FINANCIAL SECTION

SECTION 2

IN THIS SECTION

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Message from the Principal Deputy Assistant Secretary

I am honored to join Secretary Azar in presenting the Fiscal Year (FY) 2019 Agency Financial Report (AFR) for the Department of Health and Human Services (HHS). HHS is responsible for more than a quarter of all federal outlays and administers more grant dollars than all other agencies combined. HHS's Chief Financial Officer (CFO) community works to enhance and sustain a financial management environment that ensures accountability and manages risk related to the significant budgetary resources entrusted to the Department.

For the 21st consecutive year, we received an unmodified (clean) audit opinion on our financial statements from our independent auditors. A clean opinion confirms that our financial statements are presented fairly, in all material respects, and conform with generally accepted accounting principles. The AFR's "Financial Section" provides detailed information about HHS's financial statements and activities that contributed to this opinion.

The CFO community is employing financial management best practices and process improvement frameworks to strengthen our application of statutes, regulations, and other financial management requirements, resulting in stronger internal controls over financial operations. By promoting continuous process improvements across the HHS financial management environment, we are finding opportunities to modernize outdated business processes, increase stakeholder satisfaction, improve program performance, and create effective partnerships throughout the organization.

Furthermore, to better serve the needs of our customers, the CFO community is also leveraging technology and innovation to develop products and services that improve the quality and reliability of financial data, enhance the user experience, facilitate cross-functional collaboration, and reduce cost by shifting from low-value activities to high-value work. By establishing a culture of innovation, our Operating Divisions and Staff Divisions are able to realize significant business process efficiencies and achieve value for their stakeholders.

Additionally, HHS's FY 2018 financial report received the Association of Government Accountants' *Certificate of Excellence in Accountability Reporting*, our sixth consecutive award. This review program was established over 20 years ago in collaboration with the CFO Council and the Office of Management and Budget to help agencies effectively present financial management activities in AFRs and Performance and Accountability Reports.

I want to thank our employees and partners for their remarkable efforts and dedication. HHS's AFR is a reflection of our extraordinary dedication to our mission. Together, we look forward to expanding the Department's financial management capabilities.

/Jen Moughalian/

Jen Moughalian
Principal Deputy Assistant Secretary for Financial Resources
November 13, 2019

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: The Secretary

NOV 13 2019

FROM: Gloria L. Jarmon
Deputy Inspector General for Audit Services

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2019*, A-17-19-00001

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2019 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the HHS (1) consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of net cost and changes in net position; (2) the combined statements of budgetary resources for the years then ended; and (3) the sustainability statements that comprise the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 19-03, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2019 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related statements of changes in social insurance amounts for the periods ended January 1, 2019 and 2018. As a result, Ernst & Young was not able to, and did not, express an opinion on the financial condition of the HHS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young did not identify any deficiencies in internal control that it considered a material weakness. Ernst & Young noted improvements over internal controls but continued to identify two significant deficiencies related to HHS's Financial Information Systems and HHS's Financial Reporting Systems, Analyses, and Oversight, as described below:

- *Financial Information Systems*—Ernst & Young noted that HHS had continued to make strides to improve information technology (IT) controls within its financial systems. HHS management continued to establish a governance model and was consistent in focusing on strengthening the maturity over HHS's IT controls. There has been a significant reduction in the number of high-risk internal control deficiencies noted in prior years because of management's continued focus on HHS enterprise-wide corrective actions. Ernst & Young also noted that HHS continues to emphasize "the maturation of the HHS internal controls program" by making investments in key financial systems.

  Even with these improvements and as in previous fiscal years, Ernst & Young identified control deficiencies related to segregation of duties, configuration management, and access to HHS systems that could affect HHS's financial statements. These deficiencies collectively constitute a significant deficiency in internal control.

- *Financial Reporting, Analysis, and Reporting*—During the FY 2019 audit, Ernst & Young noted that HHS made significant progress in addressing certain issues that have impaired its ability to overcome significant deficiencies reported in prior years. HHS reorganized the Office of Grants and Acquisition Policy and Accountability (OGAPA) into two offices, the Office of Grants and the Office of Acquisitions, which now have separate directors who report to the Assistant Secretary of Administration. Ernst & Young also noted that HHS continued efforts to clean up its data. This included closing older grant obligations in support of the Grants Oversight and New Efficiency Act (GONE) (P.L. No. 114-117).

  Although HHS made progress in these areas, the FY 2019 audit still identified a series of deficiencies in financial systems and processes for producing financial statements, including the lack of integrated financial management systems, antiquated processes that impacted journal entries to its financial and budgetary amounts, and insufficient analysis and oversight of certain significant accounts and programs. Ernst & Young specifically described concerns over the number and amount of nonstandard journal entries, HHS's acquisition processes, Medicaid oversight, and the Statement of Social Insurance. Ernst & Young noted a significant number of nonstandard journal vouchers are needed to record entries that cannot be recorded through routine processing in HHS Financial Systems. These entries are needed to ensure accurate account balances, but Ernst & Young noted that the volume and dollar value of them are a significant portion of HHS's overall financial activity.

Ernst & Young also noted HHS, over the past several years, has identified a series of (1) concerns related to internal control and (2) violations of laws and regulations related to its acquisition processes at both the HHS Department and Operating Division levels. HHS management took certain corrective actions in FY 2019. As stated above, HHS reorganized its Acquisitions office, which resulted in a separate Office of Acquisitions with separate executive oversight. HHS has started a review of its policy and procedures against current Federal Government regulations and a review of the implementation and execution of such policies and procedures at one location. As of the date of Ernst & Young's *Report on Internal Control*, HHS has not completed the review of its acquisition policies and procedures and had not completed related corrective actions as a result of this review.

For Medicaid oversight, Ernst & Young noted that although the Centers for Medicare & Medicaid Services' (CMS's) Transformed-Medicaid Statistical Information System was fully operational, CMS still needed to work with the States to assess and improve data quality to support national and State-level program analysis with timely, accurate, and complete data for policymaking and research. CMS still did not have reliable historical claims-level data, so data analysis using this information has been limited. CMS also still had not performed a claims-level detailed look-back analysis for the Medicaid Benefits Due and Payable line item reported in both the FY 2019 CMS and HHS financial statements to determine the reasonableness of various State calculations of unpaid claims that have not yet been reported as liabilities.

For the Statement of Social Insurance, Ernst & Young identified formula errors in the spreadsheets used in the preparation of the statement. These formula errors were not detected by CMS's monitoring and review function. Ernst & Young concluded that the control over the formula was not functioning as designed. These deficiencies collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2019, HHS was not in full compliance with the requirements of the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended, and section 6411 of the Affordable Care Act[1] related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs, except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. HHS reported two high priority programs, Medicaid and CHIP, with error rates in excess of 10 percent. These are also violations of the IPIA. We will report further on agency compliance with improper payment reporting, as required by the IPIA, later in FY 2020. HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. No. 101-508) related to an obligation of funds for conference spending at the Food and Drug Administration and certain contract obligations at CMS that occurred in FYs 2014 and

[1] The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act.

2015 and at HHS's Program Support Center (PSC) that occurred between FY 2006 and FY 2011. HHS's management also determined that the agency's Medicare appeals process did not adjudicate appeals within the statutory timeframes required by the Social Security Act (P.L No. 74-271). Finally, as discussed above, HHS identified potential violations with laws and regulations related to its acquisition processes.

Evaluation and Monitoring of Audit Performance

In accordance with the requirements of OMB Bulletin 19-03, we reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2019 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or HHS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carrie A. Hug, Assistant Inspector General for Audit Services, at (202) 619-1157 or Carrie.Hug@oig.hhs.gov. Please refer to report number A-17-19-00001.

Attachment

Page 5—The Secretary

cc:
Jennifer Moughalian
Acting Assistant Secretary for Financial Resources
and Chief Financial Officer

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

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Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2019 and 2018, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements. We were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, the related statement of changes in social insurance amounts for the periods ended January 1, 2019 and 2018, and the related notes to the sustainability financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statement of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, the related statement of changes in social insurance amounts for the periods ended January 1, 2019 and 2018, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 19-03 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statement of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements.

