	1,696	1,405
Totals	**$ 1,764**	**$ 1,754**	**$ 1,707**	**$ 1,705**	**$ 1,415**

"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, and the National Institutes of Health.

Administration for Children and Families (ACF)

The ACF is able to estimate investment in human capital for the Administration for Developmental Disabilities (ADD) using existing data collection activities. Under ADD, 46 grants are anticipated to be awarded for Projects of National Significance (PNS). As of September 30, 2007, all of the 46 PNS grants have been awarded for FY 2007. 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. Monies also support the development of national and state policy to serve this community. Grants awarded total $8 million in FY 2007.

National Institutes of Health (NIH)

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. Our ability to maintain the momentum of recent scientific progress and our international leadership in medical research depends upon the continued development of new, highly trained investigators.

Investment in Research and Development
For the Year Ended September 30, 2007
(In Millions)

	2007				Total				
Responsibility Segments	Basic	Applied	Develop-mental	Total	2006	2005	2004	2003	Grand Total
ACF	$ -	$ 16	$ -	$ 16	$ 39	$ 21	$ 21	$ 24	$ 121
AHRQ	198		-	198	175	162	170	163	868
CDC		563	-	563	478	521	549	557	2,668
FDA *	37		3	40	37	31	28	31	167
HRSA			-		28	23	16	16	83
NIH	15,679	10,452	-	26,131	25,780	25,320	23,700	21,359	122,290
Totals	**$ 15,914**	**$ 11,031**	**$ 3**	**$ 26,948**	**$ 26,537**	**$ 26,078**	**$ 24,484**	**$ 22,150**	**$ 126,197**

*FDA restated its FY 2003 amount by $1 million as compared to their FY 2003 statements.

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

FDA has two programs that meet the requirements of research and development investments: Orphan Products Development (OPD) Program and FDA Research Grants Program. While 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 (Public Law 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 which is listed as No. 93-103 under the Catalog of Federal Domestic Assistance, 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.

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.

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.

ACF and AHRQ oversee 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 lead more healthy and productive lives.

Required Supplementary Information

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Combining Statement of Budgetary Resources
For the Year Ended September 30, 2007
(In Millions)

	CMS			Other Agency Budgetary Accounts[1]	Agency Combined Totals
	Medicare HI	Medicare SMI	Medicaid		
Budgetary Resources:					
1. Unobligated balance, brought forward, October 1	$ -	$ -	$ 26,486	$ 41,434	$ 67,920
2. Recoveries of prior year unpaid obligations	168	485	13,899	3,052	17,604
3. Budget Authority	222,844	187,674	168,614	367,035	946,167
4. Nonexpenditure transfers, net, anticipated & actual	(8,614)	8,036	(2,805)	3,292	(91)
5. Temporarily not available pursuant to Public Law	(8,190)	(12,603)	-	186	(20,607)
6. Permanently not available (-)	(22)	(37)	-	(29,589)	(29,648)
7. Total Budgetary Resources	$ 206,186	$ 183,555	$ 206,194	$ 385,410	$ 981,345
Status of Budgetary Resources:					
8. Obligations Incurred	$ 206,173	$ 183,543	$ 202,378	$ 364,576	$ 956,670
9. Unobligated Balances - Available	-	-	3,644	13,696	17,340
10. Unobligated Balances - Not Available	13	12	172	7,138	7,335
11. Total Status of Budgetary Resources	$ 206,186	$ 183,555	$ 206,194	$ 385,410	$ 981,345
Relationship of Obligations to Outlays:					
12. Obligated Balance, Net	$ 21,041	$ 19,495	$ 19,183	$ 75,118	$ 134,837
13. Obligations incurred, Net (+/-)	206,173	183,543	202,378	364,576	956,670
14. Gross outlays	(206,574)	(183,039)	(188,247)	(361,173)	(939,033)
15. Obligated balance transferred, Net	-	-	-	18	18
16. Recoveries of prior year unpaid obligations	(168)	(485)	(13,899)	(3,052)	(17,604)
17. Change in uncollected customer payments	-	-	-	466	466
18. Obligated balance, Net, end of period	$ 20,472	$ 19,514	$ 19,415	$ 75,953	$ 135,354
19. Net Outlays	$ 187,488	$ (53,984)	$ 187,888	$ 350,467	$ 671,859

Summary of Other Agency Budgetary Accounts

	Budgetary Resources	Status of Budgetary Resources	Net Outlays
ACF	$ 51,414	$ 51,414	$ 46,248
AoA	1,392	1,392	1,361
AHRQ	357	357	142
CDC	9,990	9,990	8,288
CMS	265,431	265,431	249,071
FDA	2,135	2,135	1,147
HRSA	7,216	7,216	6,676
IHS	4,874	4,874	3,315
NIH	32,524	32,524	28,112
OS	5,438	5,438	2,418
PSC	1,130	1,130	480
SAMHSA	3,509	3,509	3,209
	$ 385,410	$ 385,410	$ 350,467

[1] "Other Agency Budgetary Accounts" includes the budgetary accounts of the eleven HHS Agencies other than CMS, as well as the remaining budgetary accounts not reported by CMS under Medicare and Medicaid.

Deferred Maintenance
For the Years Ended September 30, 2007 and 2006
(In Millions)

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, the National Institutes of Health, and the Food and Drug Administration all use the condition assessment survey for all classes of property. The Indian Health Service uses two types of surveys to assess installations – annual general inspections and deep look surveys.

		Cost to Return to Acceptable Condition	
Category of Asset	**Condition**	**2007**	**2006**
General PP&E			
Buildings	1 - 4	$ 1,077	$ 925
Equipment	4	8	8
Other Structures	1 - 4	55	22
Total		$ 1,140	$ 955

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
For the Year Ended September 30, 2007

The HHS has two types of property, plant, and equipment (PP&E) for stewardship reporting: Heritage Assets, and Indian Trust Lands.

Heritage Assets are PP&E of historical, natural, cultural, educational, or artistic significance. Heritage Assets are generally expected to be preserved indefinitely. This category includes buildings on the National Historic Register, cemetery sites, etc.

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

The IHS' draft guidelines will establish procedures for stewardship real property accountability and reporting. Currently, the IHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. Indian Trust land balances are removed from IHS FY 2007 Balance Sheet, and reported as Stewardship Assets - Indian Trust Lands.

IHS Stewardship Classes and Trust Land

Asset Description	Number of Sites	Total Square Footage	Federal Hectares	Total Hectares
Heritage Assets	1	2,295		
Indian Trust Lands	79	N/A	424.9 (1,049 acres)	424.9 (1,049acres)

Distribution of Stewardship Assets by Type and Area

	Heritage Assets			Indian Trust Lands	
	Number of Sites	Square Footage	Total Hectares	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	1	2,295		13	19
Portland				3	1
Tucson				5	12
Total IHS	1	2,295		79	425

Social Insurance
For the Year Ended September 30, 2007

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for slightly over four decades. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a prescription drug benefit. A separate Part D account within the SMI trust fund handles the transactions for this coverage. 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 Note 1 of 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 a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

The RSI material is generally drawn from the *2007 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 have been revised slightly since the preparation of the 2007 Trustees Report, to adjust for the impact of an accounting error that was discovered in August of this year. Beginning in May of 2005, Part A hospice expenditures were inadvertently drawn from the Part B account of the SMI trust fund rather than from the HI trust fund. Therefore, Part A expenditures in the 2007 Trustees Report were understated slightly and Part B expenditures were correspondingly overstated.