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

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

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As further described in Note 24 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2019, 2018, 2017, 2016, and 2015, the current-law expenditure projections reflect the positions payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 24, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent a change in the health care delivery system or level of update by subsequent legislation, access to Medicare-participating providers may become significant issues in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statement of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related statement of changes in social insurance amounts for the periods ended January 1, 2019 and 2018.

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

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related changes in the social insurance program for the periods ended January 1, 2019 and 2018.

Opinion

In our opinion, the consolidated balance sheets, consolidated statements of net cost and changes in net position, and combined statement of budgetary resources referred to above present fairly, in all material respects, the consolidated financial position of HHS as of September 30, 2019 and 2018, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

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Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the Management's Discussion and Analysis, Required Supplementary Stewardship Information, and Required Supplementary Information as identified on HHS's Agency Financial Report Table of Contents, be presented to supplement the financial statements. Such information, although not a part of the financial statements, is required by the Federal Accounting Standards Advisory Board, which considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audits of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Financial Information and Other Information

Our audits were conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS's financial statements. The Other Financial Information, as identified on HHS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the financial statements.

The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. Such information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Except for the Other Financial Information described above, the Other Information has not been subjected to the auditing procedures applied in the audits of the financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

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Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 13, 2019, on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations, contracts and grant agreements, and other matters. The purpose of those reports is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of HHS' internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 13, 2019

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Report of Independent Auditors on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2019, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year (FY) then ended, and the related notes to the principal financial statements, and we were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019, and have issued our report thereon dated November 13, 2019. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 19-03. We did not test all internal controls relevant to operating objectives as broadly defined by the *Federal Managers' Financial Integrity Act of 1982*, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may

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exist that have not been identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control related to Financial Information Systems and Financial Systems, Analysis and Reporting, as described below, to be significant deficiencies.

Significant Deficiencies

Financial Information Systems

As a part of our procedures for the FY 2019 HHS financial statement audit, we noted that the Department continues to make strides to improve the controls within its supporting information technology (IT) financial systems. In particular, management has continued to establish a governance model and consistent tone at the top focused on strengthening the maturity of the Department's IT controls. Specifically, management has taken a leadership role in monitoring remediation activities across all IT systems in scope, with a focus on general ledger systems and control deficiencies that contributed to the IT significant deficiency of the consolidated Financial Statement Audit. These efforts have led to a significant reduction of the number of internal control deficiencies that contributed to the FY 2018 IT significant deficiency related to in-scope information systems and applications. The following summarizes additional improvements achieved that resulted from this increased attention:

- Management has continued to prioritize the maturation of the HHS internal controls program. This focus on strengthening controls coupled with operationalizing a number of differential investments made in key financial systems (i.e., Unified Financial Management System (UFMS) access control/segregation of duties redesign) have provided a more mature controls baseline.

- Management has continued their enterprise-wide focus on corrective actions which has led to the remediation of a number of prior year control deficiencies.

The following is a summary of the deficiencies that we considered most critical at the application layer. When assessed in aggregate, our conclusion of IT significant deficiency is based on the following:

- **Access controls –** We identified four (4) high risk access control exceptions across three (3) of the applications in-scope of our review, which spanned non-Centers for Medicare & Medicaid Services' (CMS) systems. Specifically, we noted (1) all auditable events required are not being logged and monitored and the procedures required to be performed in the event that the logging and monitoring tool is down or unavailable were not consistently performed by management, (2) management was unable to produce a complete and accurate population of all current database administrators (DBAs) and Developers, (3) management did not recertify all privileged users as part of the FY19 annual recertification effort, and (4) management has not consistently adhered to Department and system-level logging and monitoring requirements. We identified similar exceptions at CMS: (1) Procedures for the removal of users who no longer required access were not consistently followed, and (2) Monitoring of privileged access for key applications and underlying IT infrastructure was not performed or evidence of such monitoring activity was not retained.

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- **Configuration management** – We identified one (1) configuration management exception in an in-scope, non-CMS application. Specifically, we noted management was not able to provide a system generated listing/population of changes deployed into production during the audit period. In addition, CMS continues to experience deficiencies in the implementation and monitoring of compliance with its information systems control standards and processes. Specifically, the remediation, mitigation of risks, or monitoring of vulnerabilities, identified related to system configurations with the Central Office information systems, were not performed or not performed timely.

- **Segregation of duties** – We identified three (3) segregation of duties exceptions across two (2) applications in scope of our review which spanned non-CMS systems. Specifically, we noted (1) Management has not implemented a process for validating the completeness and accuracy of supporting their segregation of duties (SOD) monitoring controls and sufficient evidence was not provided to support all SOD rules/colliding transactions, (2) management has not documented a complete and accurate listing of all cross-application SOD conflicts between two (2) financially significant applications, and (3) management was unable to provide evidence to demonstrate that appropriate monitoring procedures were performed for a user with a segregation of duties waiver.

Recommendations

HHS should continue the progress achieved in FY2019 to remediate the remaining deficiencies contributing to the significant deficiency and focus on continuous improvement. The following are some specific considerations:

- Continue to prioritize high impact remediation activities ultimately strengthening the IT controls maturity, with specific attention on the remaining high-risk control deficiencies identified as a part of the FY2019 Financial Statement Audit centered on access controls, configuration management, and segregation of duties;

- Work to strengthen overarching governance/oversight to improve sustainability of remediation activities limiting the identification of new internal control deficiencies that could contribute to the IT significant deficiency during the audit;

- Execute on planned modernization of legacy systems with further investment, while ensuring that any major changes to the IT environment are performed with internal controls at the forefront, leading to strengthened overarching governance/oversight to improve sustainability of controls; and

- Continue to build on the maturity of the IT controls enterprise and strengthen all aspects of the HHS/CMS IT enterprise, to include operating system, data tier, and application layer, while being cognizant of the identification of new internal control deficiencies on material systems that could contribute to the IT significant deficiency.

We have performed a separate financial statement audit of CMS for FY2019 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions.

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Financial Systems, Analysis and Reporting

During FY 2019, HHS made significant progress in addressing certain issues that have impaired its ability to overcome its significant deficiencies in the past. Improvements included:

- Reorganizing its Office of Grants and Acquisition Policy and Accountability (OGAPA) into two separate offices: Office of Grants and the Office of Acquisitions. Each office reports to a separate Deputy Assistant Secretary who report up to the Assistant Secretary for Financial Resources.
- Continued clean-up efforts of its data, including closing older grant obligations in support of the GONE Act.
- Performed a hardware refresh for the financial systems hosted at Oracle Managed Cloud Services (UFMS, FBIS, CFRS and supporting systems).
- Developed a proof of concept, known as Snap, to modernize the delivery and accessibility of HHS accounting guidance. Snap is transforming the excel-based Accounting Treatment Manual (ATM) to an interactive platform that provides a centralized, automated, and intuitive presentation of accounting treatment information.
- Developed a comprehensive Department-wide DATA Act systems-based solution that significantly improved enterprise-wide data quality and integration, enabling HHS to link financial data to corresponding data in grants, financial assistance, and acquisition systems; eliminating interim solution manual crosswalks; and establishing microservice-based, automated interconnectivity to the Treasury DATA Act Broker.

Although progress in certain areas have been identified, our review of internal control disclosed a series of deficiencies in financial systems and processes for producing financial statements, including the need for a number of non-standard journal entries to significantly adjust financial and budgetary amounts, and/or insufficient analysis and oversight of certain significant accounts or programs. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required.

Non-Standard Journal Voucher Processes

HHS posts a significant number of non-standard journal vouchers to record entries that are unable to be recorded through routine systematic processing. The majority of these entries are generated by NIH; however, in comparison to their budgetary resources, many of the other operating divisions also have a significant number of non-standard entries recorded to ensure consolidated financial statement amounts are accurate. During FY 2019, although HHS' annual total budgetary resources was $1.9 trillion, HHS was required to process approximately 9,498 manual entries totaling an absolute value of more than $623.3 billion to its NIH Business System (NBS) or Unified Financial Management Systems (UFMS). Although the number of manual entries decreased, there was a 32% overall increase in absolute dollar value compared to FY 2018 where 9,914 manual entries totaling an absolute value of more than $471.0 billion were posted. These entries consist of non-standard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post

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automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. Although necessary to ensure balances are accurate, the volume and dollar value of manual entries is significant compared to the HHS's overall activity.