The Medicare Trustees emphasize that the SMI Part B expenditures projected under current law are significantly understated. Congress is very likely to continue overriding certain statutory provisions that would otherwise require reductions in physician payment rates of about 10 percent in 2008 and another 5 percent per year in 2009 through at least 2016.

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

Actuarial Projections

Cashflow in Nominal Dollars

Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. 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.

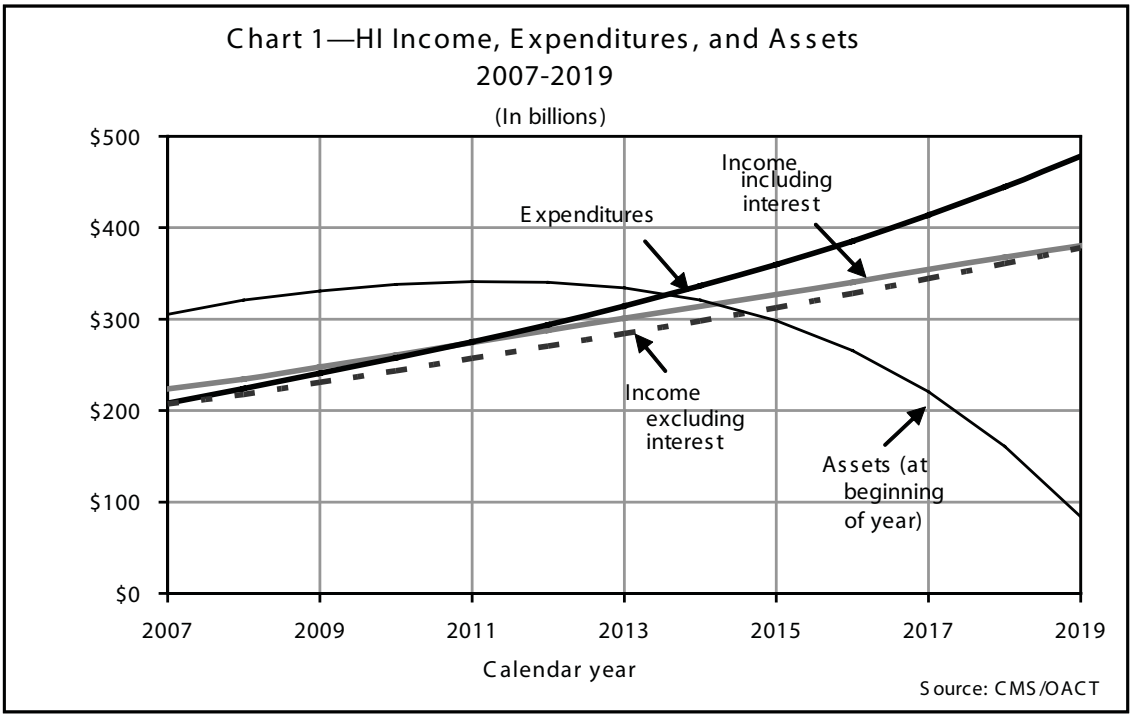
For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2018[2]. Corresponding estimates for SMI Parts 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 2007 through 2018, 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 will enter the workforce through 2018. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.

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

[2] The 2007 Trustees Report projected that the HI trust fund would be depleted in 2019, which was one year later than what was estimated in the 2006 Trustees Report. However, due to the accounting error explained earlier, Part A expenditures were understated in the 2007 Trustees report. Correcting for this error moves the depletion date from 2019 to 2018.



As chart 1 shows, HI expenditures are expected to exceed income excluding interest in 2007 and, under the intermediate assumptions, would begin to exceed income including interest in 2010. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the HI trust fund would start redeeming its assets; by the end of 2018, the assets would be depleted. For the fourth year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

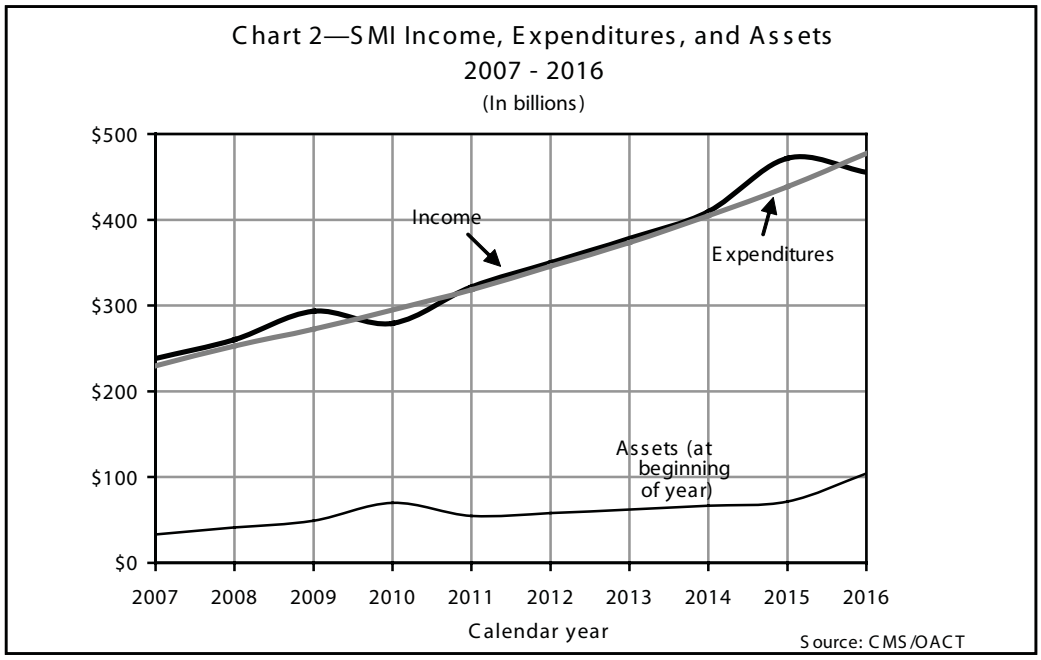
The projected year of depletion of the HI trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2007 through 2016, in nominal dollars. Whereas HI estimates are displayed through 2018, SMI estimates cover only the years through 2016, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures.[3]

[3] The Part D account also receives special payments from the States, representing a portion of their forgone Medicaid expenditures attributable to the Medicare drug benefit.

Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 2016.[4]



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, and interest earned on the U.S. Treasury securities held by the SMI trust fund. 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.

As chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.

HI Cashflow as a Percentage of Taxable Payroll

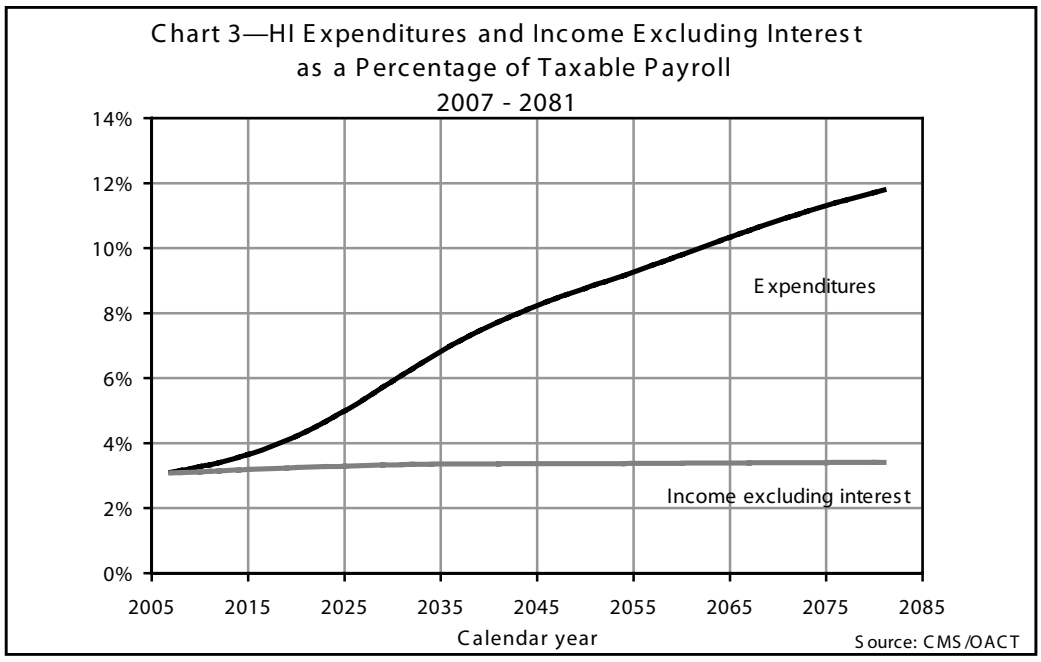
Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because it is difficult to meaningfully compare dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings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

[4] Delivery of Social Security benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. 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, 2009. Likewise, January 3, 2016 will fall on a Sunday, and therefore delivery of the majority of Social Security checks is expected to occur on December 31, 2015. These amounts are excluded from the premium income and general revenue income for 2010 and 2016, resulting in the income pattern shown in chart 2.

[5] Interest income is generally about 1 percent of total SMI income.

Chart 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to last year's Trustees Report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 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.

Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI trust fund fails this test by a wide margin, as it has in almost all previous years.



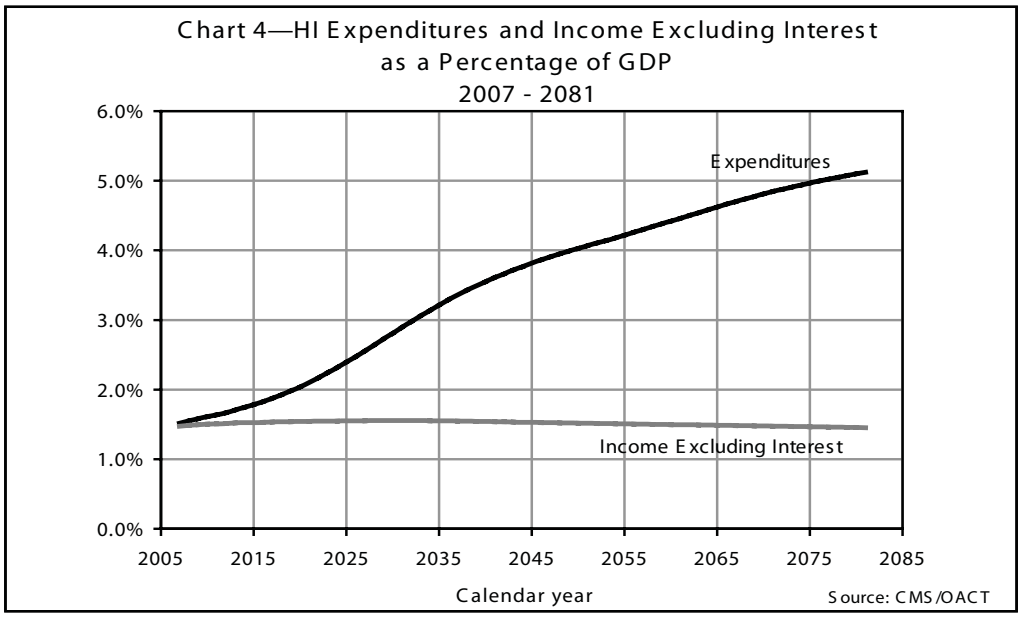
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.

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

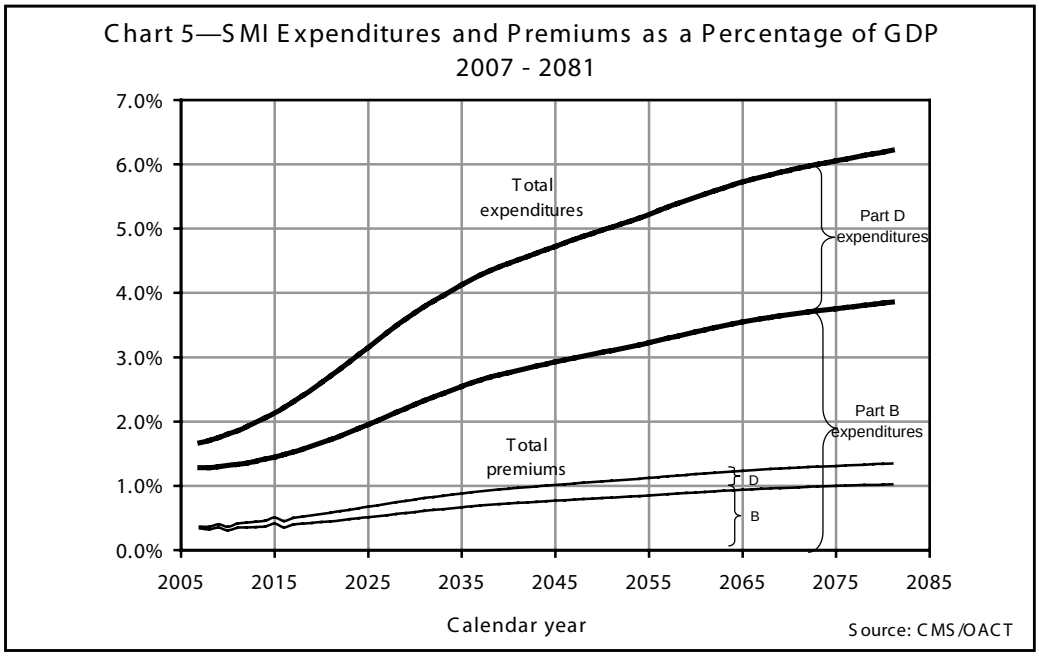
Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2006, the expenditures were $191.9 billion, which was 1.4 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



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 was refined in last year's Trustees Report. This refinement provides a more gradual transition from current health cost growth rates to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures were $216.4 billion, or about 1.6 percent of GDP, in 2006. Then, in about 25 years, they would grow to almost 4 percent of GDP and to more than 6 percent by the end of the projection period.