HHS Procurement Processes

Over the past several years, HHS has identified several (1) concerns related to internal control and (2) violations of laws and regulations related to its acquisition processes at both the HHS department and Operating Division Levels. We have reported current and potential violations within our accompanying Report on Compliance and Other Matters. HHS management has taken certain corrective actions in FY 2019, including a reorganization of the HHS's Acquisitions office resulting in a separate Office of Acquisitions with separate executive oversight, a review of its policy and procedures against current Federal government regulations, and a review of the implementation and execution of such policies and procedures at one location. As of November 13, 2019, HHS has not completed its review and related corrective actions.

CMS Oversight Processes

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls, dated November 6, 2019. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting.

The most significant of those deficiencies fell within the oversight of the CMS Medicaid program and the Statements of Social Insurance.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters.

CMS previously completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. Although operational data is currently available, CMS must continue to work with states to assess and improve T-MSIS state data quality to support national and state level program analysis with timely, accurate, and complete data for policymaking and research. At this time the information contained within T-MSIS requires additional verification before it would be considered reliable. CMS should continue to enhance the usefulness of T-MSIS data so they will be able to perform robust analytical procedures and develop benchmarks to monitor and identify risks associated with the Medicaid program. Examples of risks to monitor could include outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures and/or allow CMS to assess the reliability of the T-MSIS data. Given that CMS does not currently maintain reliable historical claims level detail for Medicaid, data analyses have been limited. At this time, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine

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the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2019 financial statements and is subject to volatility based on the complexity and judgement required in establishing this estimate. From time to time, claim processing cycle changes, such as a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence. Despite the implementation of T-MSIS, CMS must continue to evaluate and improve the quality and completeness of data reported by the states in T-MSIS before a claims level detailed look-back analysis for Medicaid EBDP can be suitably relied upon. Until further analysis is developed and performed to verify the reliability of T-MSIS data, there remains a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS' policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. During our procedures, formula errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

Recommendations

We recommend that HHS continue to develop and refine their financial management systems and processes to improve their accounting, analysis, and oversight of financial management activity. This will require focused efforts and continued prioritization of issues related to controls within and surrounding their financial information management systems. Specifically, we recommend the following:

- For non-standard journal processes, we recommend that HHS continue to focus on automating and reducing the number of non-standard journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of high-volume routine transactions and to ensure financial data is accurate.

- We recommend that HHS continue its review over all of its acquisition activities. As potential internal control and law and regulation concerns are identified, we strongly recommend that policies and procedures are updated with training provided to the acquisition's personnel to provide assurances that processes are executed properly. Further, we recommend that the on-going monitoring process be enhanced to provide stronger internal controls so that anomalies can be prevented or identified timely.

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- We recommend that CMS continue to refine its financial management controls as a means to improve its accounting, analysis, and oversight of financial management activity, primarily relating to the oversight of the Medicaid program. Additionally, we recommend that CMS continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision. Finally, we recommend that CMS establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record its accruals. More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

Status of Prior Year Findings

In the reports on the results of the FY 2018 audit of the HHS consolidated financial statements, a number of issues were raised relating to internal control over financial reporting. The chart below summarizes the current status of the prior year items:

Significant Deficiencies		
Issue Area	**FY 2018 Summary Control Issue**	**FY 2019 Status**
Financial Information Systems	• Access Controls • Configuration Management • Segregation of Duties • Risk Management	Significant progress noted; certain issues need continued focus. Modified Repeat Condition

Financial Systems, Analysis, and Reporting	• Non-Standard Journal Voucher Processes
	• CMS Oversight Processes
	  ○ Medicaid Oversight
	  ○ Statement of Social Insurance
		Progress noted.
		Modified Repeat Condition.

HHS's Response to Findings

HHS's response to the findings identified in our audit are included in the accompanying letter dated November 13, 2019. HHS's response was not subjected to the auditing procedures applied in the audit of the consolidated financial statements, and, accordingly, we express no opinion on it.

Purpose of This Report

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

Ernst & Young LLP

November 13, 2019

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Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2019, and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year (FY) then ended, and the related notes to the principal financial statements, and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019, and have issued our report thereon dated November 13, 2019. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 19-03, including the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 19-03, as described below.

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During FY 2019, HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to an obligation of funds for conference spending at Food and Drug Administration and certain contract obligations serviced by the Program Support Center between FY 2006 and FY 2011 and Centers for Medicare & Medicaid Services occurring between FY 2014 and FY 2015. Additionally, HHS's management determined that its Medicare appeals process did not adjudicate appeals within the statutory decisional time frames required by the *Social Security Act*. Finally, HHS places a high priority on complying with appropriations and acquisitions law and avoiding violations of the Federal Acquisition Regulation (FAR). When a violation is suspected, HHS obtains legal review and advice from the Office of the General Counsel (OGC) before determining whether a violation exists. HHS internal reviews have revealed noncompliance issues related to three subparts of the FAR, including FAR 4.4, FAR 17.5, and FAR 17.7.

The *Improper Payments Information Act of 2002* (IPIA) (P.L. 107-300) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) (P.L. 111-204) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (P.L. 112-248) (hereinafter, the "Acts") require federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. While the Department continues to make progress, HHS currently is not in full compliance with the requirements of the Acts. For example, HHS has reported improper payment error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the *Social Security Act*, which specifies the data elements that HHS may require states to report, and Section 417 of the same *Social Security Act*, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS states that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the *Social Security Act*. Additionally, the Medicaid and CHIP improper payment rates exceeded the statutorily required maximum of 10 percent. Finally, HHS is not in full compliance with Section 6411 of the *Patient Protection and Affordable Care Act*, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed no instances in which HHS's financial management systems did not substantially comply with requirements as discussed above.

* * * * *

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HHS's Response to Findings

HHS' response to the findings identified in our audit are described in their letter dated November 13, 2019. HHS's response was not subjected to the auditing procedures applied in the audit of the financial statements, and, accordingly, we express no opinion on it. Additionally, HHS is updating its Department-wide corrective action plan to address the financial management issues discussed above.

Purpose of This Report

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

Ernst & Young LLP

November 13, 2019

Department's Response to the Report of the Independent Auditors

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

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

To: Joanne Chiedi, Acting Inspector General

From: Jen Moughalian, Principal Deputy Assistant Secretary

Subject: FY 2019 Independent Auditors' Financial Statement Audit Report

Thank you for the opportunity to comment on the FY 2019 Independent Auditors' Report. We appreciate the tremendous effort put forth by the Office of Inspector General (OIG) and our independent auditors, Ernst & Young LLP (EY), to audit the Department of Health and Human Services' (HHS) financial statements.

We are proud to once again have an unmodified opinion on our financial statements. We acknowledge the identified material noncompliances with laws and regulations, and we generally concur with the auditor's findings. We will continue to actively engage in effective corrective actions and monitor remediation efforts. The Department has diligently worked to improve our control environment, and we intend to remain flexible as new challenges and concerns emerge.

The Department has greatly benefited from the annual audit process and its resulting perspective and insight over the years. We thank OIG and EY for their effort and look forward to partnering with you and our valued stakeholders to address these issues and improve our financial management practices.