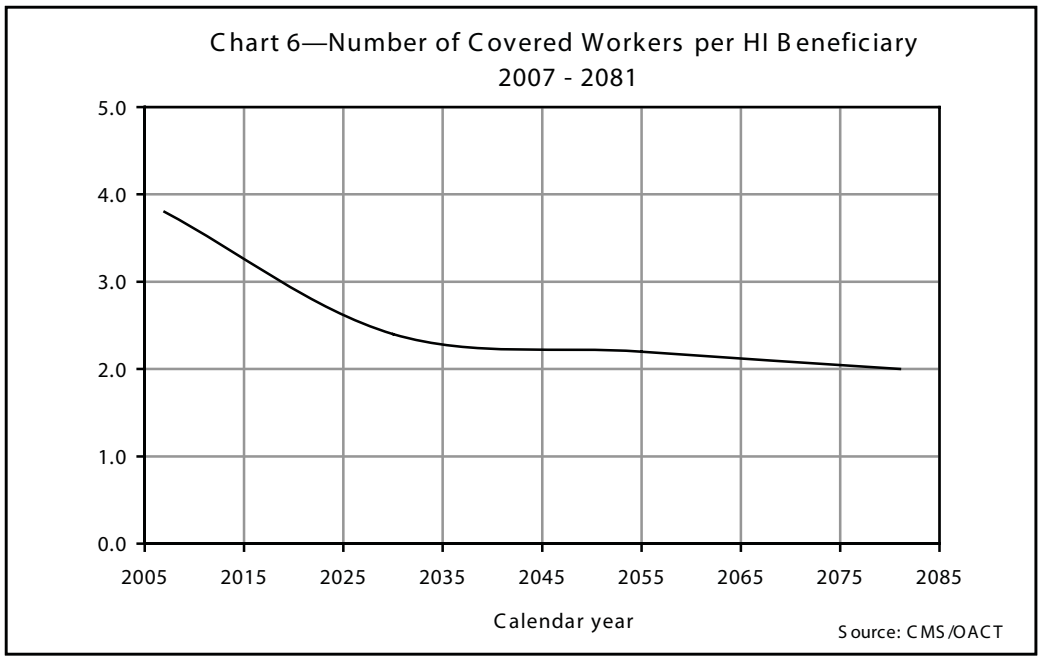


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. 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 2006, every beneficiary had 3.9 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2081.



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 more information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

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.[6] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, CPI, and real-interest rate.[7]

For this analysis, the intermediate economic and demographic assumptions in the *2007 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, 2007 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.[8] In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2081 under all three scenarios displayed. On the present value charts, the same pattern is evident, in most cases, until around 2060, when the present values begin to increase (or become less negative). This occurs as a result 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 today to cover this deficit begins to decrease at the end of the 75-year period.

Health Care Cost Factors

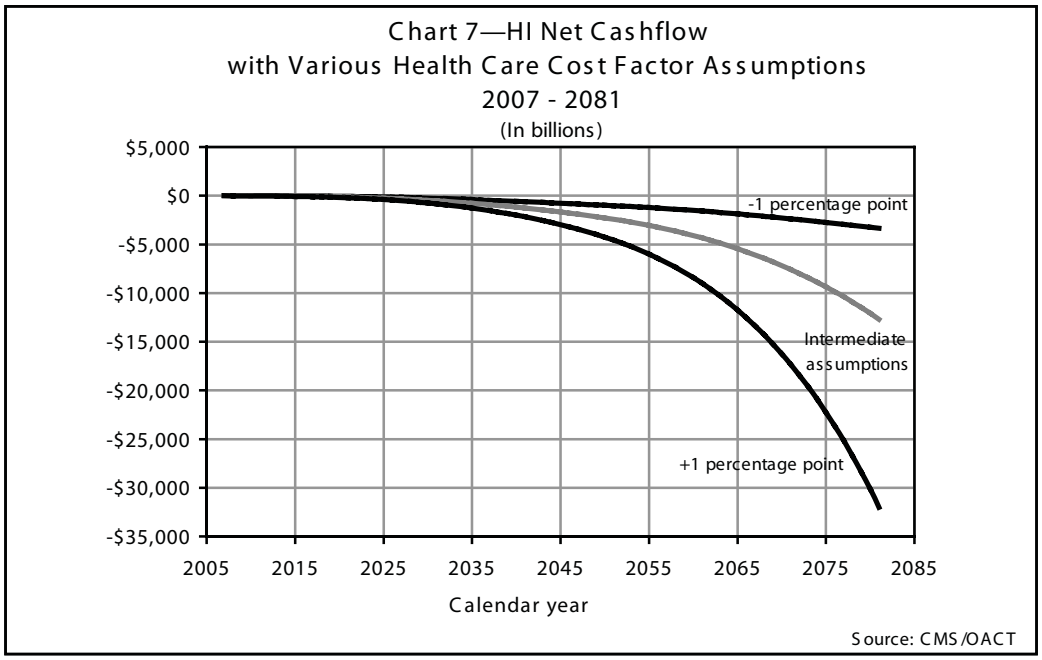
Table 1 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs,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

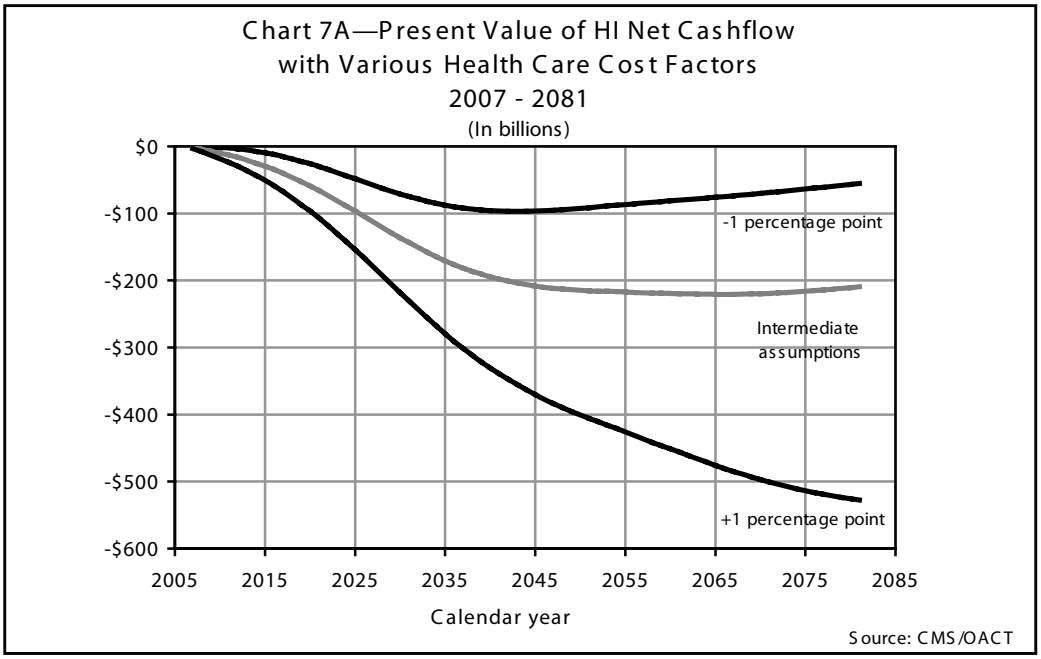
[6] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.
[7] The sensitivity of the projected HI net cash 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.
[8] 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—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)	-$5,053	-$12,292	-$24,051

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,240 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $11,758 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 1.





This assumption has a dramatic impact on projected HI cashflow. 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.

Fertility Rate

Table 2 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.