/Jen Moughalian/

Jen Moughalian
Principal Deputy Assistant Secretary
November 13, 2019

Principal Financial Statements

U.S. Department of Health and Human Services
Consolidated Balance Sheets

As of September 30, 2019 and 2018
(in Millions)

	2019	2018
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 296,257	$ 250,163
Investments, Net (Note 4)	309,349	307,115
Accounts Receivable, Net (Note 5)	812	1,129
Advances (Note 8)	180	255
Total Intragovernmental Assets	**606,598**	**558,662**
Accounts Receivable, Net (Note 5)	24,156	26,802
Inventory and Related Property, Net (Note 6)	10,781	9,815
General Property, Plant and Equipment, Net (Note 7)	6,544	6,350
Advances (Note 8)	2,452	2,694
Other Assets	197	204
Total Assets	**$ 650,728**	**$ 604,527**
Stewardship Land (Notes 19)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 1,153	$ 1,029
Other Liabilities (Note 13)	5,573	8,080
Total Intragovernmental Liabilities	**6,726**	**9,109**
Accounts Payable	1,221	957
Entitlement Benefits Due and Payable (Note 10)	110,100	99,148
Accrued Liabilities (Note 12)	15,543	14,521
Federal Employee and Veterans' Benefits (Note 11)	14,826	14,386
Contingencies and Commitments (Note 14)	17,083	13,475
Other Liabilities (Note 13)	3,695	5,736
Total Liabilities	**169,194**	**157,332**
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 18)	57,968	22,934
Unexpended Appropriations - All Other funds	170,438	163,667
Cumulative Results of Operations - Funds from Dedicated Collections (Note 18)	258,392	262,972
Cumulative Results of Operations - All Other funds	(5,264)	(2,378)
Total Net Position - Funds from Dedicated Collections	**316,360**	**285,906**
Total Net Position - All Other Funds	**165,174**	**161,289**
Total Net Position	**481,534**	**447,195**
Total Liabilities and Net Position	**$ 650,728**	**$ 604,527**

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

U.S. Department of Health and Human Services
Consolidated Statements of Net Cost
For the Years Ended September 30, 2019 and 2018
(in Millions)

	2019	2018
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,201,630	$ 1,115,161
Exchange Revenue	(114,723)	(106,304)
CMS Net Cost of Operations	$ 1,086,907	$ 1,008,857
Other Segments:		
Administration for Children and Families (ACF)	$ 56,087	$ 54,091
Administration for Community Living (ACL)	2,176	1,994
Agency for Healthcare Research and Quality (AHRQ)	335	344
Centers for Disease Control and Prevention (CDC)	12,285	12,382
Food and Drug Administration (FDA)	5,339	5,023
Health Resources and Services Administration (HRSA)	11,655	11,684
Indian Health Service (IHS)	7,550	10,766
National Institutes of Health (NIH)	35,822	33,587
Office of the Secretary (OS)	3,439	3,221
Program Support Center (PSC)	2,771	2,588
Substance Abuse and Mental Health Services Administration (SAMHSA)	4,525	4,124
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	$ 141,984	$ 139,804
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes (Note 11)	(27)	416
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	$ 141,957	$ 140,220
Exchange Revenue	(6,015)	(5,806)
Other Segments Net Cost of Operations	135,942	134,414
Net Cost of Operations (Note 20)	**$ 1,222,849**	**$ 1,143,271**

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2019
(in Millions)

	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 22,934	$ 163,667	$ -	$ 186,601
Budgetary Financing Sources:				
Appropriations Received	402,356	657,034	-	1,059,390
Appropriations Transferred in/out (+/-)	-	3	-	3
Other Adjustments (+/-)	(5,861)	(89,481)	-	(95,342)
Appropriations Used	(361,461)	(560,785)	-	(922,246)
Total Budgetary Financing Sources	35,034	6,771	-	41,805
Total Unexpended Appropriations	**$ 57,968**	**$ 170,438**	**$ -**	**$ 228,406**
Cumulative Results of Operations:				
Beginning Balances	$ 262,972	$ (2,378)	$ -	$ 260,594
Budgetary Financing Sources:				
Other Adjustments (+/-)	(3)	(5)	-	(8)
Appropriations Used	361,461	560,785	-	922,246
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	281,441	-	-	281,441
Nonexchange Revenue - Investment Revenue	9,519	252	-	9,771
Nonexchange Revenue - Other	3,533	-	-	3,533
Donations and Forfeitures of Cash and Cash Equivalents	69	-	-	69
Transfers-in/out without Reimbursement (+/-)	(3,230)	1,010	-	(2,220)
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	7	-	7
Transfers-in/out Without Reimbursement (+/-)	(2)	2	-	-
Imputed Financing	56	813	(321)	548
Other (+/-)	3	(7)	-	(4)
Total Financing Sources	652,847	562,857	(321)	1,215,383
Net Cost of Operations (+/-)	657,427	565,743	(321)	1,222,849
Net Change	(4,580)	(2,886)	-	(7,466)
Cumulative Results of Operations:	**$ 258,392**	**$ (5,264)**	**$ -**	**$ 253,128**
Net Position	**$ 316,360**	**$ 165,174**	**$ -**	**$ 481,534**

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

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

For the Year Ended September 30, 2018

(in Millions)

	Funds From Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 17,284	$ 129,688	$ -	$ 146,972
Budgetary Financing Sources:				
Appropriations Received	376,964	653,567	-	1,030,531
Appropriations Transferred in/out (+/-)	-	1	-	1
Other Adjustments (+/-)	(34,637)	(85,787)	-	(120,424)
Appropriations Used	(336,677)	(533,802)	-	(870,479)
Total Budgetary Financing Sources	5,650	33,979	-	39,629
Total Unexpended Appropriations	**$ 22,934**	**$ 163,667**	**$ -**	**$ 186,601**
Cumulative Results of Operations:				
Beginning Balances	$ 257,676	$ (1,730)	$ -	$ 255,946
Budgetary Financing Sources:				
Other Adjustments (+/-)	(3)	(5)	-	(8)
Appropriations Used	336,677	533,802	-	870,479
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	264,566	-	-	264,566
Nonexchange Revenue - Investment Revenue	9,746	27	-	9,773
Nonexchange Revenue - Other	4,946	-	-	4,946
Donations and Forfeitures of Cash and Cash Equivalents	75	-	-	75
Transfers-in/out without Reimbursement (+/-)	(5,203)	2,551	-	(2,652)
Other (+/-)	-	1	-	1
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	5	-	5
Transfers-in/out Without Reimbursement (+/-)	(2)	3	-	1
Imputed Financing	64	1,001	(323)	742
Other (+/-)	(8)	(1)	-	(9)
Total Financing Sources	610,858	537,384	(323)	1,147,919
Net Cost of Operations (+/-)	605,562	538,032	(323)	1,143,271
Net Change	5,296	(648)	-	4,648
Cumulative Results of Operations:	**$ 262,972**	**$ (2,378)**	**$ -**	**$ 260,594**
Net Position	**$ 285,906**	**$ 161,289**	**$**	**$ 447,195**

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

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources

For the Years Ended September 30, 2019 and 2018
(in Millions)

	2019	2018
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 120,849	$ 97,593
Appropriations (Discretionary and Mandatory)	1,777,690	1,646,670
Borrowing Authority (Discretionary and Mandatory)	5	(127)
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	25,621	13,644
Total Budgetary Resources (Note 21)	**$ 1,924,165**	**$ 1,757,780**
Status of Budgetary Resources		
New Obligations and Upward Adjustments (Note 21)	$ 1,814,780	$ 1,680,053
Unobligated Balance, End of Year:		
Apportioned, Unexpired Accounts	50,356	43,508
Exempt from Apportionment, Unexpired Accounts	172	188
Unapportioned, Unexpired Accounts	30,976	9,970
Unexpired Unobligated Balance, End of Year	81,504	53,666
Expired Unobligated Balance, End of Year	27,881	24,061
Unobligated Balance, End of Year	109,385	77,727
Total Budgetary Resources (Note 21)	**$ 1,924,165**	**$ 1,757,780**
Outlays, Net		
Outlays, Net (Discretionary and Mandatory) (Note 20)	1,706,314	1,589,140
Distributed Offsetting Receipts (Note 20)	(492,692)	(468,877)
Agency Outlays, Net (Discretionary and Mandatory) (Note 20)	**$ 1,213,622**	**$ 1,120,263**

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

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

75-Year Projection as of January 1, 2019 and Prior Base Years

(in Billions)