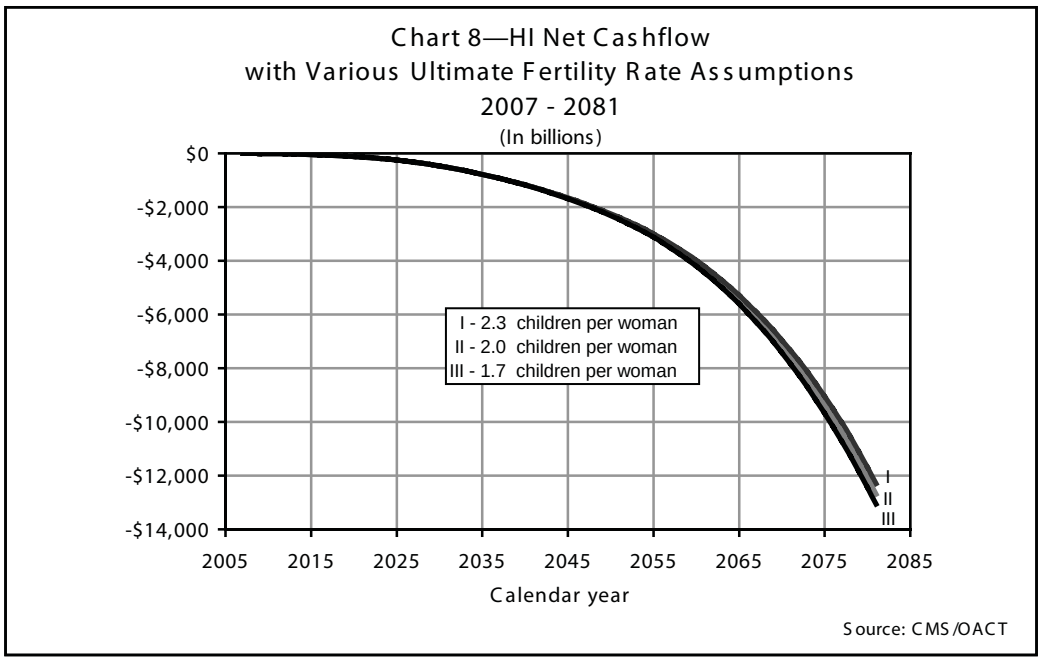
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

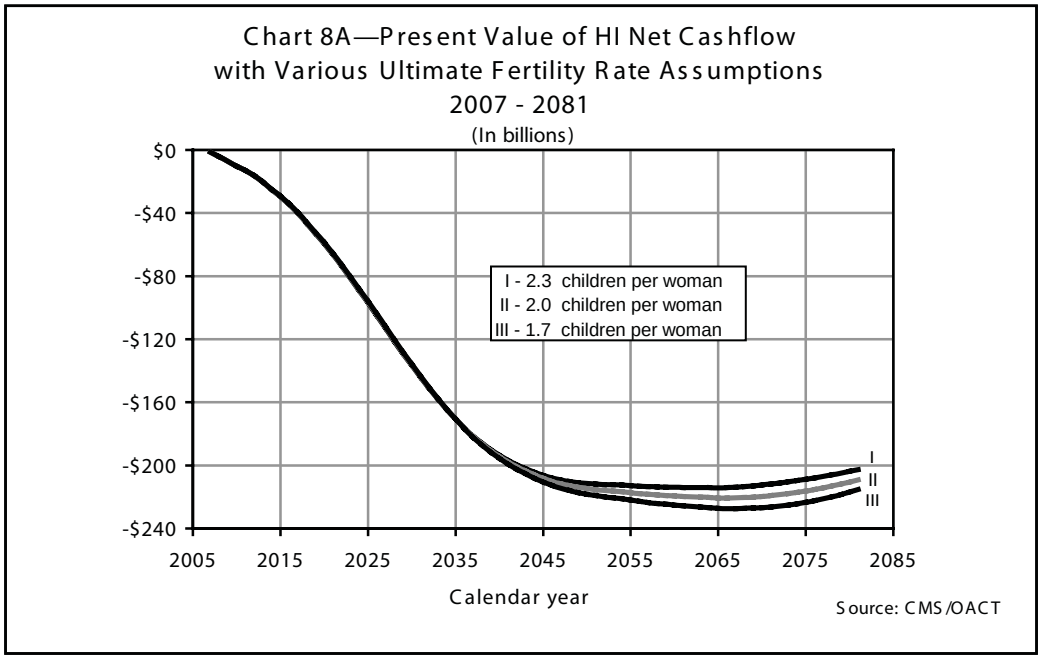
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures (in billions)	-$12,503	-$12,292	-$12,091

[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 2 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $205 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 2.





As charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows. In fact, higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the impacts are expected to be somewhat greater, as illustrated by the present values in table 2.