		Estimates from Prior Years			
	2019	2018	2017	2016	2015
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 11,995	$ 11,323	$ 10,679	$ 10,294	$ 9,134
SMI Part B	27,556	24,143	21,641	19,386	17,027
SMI Part D	7,181	7,176	6,929	7,659	6,424
Have attained eligibility age (age 65 or over)					
HI	559	525	492	455	382
SMI Part B	5,232	4,725	4,122	3,660	3,300
SMI Part D	1,052	1,015	958	952	887
Those expected to become participants					
HI	11,805	10,959	10,567	9,952	8,386
SMI Part B	6,864	5,586	5,019	4,437	3,668
SMI Part D	3,000	2,932	2,869	3,602	2,845
All current and future participants					
HI	24,359	22,807	21,738	20,701	17,902
SMI Part B	39,652	34,453	30,783	27,484	23,995
SMI Part D	11,232	11,124	10,756	12,213	10,156
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 20,028	$ 18,604	$ 17,193	$ 16,800	$ 14,494
SMI Part B	27,270	23,832	21,392	19,178	16,81
SMI Part D	7,181	7,176	6,929	7,659	6,424
Have attained eligibility age (age 65 and over)					
HI	5,348	5,027	4,539	4,285	3,803
SMI Part B	5,741	5,180	4,531	4,026	3,637
SMI Part D	1,052	1,015	958	952	887
Those expected to become participants					
HI	4,467	3,884	3,539	3,437	2,791
SMI Part B	6,641	5,442	4,860	4,281	3,540
SMI Part D	3,000	2,932	2,869	3,602	2,845
All current and future participants:					
HI	29,843	27,515	25,270	24,523	21,089
SMI Part B	39,652	34,453	30,783	27,484	23,995
SMI Part D	11,232	11,124	10,756	12,213	10,156
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 23 and 24)					
HI	$ (5,484)	$ (4,708)	$ (3,532)	$ (3,822)	$ (3,187)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 23 and 24)					
HI	$ (5,484)	$ (4,708)	$ (3,532)	$ (3,822)	$ (3,187)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	200	202	199	194	197
SMI Part B	96	80	88	68	68
SMI Part D	8	8	8	1	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 23 and 24)					
HI	$ (5,283)	$ (4,506)	$ (3,333)	$ (3,628)	$ (2,990)
SMI Part B	96	80	88	68	68
SMI Part D	8	8	8	1	1

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

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

75-Year Projection as of January 1, 2019 and Prior Base Years

(in Billions)

		Estimates from Prior Years			
	2019	2018	2017	2016	2015
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 6,843	$ 6,266	$ 5,572	$ 5,067	$ 4,569
Expenditures	12,140	11,222	10,027	9,263	8,328
Income less expenditures	(5,297)	(4,957)	(4,455)	(4,196)	(3,759)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	46,731	42,643	39,250	37,339	32,585
Expenditures	54,479	49,612	45,514	43,637	37,736
Income less expenditures	(7,748)	(6,970)	(6,264)	(6,298)	(5,151)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,045)	(11,926)	(10,719)	(10,493)	(8,909)
Combined Medicare Trust Fund assets at start of period	305	290	295	263	266
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(12,740)	(11,637)	(10,425)	(10,230)	(8,643)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	21,669	19,477	18,456	17,992	14,898
Expenditures	14,108	12,258	11,268	11,320	9,176
Income less expenditures	7,561	7,219	7,187	6,672	5,722
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,484)	(4,708)	(3,532)	(3,822)	(3,187)
Combined Medicare Trust Fund assets at start of period	305	290	295	263	266
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (5,179)	$ (4,418)	$ (3,237)	$ (3,559)	$ (2,921)

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

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

January 1, 2018 to January 1, 2019

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	
Total Medicare (Note 25)					
As of January 1, 2018	$ 68,385	$ 73,092	$ (4,708)	$ 290	$ (4,418)
Reasons for change					
Change in the valuation period	2,427	2,628	(201)	7	(193)
Change in projection base	251	451	(200)	8	(193)
Changes in the demographic assumptions	(852)	(879)	27	-	27
Changes in economic and health care assumptions	5,032	5,435	(402)	-	(402)
Changes in law	-	-	-	-	-
Net changes	6,858	7,634	(776)	15	(761)
As of January 1, 2019	$ 75,243	$ 80,727	$ (5,484)	$ 305	$ (5,179)
HI - Part A (Note 25)					
As of January 1, 2018	$ 22,807	$ 27,515	$ (4,708)	$ 202	$ (4,506)
Reasons for change					
Change in the valuation period	748	949	(201)	(5)	(206)
Change in projection base	(100)	100	(200)	4	(197)
Changes in the demographic assumptions	(243)	(270)	27	-	27
Changes in economic and health care assumptions	1,146	1,548	(402)	-	(402)
Changes in law	-	-	-	-	-
Net changes	1,552	2,328	(776)	(2)	(778)
As of January 1, 2019	$ 24,359	$ 29,843	$ (5,484)	$ 200	$ (5,283)
SMI - Part B (Note 25)					
As of January 1, 2018	$ 34,453	$ 34,453	$ -	$ 80	$ 80
Reasons for change					
Change in the valuation period	1,232	1,232	-	13	13
Change in projection base	70	70	-	3	3
Changes in the demographic assumptions	(507)	(507)	-	-	-
Changes in economic and health care assumptions	4,404	4,404	-	-	-
Changes in law	-	-	-	-	-
Net changes	5,199	5,199	-	16	16
As of January 1, 2019	$ 39,652	$ 39,652	$ -	$ 96	$ 96
SMI - Part D (Note 25)					
As of January 1, 2018	$ 11,124	$ 11,124	$ -	$ 8	$ 8
Reasons for change					
Change in the valuation period	447	447	-	(1)	(1)
Change in projection base	281	281	-	1	1
Changes in the demographic assumptions	(103)	(103)	-	-	-
Changes in economic and health care assumptions	(517)	(517)	-	-	-
Changes in law	-	-	-	-	-
Net changes	108	108	-	-	-
As of January 1, 2019	$ 11,232	$ 11,232	$ -	$ 8	$ 8

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

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

January 1, 2017 to January 1, 2018

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	
Total Medicare (Note 25)					
As of January 1, 2017	$ 63,277	$ 66,809	$ (3,532)	$ 295	$ (3,237)
Reasons for change					
Change in the valuation period	2,355	2,523	(168)	-	(168)
Change in projection base	(502)	419	(921)	(5)	(926)
Changes in the demographic assumptions	(551)	(985)	434	-	434
Changes in economic and health care assumptions	3,176	3,162	14	-	14
Changes in law	629	1,165	(535)	-	(535)
Net changes	5,107	6,283	(1,176)	(5)	(1,181)
As of January 1, 2018	$ 68,385	$ 73,092	$ (4,708)	$ 290	$ (4,418)
HI - Part A (Note 25)					
As of January 1, 2017	$ 21,738	$ 25,270	$ (3,532)	$ 199	$ (3,333)
Reasons for change					
Change in the valuation period	747	915	(168)	11	(157)
Change in projection base	(612)	309	(921)	(8)	(929)
Changes in the demographic assumptions	(214)	(648)	434	-	434
Changes in economic and health care assumptions	1,223	1,208	14	-	14
Changes in law	(74)	461	(535)	-	(535)
Net changes	1,069	2,245	(1,176)	3	(1,173)
As of January 1, 2018	$ 22,807	$ 27,515	$ (4,708)	$ 202	$ (4,506)
SMI - Part B (Note 25)					
As of January 1, 2017	$ 30,783	$ 30,783	$ -	$ 88	$ 88
Reasons for change					
Change in the valuation period	1,154	1,154	-	(10)	(10)
Change in projection base	197	197	-	2	2
Changes in the demographic assumptions	(358)	(358)	-	-	-
Changes in economic and health care assumptions	2,087	2,087	-	-	-
Changes in law	591	591	-	-	-
Net changes	3,670	3,670	-	(8)	(8)
As of January 1, 2018	$ 34,453	$ 34,453	$ -	$ 80	$ 80
SMI - Part D (Note 25)					
As of January 1, 2017	$ 10,756	$ 10,756	$ -	$ 8	$ 8
Reasons for change					
Change in the valuation period	455	455	-	(1)	(1)
Change in projection base	(87)	(87)	-	1	1
Changes in the demographic assumptions	21	21	-	-	-
Changes in economic and health care assumptions	(133)	(133)	-	-	-
Changes in law	113	113	-	-	-
Net changes	368	368	-	-	-
As of January 1, 2018	$ 11,124	$ 11,124	$ -	$ 8	$ 8

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

Notes to the Principal Financial Statements

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

HHS is a Cabinet-level agency within the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law. The law established a new federal entity, the Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The accompanying financial statements include activities and operations of the United States (U.S.) Department of Health and Human Services (HHS or the Department). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, HHS has included all consolidation entities for which it is accountable in this general purpose federal financial report. The Office of the Secretary (OS) and 11 Operating Divisions (OpDivs) listed below and all of their federal funding are consolidated into the HHS financial statements. HHS conducted a systematic and thorough review of all organizations and found two Federally Funded Research and Development Centers (FFRDC) that are contract based. The Department analyzed its existing relationship with the FFRDCs and determined they do not require a separate disclosure, as they are immaterial and part of the Department's consolidated financial statements.