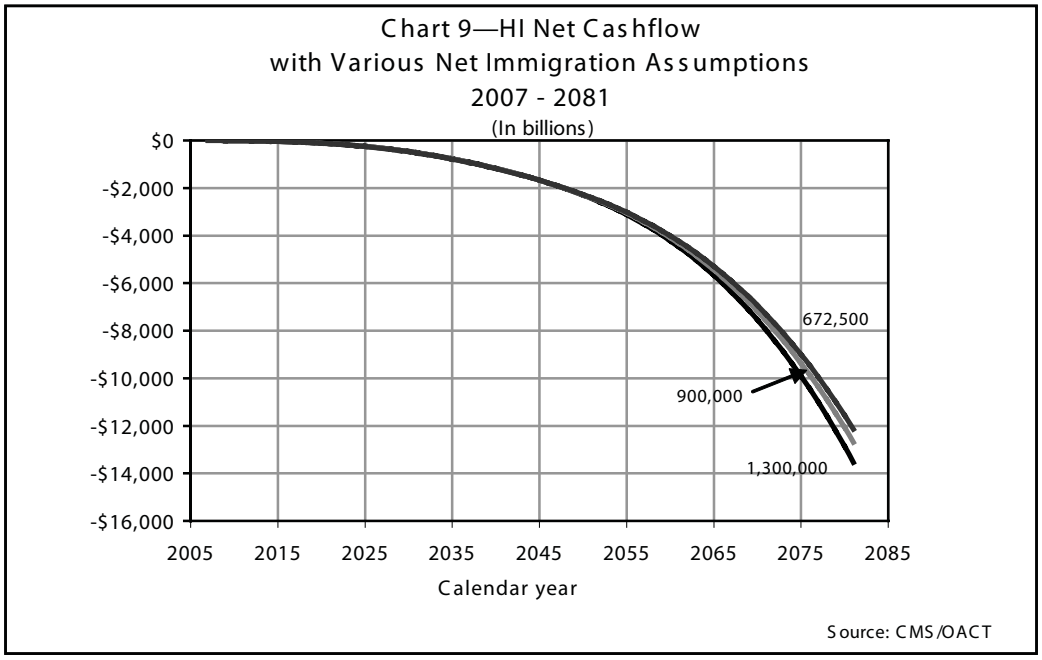
Net Immigration

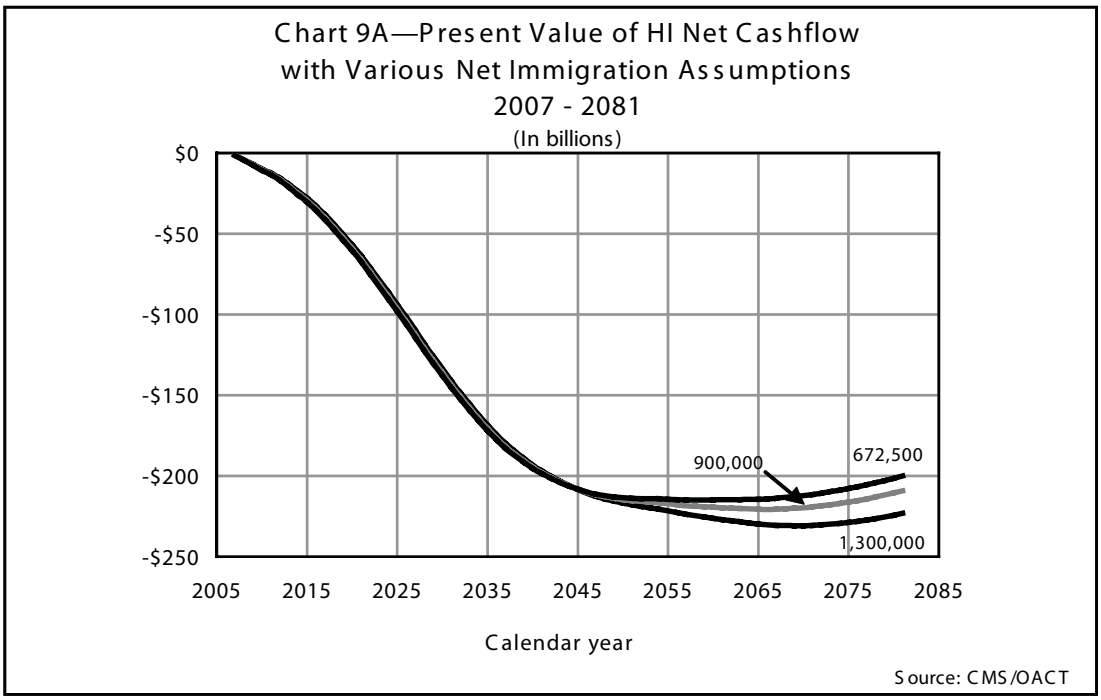
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions			
Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures (in billions)	-$12,149	-$12,292	-$12,516

As shown in table 3, if the ultimate net immigration assumption is 672,500 persons, the deficit decreases by $144 billion. Conversely, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by $224 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 3.





As charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

Real-Wage Differential

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[9] assumptions: 0.6, 1.1, and 1.6 percentage points. 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, 3.9, and 4.4 percent, respectively.

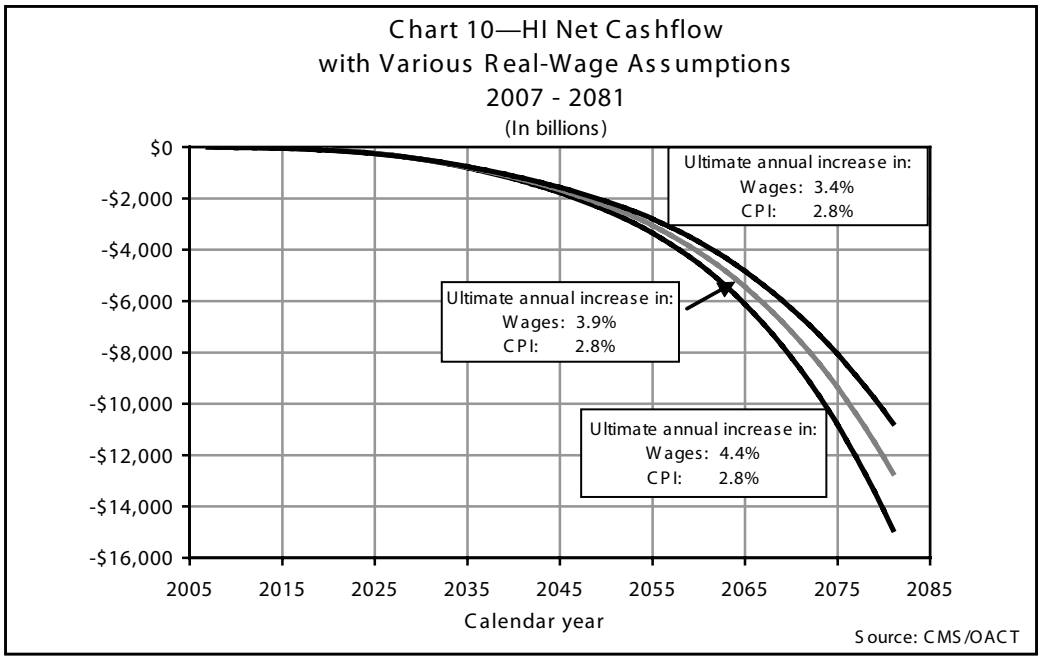
Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions			
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures (in billions)	-$11,411	-$12,292	-$13,376
Income minus expenditures (as a percentage of taxable payroll)	-4.04%	-3.69%	-3.43%

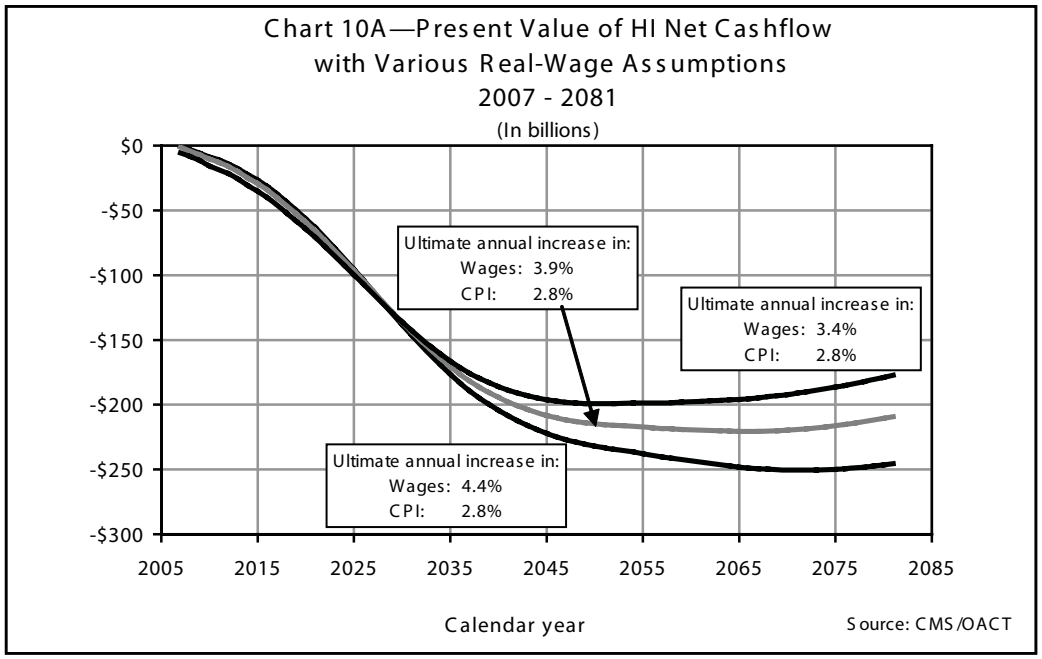
As indicated in table 4, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $980 billion. In this instance, the results expressed in present-value dollars do not reveal the full implications of faster or slower growth