Organization and Structure of HHS

Each HHS OpDiv is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Responsibility segment management report directly to the Department's top management, and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

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

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

B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officers Act of 1990* (CFO Act), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These financial statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the U.S. The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as federal GAAP. Therefore, these statements are different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when resources are consumed without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to 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 214 appropriation fund accounts. The fund accounts include accounts used for suspense, collection of receipts, and general government functions. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets, Statements of Net Cost, and Statement of Changes in Net Position. The Statement of Budgetary Resources is represented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from that statement. Supplemental information is accumulated from the OpDivs, regulatory reports, and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

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

C. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

D. *Patient Protection and Affordable Care Act*

In FY 2010, President Barack Obama signed the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act*, collectively referred to as the PPACA. Further information is available at Healthcare.gov.

The PPACA contains the most significant changes to health care coverage since the *Social Security Act*. The PPACA provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). One of the main programs under CCIIO is the Health Insurance Exchanges (the "Exchanges"). A brief description of the remaining programs is presented below. There were two additional programs - Transitional Reinsurance and Risk Corridors – that are no longer in operation.

Health Insurance Exchanges

Grants have been provided to the states to establish Health Insurance Exchanges. The initial grants were made by HHS to the states "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Exchanges were launched on October 1, 2013.

Risk Adjustment Program

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

E. Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS has allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

HHS received an exception to the parent/child reporting requirements of OMB Circular A−136, as it pertains to the allocation transfer from the Department of Homeland Security to HHS for the Biodefense Countermeasures Fund for Fiscal Year (FY) 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

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

HHS also receives allocation transfers, as the child, from the Departments of Agriculture, Justice, and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Treasury, and Social Security Administration (SSA).

F. Changes, Reclassifications and Adjustments

Certain FY 2018 balances have been reclassified to conform to FY 2019 financial statement presentations. The effects are immaterial.

G. Funds from Dedicated Collections

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

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

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

Medicare Hospital Insurance Trust Fund – Part A

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

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contribution Act* (FICA) and the *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports.

Medicare Supplementary Medical Insurance Trust Fund – Part B

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

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

Medicare Supplementary Medical Insurance Trust Fund – Part D

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

The PPACA provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs by 7 percentage points per year until coinsurance is 25 percent by 2019. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

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

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

H. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriations and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred, or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one fiscal year. Funds for long-term projects such as major construction will be available for the expected life of the project, and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended; the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

Exchange Revenue

Exchange revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

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

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting Reporting System. Regardless if they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General Fund or HHS designated Special Funds. Amounts not retained for use by HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

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

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

Imputed Financing Sources

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management (OPM) and certain legal judgments against HHS are paid from the Judgment Fund maintained by Bureau of Fiscal Service (Fiscal Service), Treasury. When costs are identifiable to HHS, directly attributable to HHS's operations, and paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statements of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

I. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

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

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies including SSA and Treasury. SSA determines eligibility for Medicare programs and also deducts Medicare Part B premiums from Social Security benefit payments for beneficiaries who elect to enroll in the Medicare Part B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part B trust fund. Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part D is primarily financed by the General Fund as well as beneficiary premiums and payments from states.

J. Entity and Non-Entity Assets

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet entity obligations.

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

K. Fund Balance with Treasury (FBwT)

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

L. Custodial Activity

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

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

M. Investments, Net

HHS invests entity Medicare trust fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that funds in the HI and SMI trust funds not needed to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Fiscal Service to the HI and SMI trust funds as evidence of their receipt and are reported as an asset of the trust funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI trust funds.

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

The Treasury securities issued and redeemed to the HI and SMI trust funds are Non-marketable (Par Value) securities. These investments are carried at face value as determined by the Fiscal Service. Interest income is compounded semi-annually (i.e., June and December) by the Fiscal Service; and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30 (See Note 4).

The Vaccine Injury Compensation trust fund, a dedicated collections fund similar to the HI and SMI trust funds, invests in Non-Marketable, Market-Based securities issued by the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

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

The *Children's Health Insurance Program Reauthorization Act of 2009* established a Child Enrollment Contingency Fund to cover shortfalls in funding for the States. This fund is invested in interest-bearing Treasury securities.

N. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible accounts on public receivables. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for

reimbursable work. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible. Accounts Receivable, Net from the public are primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties, criminal restitution, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, and Medicare Secondary Payer accounts receivable.

Accounts Receivable, Net from the public is net of an allowance for uncollectible accounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past 5 years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable have been recorded to account for amounts due related to collections for Exchange activities.

O. Advances and Accrued Grant Liability

HHS awards grants and provides advance payments to meet grantees' cash needs in carrying out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability is shown on the Consolidated Balance Sheets when the accrued grant expenses exceed the outstanding advances to grantees.

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

All other grants are funded when the grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses and their advance balances are reduced. At year-end, the OpDivs report both actual payments made through the fourth quarter and an amount accrued for unreported grant expenditures estimated for the fourth quarter based on the grantees' historical spending patterns.

P. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of inventory held for sale and use, operating materials and supplies, and stockpile materials held for emergency and contingency.

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

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

Stockpile Materials are held in reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS) and Vaccines for

Children (VFC). The stockpile contains several million doses of vaccine in bulk, which are stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC.

Q. General Property, Plant and Equipment, Net

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

The cost of General Property, Plant and Equipment acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of General Property, Plant and Equipment transferred from other federal entities is the transferring entity's net book value. Except for internal use software, HHS capitalizes all General Property, Plant and Equipment with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or more.

HHS has commitments under various operating leases with private entities as well as the General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining noncancelable lease terms from 1 to 50 years; however, some GSA leases are cancelable with 120 days' notice. Under an operating lease, the cost of the lease is expensed as incurred.

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

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

R. Stewardship Land

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

HHS asset accountability reports differentiate Indian Trust land parcels from General Property, Plant and Equipment situated thereon.

S. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI trust fund, since liabilities are only those items that are present obligations of the government. HHS's liabilities are classified as covered by budgetary resources, not covered by budgetary resources, or not requiring budgetary resources.

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for disability payments. The actuarial *Federal Employee Compensation Act* (FECA) liability determined by the DOL but not yet billed is also included in this category.

Liabilities Not Requiring Budgetary Resources

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

T. 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.

U. Accrued Payroll and Benefits

Accrued Payroll and Benefits consist of salaries, wages, leave, and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability, since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consist primarily of HHS's current FECA liability to DOL.

V. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims incurred but not reported (IBNR) as of the end of the reporting period.

Medicare

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

have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year and (e) an estimate of retroactive settlements of cost reports. The September 30, 2019 and 2018 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2019. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2019.

Medicaid and CHIP

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

Other

The Other liability line item includes estimates of payments due to those participating in Exchange activities.

W. Federal Employee and Veterans' Benefits

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active duty officers, retiree annuitants, and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits on the Consolidated Balance Sheets. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statements of Net Cost.

The liability for Federal Employee and Veterans' Benefits also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by DOL, which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has 3 parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes 1 percent of each employee's pay to the Thrift Savings Plan and matches the first 3 percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

OPM is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to federal employees. Therefore, HHS does not recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, or other post-

employment benefits of its federal employees with the exception of the PHS Commissioned Corps. However, HHS does recognize an expense in the Consolidated Statements of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

X. Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

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

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

Y. Statement of Social Insurance (unaudited)

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

Actuarial present values are computed under the intermediate set of assumptions specified in the 2019 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies

in effect on April 22, 2019, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs, required by the Affordable Care Act, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

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

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

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

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on April 22, 2019, except that the projections disregard payment

reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, 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.

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

	2019	2018
Non-Entity Intragovernmental Assets	$ 1	$ -
Non-Entity With the Public Assets	46	45
Total Non-Entity Assets	47	45
Total Entity Assets	650,681	604,482
Total Assets	**$ 650,728**	**$ 604,527**

Note 3. Fund Balance with Treasury (in Millions)

	2019	2018
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 50,528	$ 43,696
Unavailable	58,857	34,031
Obligated Balance not yet Disbursed	258,872	237,535
Non-Budgetary Fund Balance with Treasury	(72,000)	(65,099)
Total Fund Balance with Treasury	**$ 296,257**	**$ 250,163**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $16.6 billion as of September 30, 2019 ($14.7 billion in FY 2018). The restricted amount is primarily for PPACA, CHIP, CMS Program Management, and State Grants and Demonstrations.

Note 4. Investments, Net (in Millions)

2019	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 303,341	$ -	$ 2,037	$ 305,378	$ 305,378
Non-Marketable: Market-Based	3,968	(7)	10	3,971	3,971
Total, Intragovernmental	**$ 307,309**	**$ (7)**	**$ 2,047**	**$ 309,349**	**$ 309,349**

2018	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 301,003	$ -	$ 2,249	$ 303,252	$ 303,252
Non-Marketable: Market-Based	3,827	20	16	3,863	3,863
Total, Intragovernmental	**$ 304,830**	**$ 20**	**$ 2,265**	**$ 307,115**	**$ 307,115**

HHS investments consist primarily of Medicare Trust Fund investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2020 through June 30, 2034, with interest rates ranging from 1.875 percent to 5.125 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2020, with interest rates ranging from 1.625 percent to 2.125 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2019 through FY 2024. The Market-Based Notes paid from 1.0 percent to 2.375 percent during October 1, 2018 to September 30, 2019, and 1.0 percent to 2.0 percent during October 1, 2017 to September 30, 2018. The Market-Based Bonds pay 6.875 percent through FY 2025.

The Market-Based Securities held in the NIH gift funds during 12 months of FY 2019, yielded from 1.9439 percent to 2.5115 percent depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

2019	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 812	$ -	$ 812	$ -	$ 812
Total, Intragovernmental	**$ 812**	**$**	**$ 812**	**$**	**$ 812**
With the Public					
Entity					
Medicare	$ 18,515	$ -	$ 18,515	$ (3,507)	$ 15,008
Medicaid	4,943	-	4,943	(785)	4,158
Other	5,576	325	5,901	(957)	4,944
Non-Entity	18	72	90	(44)	46
Total with the Public	**$ 29,052**	**$ 397**	**$ 29,449**	**$ (5,293)**	**$ 24,156**

2018	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 1,129	$ -	$ 1,129	$ -	$ 1,129
Total, Intragovernmental	**$ 1,129**	**$**	**$ 1,129**	**$**	**$ 1,129**
With the Public					
Entity					
Medicare	$ 21,039	$ -	$ 21,039	$ (3,286)	$ 17,753
Medicaid	5,101	-	5,101	(957)	4,144
Other	5,379	305	5,684	(824)	4,860
Non-Entity	12	65	77	(32)	45
Total with the Public	**$ 31,531**	**$ 370**	**$ 31,901**	**$ (5,099)**	**$ 26,802**

As of September 30, 2019, the other accounts receivable with the public is primarily related to collections for Exchange activities and restitution. For FY 2019, restitution gross balances are approximately $2.2 billion with a net balance of $67 million ($2.0 billion with a net balance of $65 million in FY 2018).

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

	2019	2018
Inventory Held for Sale or Use	$ 91	$ 48
Stockpile Materials Held for Emergency or Contingency	10,690	9,767
Inventory and Related Property, Net	**$ 10,781**	**$ 9,815**

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

			2019		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 54	$ -	$ 54
Construction in Progress	-	-	969	-	969
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,232	(3,415)	2,817
Equipment	Straight-Line	3-20 Yrs	2,259	(1,288)	971
Internal Use Software	Straight-Line	5-10 Yrs	3,965	(2,288)	1,677
Assets Under Capital Lease	Straight-Line	1-30 Yrs	119	(75)	44
Leasehold Improvements	Straight-Line	*Life of Lease	60	(48)	12
Totals			**$ 13,658**	**$ (7,114)**	**$ 6,544**

			2018		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	-	-	$ 54	$ -	$ 54
Construction in Progress	-	-	771	-	771
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,191	(3,247)	2,944
Equipment	Straight-Line	3-20 Yrs	2,146	(1,258)	888
Internal Use Software	Straight-Line	5-10 Yrs	3,439	(1,805)	1,634
Assets Under Capital Lease	Straight-Line	1-30 Yrs	119	(71)	48
Leasehold Improvements	Straight-Line	*Life of Lease	56	(45)	11
Totals			**$ 12,776**	**$ (6,426)**	**$ 6,350**

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

Note 8. Advances (in Millions)

	2019	2018
Intragovernmental		
Advances to Other Federal Entities	$ 180	$ 255
Total Intragovernmental	**$ 180**	**$ 255**
With the Public		
Grant Advances	2,395	2,644
Other	57	50
Total with the Public	**$ 2,452**	**$ 2,694**

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

	2019	2018
Intragovernmental		
Accrued Payroll and Benefits	$ 53	$ 55
Other	1,533	1,533
Total Intragovernmental	**$ 1,586**	**$ 1,588**
Federal Employee and Veterans' Benefits (Note 11)	14,826	14,386
Accrued Payroll and Benefits	722	681
Contingencies and Commitments (Note 14)	17,083	13,475
Accrued Liabilities	5,057	6,933
Other	229	231
Total Liabilities Not Covered by Budgetary Resources	$ 39,503	$ 37,294
Total Liabilities Covered by Budgetary Resources	127,437	117,991
Total Liabilities Not Requiring Budgetary Resources	2,254	2,047
Total Liabilities	**$ 169,194**	**$ 157,332**

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

	2019	2018
Medicare Fee-For-Service	$ 54,752	$ 51,031
Medicare Advantage/Prescription Drug Program	16,839	11,165
Medicaid	37,147	35,570
CHIP	1,360	1,377
Other	2	5
Totals	**$ 110,100**	**$ 99,148**

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

The Medicare fee-for-service liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (d) periodic interim payments for services rendered in the current fiscal year

but paid in the subsequent fiscal year; and (e) an estimate of retroactive settlements of cost reports. The September 30, 2019 and 2018 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represent amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment-related adjustments including the estimate for the first nine months of the calendar year 2019. In Addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2019.

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

The Other line item includes estimates of payments due to those participating in Exchange activities.

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

	2019	2018
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 13,758	$ 13,338
PHS Commissioned Corp Post-Retirement Health Benefits	792	772
Workers' Compensation Benefits (Actuarial FECA Liability)	276	276
Total, Federal Employee and Veterans Benefits	**$ 14,826**	**$ 14,386**

Public Health Service (PHS) Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 6,219 active duty officers and 7,244 retiree annuitants and survivors. As of September 30, 2019, the actuarial accrued liability for the retirement benefit plan was $13.8 billion and $0.8 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commissioned Corps Retirement System and the Post-Retirement Medical Plan are not funded. Therefore, in accordance with SFFAS 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*, the discount rate should be based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flow, as long as the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2019, and September 30, 2018, were:

	2019	2018
Discount rate	3.76 percent	3.92 percent
Annual basic pay scale increase	2.31 percent	2.62 percent
Annual inflation	2.01 percent	2.12 percent

	2019	2018
Beginning Liability Balance	$ 14,110	$ 13,253
Expense		
Normal Cost	397	380
Interest on the liability balance	542	526
Actuarial (Gain)/Loss		
From experience	77	57
From assumption changes		
Change in discount rate assumption	307	236
Change in inflation/salary increase assumption	(213)	109
Change from Experience Study	(105)	-
Change in mortality rate/others	(16)	71
Total From assumption changes	$ (27)	$ 416
Net Actuarial (Gain)/Loss	50	473
Total expense	989	1,379
Less amounts paid	(549)	(522)
Ending Liability Balance	**$ 14,550**	**$ 14,110**

The above shows key valuation results as of September 30, 2019, and 2018, in conformance with the actuarial reporting standards set forth in the SFFAS 5, *Accounting for Liabilities of the Federal Government* and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of June 30, 2019, and actuarial assumptions. The September 30, 2019, valuation includes an increase in liabilities of $440 million resulting from changes in the assumed annual inflation rate, the assumed salary scale, and in the assumed discount rate. These changes in combination with the actual plan experience over the past year (based upon new census data) and changes in other actuarial assumptions since the prior valuation, resulted in an overall net increase in the actuarial accrued liability as compared to the prior valuation. The annual expense for the Retirement Benefit Plan for FY 2019 has decreased relative to the prior year expense.