[9] The difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

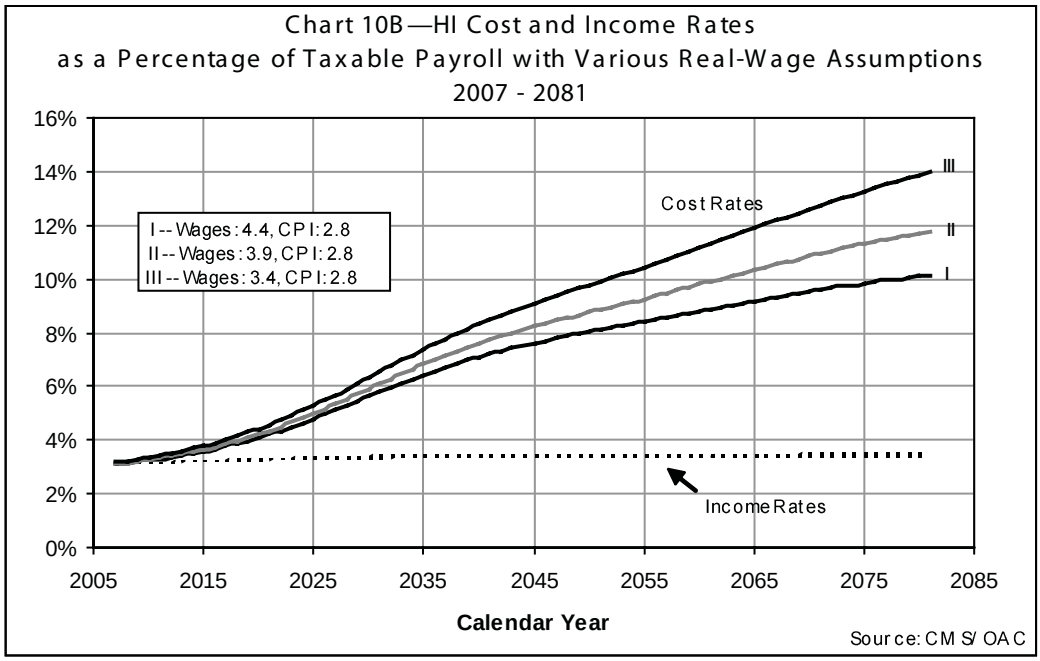
in real wages. While the dollar amount of the trustfund deficit is lower, for a smaller real-wage differential, table 4 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with slower growth in real wages, a higher tax increase would be necessary to cover the corresponding HI trust fund deficit. In practice, slow growth in real wages worsens the financial status of the HI trust fund, and, conversely, rapid growth in real wages improves the fund's condition. The reasons for the apparent inconsistency between the present-value and taxable-payroll measures are described below.

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





As noted previously and illustrated in charts 10 and 10A, slower real-wage growth results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. While this result appears to suggest that the financial status of the HI trust fund improves with slower real-wage growth, in practice the opposite is true. To better illustrate this result, chart 10B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.



As indicated in chart 10B, HI expenditures represent a significantly higher proportion of taxable payroll under conditions of slow real-wage growth (and vice versa). HI tax revenues, however, as a percentage of taxable payroll, are largely unaffected. As a result, the HI deficit as a percentage of taxable payroll increases substantially with slow wage growth, and faster real-wage growth leads to lower HI cost rates and deficits.

A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In dollar terms (either nominal or present-value), expenditures, revenues, deficits, and taxable payroll all increase with faster real-wage growth. In relative terms, however, faster wage growth increases taxable payroll, and thus tax revenues, more than it increases expenditures. This scenario leads to an improved financial status, where a smaller increase in the HI payroll tax rate would be required to attain financial balance. Similarly, slower real-wage growth worsens the financial outlook for the HI trust fund. For these reasons, the dollar cashflow measures required by Federal accounting standards do not adequately describe the sensitivity of the HI financial status to changes in the real-wage assumptions and must be supplemented by other measures.

Consumer Price Index

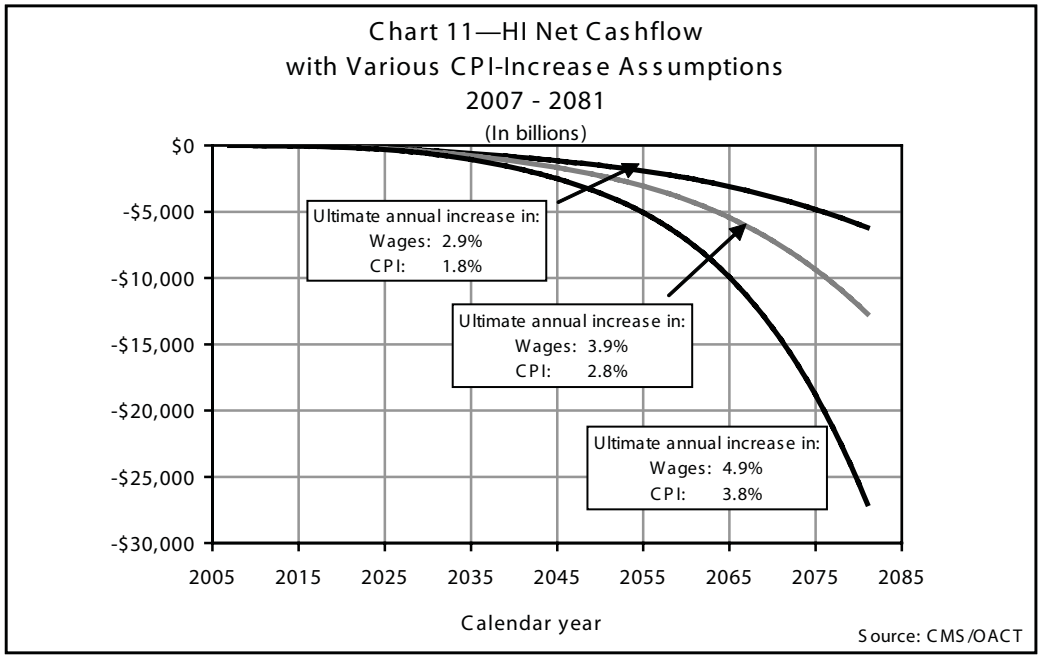
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

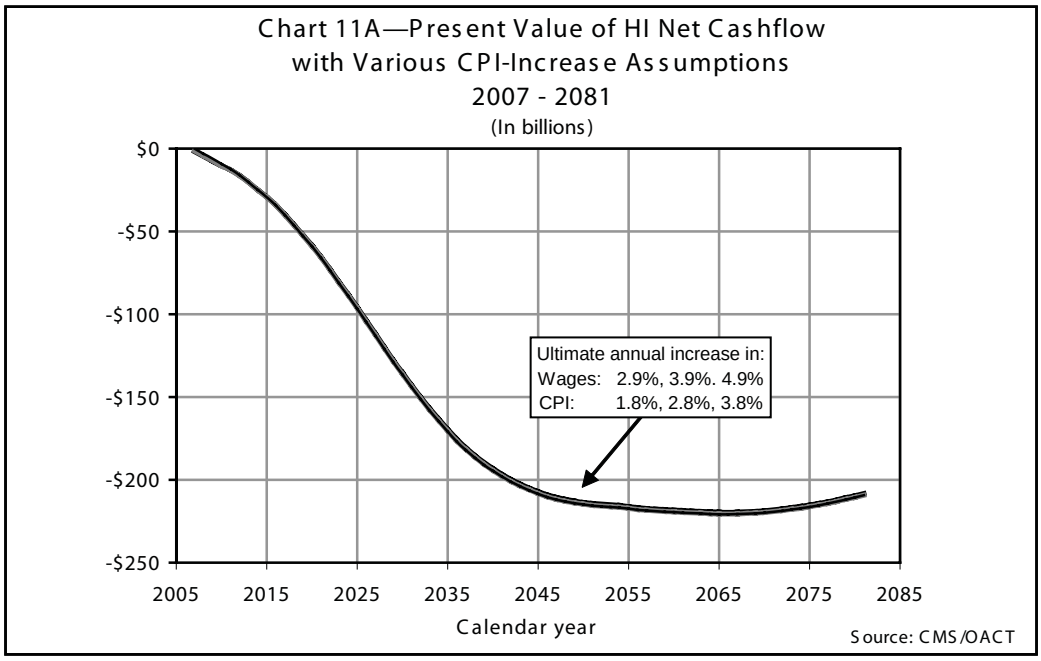
Table 5—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures (in billions)	-$12,230	-$12,292	-$12,299

Table 5 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $63 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by only $6 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 5.





As charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In nominal dollars, however, a given deficit "looks bigger" under high-inflation conditions but is not significantly different when it is 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.

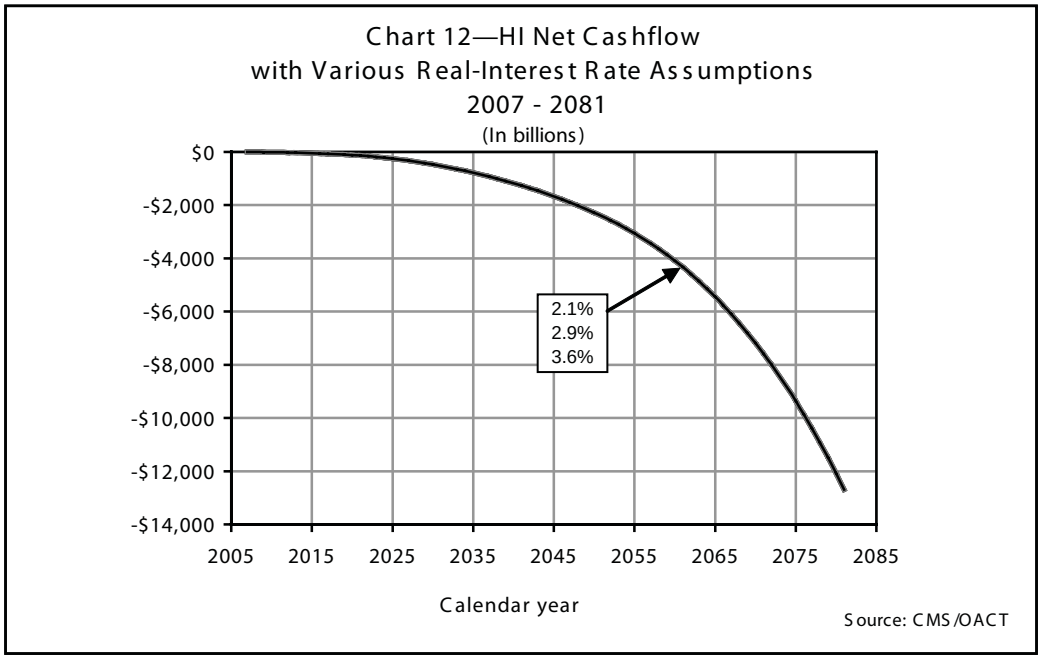
Real-Interest Rate

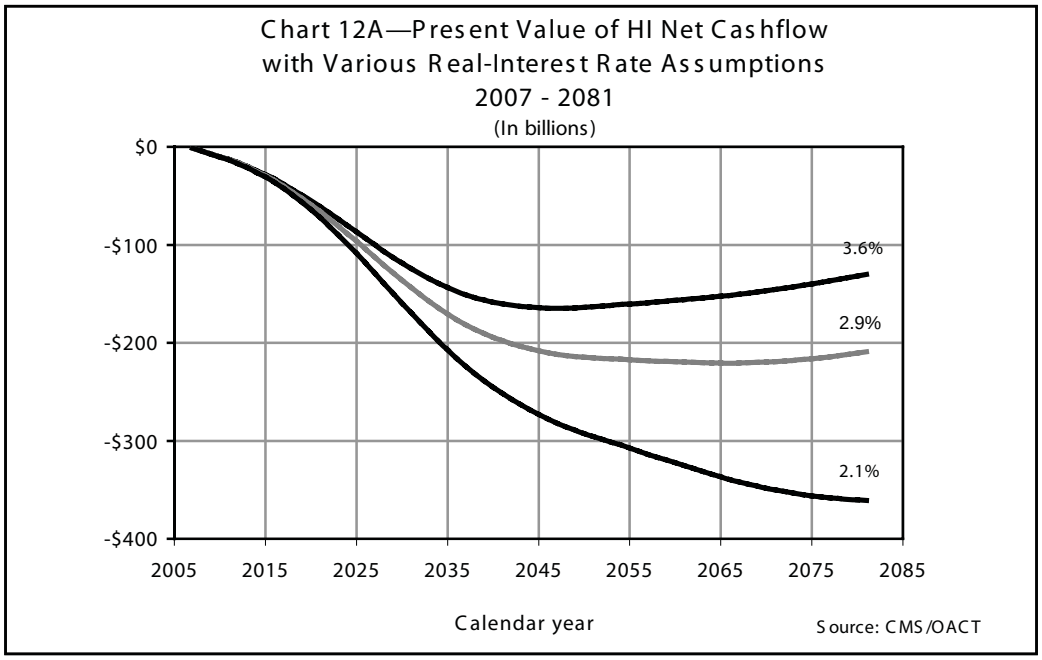
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 percent, respectively.

Table 6—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)	-$17,269	-$12,292	-$9,264

As illustrated in table 6, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $530 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 6.





As shown in charts 12 and 12A, 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 2018. 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.

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2018, the same as was estimated in last year's report. Income from all sources is projected to exceed expenditures for only the next 4 years and to fall short by steadily increasing amounts in 2010 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those 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.

The HI trust fund is substantially 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 very substantial increases in revenues and/or reductions in benefits. These changes are needed in part as a result of the impending retirement of the baby boom generation.

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

The financing established for the Part B account for calendar year 2007 is adequate to cover 2007 expected expenditures and to restore the financial status of the Part B account in 2007 to a satisfactory level. Because the net trust fund ratio would still be at the lower end of the desirable range, the Part B financing rates for 2008 would have to be increased slightly above the estimated expenditure increase.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. The projected Part D costs shown in this section are significantly lower than previously estimated, reflecting the latest data on drug cost trends generally and Part D bid and enrollment levels.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. However, a critical issue for the SMI trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily 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 (2007-2013).[10] This difference is projected to first exceed 45 percent of total expenditures in 2013, which is within the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. A similar determination was made in their 2006 annual report to Congress. Under the MMA, these two consecutive determinations trigger a "Medicare funding warning," 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.[11] Congress is then required to consider this legislation on an expedited basis. This new requirement will help call attention to Medicare's impact on the Federal Budget.

[10] 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; and any gifts received by the Medicare trust funds.
[11] The next such budget submission will be the President's Fiscal Year 2009 Budget, which will be released in early February 2008.

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. In their 2007 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "prompt, effective, and decisive action…to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."

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