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. For FYs 2019 and 2018, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues (the TNC Yield Curve) for the current and prior 4 years. Interest rate assumptions utilized for discounting as of September 30, 2019, and September 30, 2018, as follows.

	2019	2018
Wage Benefits	2.610% in Year 1 and years thereafter	2.716% in Year 1 and years thereafter
Medical Benefits	2.350% in Year 1 and years thereafter	2.379% in Year 1 and years thereafter

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

FY	COLA	CPIM
2019	N/A	N/A
2020	1.47%	2.86%
2021	1.85%	3.05%
2022	2.12%	3.09%
2023	2.17%	3.47%
2024	2.21%	3.88%

Note 12. Accrued Liabilities (in Millions)

	2019	2018
Grant Liability	$ 7,582	$ 7,588
Other Accrued Liabilities	7,961	6,933
Accrued Liabilities	**$ 15,543**	**$ 14,521**

Note 13. Other Liabilities (in Millions)

	2019		2018	
	Intragovernmental	With the Public	Intragovernmental	With the Public
Accrued Payroll & Benefits	$ 151	$ 1,197	$ 141	$ 1,108
Advances from Others	520	842	899	888
Deferred Revenue	-	1,250	-	1,066
Custodial Liabilities	332	8	342	8
Legal Liabilities	1,172	-	1,155	-
Other	3,398	398	5,543	2,666
Total Other Liabilities	**$ 5,573**	**$ 3,695**	**$ 8,080**	**$ 5,736**

The *Bipartisan Budget Act of 2015* (Section 601) authorized a transfer from the General Fund to SMI, to temporarily replace the reduction in Medicare Part B premiums. Section 601 created an "additional premium" charged alongside the normal Medicare Part B monthly premiums, for calendar years 2016 and 2017, which will be used to pay back the General Fund transfer without interest. These repayments are transferred quarterly. As of September 30, 2019, $3.2 billion ($5.0 billion in FY 2018) is still owed and is reported as Other. Legal Liabilities of $1.2 billion as of September 30, 2019 ($1.2 billion as of September 30, 2018) consist of reimbursable claims due to the Judgment Fund, which is administered by Fiscal Service.

Note 14. Contingencies and Commitments (in Millions)

HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated.

Medicaid Audit and Program Disallowances

The Medicaid amount of $9.9 billion ($6.3 billion in FY 2018) consists of Medicaid audit and program disallowances and 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. The funds could have been returned or HHS can decrease the state's authority. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v Ramah Navajo Chapter*, dated June 18, 2012, and subsequent cases related to contract support costs have resulted in increased claims against IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. The estimated amount recorded for contract support costs is $5.2 billion in FY 2019 ($4.8 billion in FY 2018).

Other contingent liabilities against HRSA have been accrued in the financial statements for the Vaccine Injury Compensation program and other Health Center claims.

Note 15. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, cooperative research and development agreement funds, and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for 5 subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Combined Statement of Budgetary Resources; therefore, it is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and become available for obligation, as needed. The entire trust fund balances in the amount of $223.6 billion, as of September 30, 2019, ($230.9 billion as of September 30, 2018), are included in Investments on the Consolidated Balance Sheets.

Note 16. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

	2018			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (total) (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 1,757,780	$ 1,680,053	$ 468,877	$ 1,589,140
Expired Accounts	(25,399)	-	-	-
Other	235	(31)	134	7
Budget of the U.S. Government	**$ 1,732,616**	**$ 1,680,022**	**$ 469,011**	**$ 1,589,147**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2019, has not been published, therefore, no comparisons can be made between FY 2019 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2021 President's Budget* is expected to be released in February 2020 and may be obtained from OMB or from Government Printing Office.

HHS reconciled the amounts of the FY 2018 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2018 from the Appendix in the *FY 2020 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays (i.e., gross outlays less offsetting collections), as presented above.

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

The Other differences in the budgetary resources are mainly due to adjustments made to recoveries of prior year obligations.

Note 17. Undelivered Orders (in Millions)

	2019			2018		
	Federal	Non Federal	Total	Federal	Non Federal	Total
Undelivered Orders, Paid	$ 323	$ 2,527	$ 2,850	$ 249	$ 2,873	$ 3,122
Undelivered Orders, Unpaid	7,052	131,458	138,510	6,474	122,662	129,136
Total Undelivered Orders	**$ 7,375**	**$ 133,985**	**$ 141,360**	**$ 6,723**	**$ 125,535**	**$ 132,258**

Undelivered Orders include obligations that have been issued but not yet drawn down, as well as goods and services ordered that have not been received. HHS reported $141.4 billion of budgetary resources obligated for undelivered orders as of September 30, 2019 ($132.3 billion as of September 30, 2018).

Note 18. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the table below. The Medicare program includes the HI Trust Fund; the SMI Trust Fund which includes both Part B medical insurance, and the Medicare Prescription Drug Benefit – Part D; and the Medicare and Medicaid Integrity Programs. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. See Note 1 for a description of each major fund's purpose and how HHS accounts for and reports the funds.

2019 Balance Sheet as of September 30	Medicare	Other	Eliminations	Total
Fund Balance with Treasury	$ 63,442	$ 11,155	$ -	$ 74,597
Investments	305,378	3,971	-	309,349
Other Assets	93,327	13,880	(86,036)	21,171
Total Assets	**$ 462,147**	**$ 29,006**	**$ (86,036)**	**$ 405,117**
Entitlement Benefits Due and Payable	$ 71,591	$ 3	$ -	$ 71,594
Other Liabilities	92,676	10,523	(86,036)	17,163
Total Liabilities	**$ 164,267**	**$ 10,526**	**$ (86,036)**	**$ 88,757**
Unexpended Appropriations	$ 57,895	$ 73	$ -	$ 57,968
Cumulative Results of Operations	239,985	18,407	-	258,392
Total Liabilities and Net Position	**$ 462,147**	**$ 29,006**	**$ (86,036)**	**$ 405,117**
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 759,898	$ 15,304	$ (308)	$ 774,894
Less: Exchange Revenues	106,755	11,020	(294)	117,481
Net Cost of Operations	**$ 653,143**	**$ 4,284**	**$ (14)**	**$ 657,413**
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 275,348	$ 10,558	$ -	$ 285,906
Nonexchange Revenue	294,129	364	-	294,493
Other Financing Sources	381,546	11,842	(14)	393,374
Net Cost of Operations	(653,143)	(4,284)	14	(657,413)
Change in Net Position	$ 22,532	$ 7,922	$ -	$ 30,454
Net Position End of Period	**$ 297,880**	**$ 18,480**	**$**	**$ 316,360**

2018 Balance Sheet as of September 30	Medicare	Other	Eliminations	Total
Fund Balance with Treasury	$ 27,389	$ 11,152	$ -	$ 38,541
Investments	303,253	3,862	-	307,115
Other Assets	90,933	6,908	(74,037)	23,804
Total Assets	**$ 421,575**	**$ 21,922**	**$ (74,037)**	**$ 369,460**
Entitlement Benefits Due and Payable	$ 62,196	$ 3	$ -	$ 62,199
Other Liabilities	84,031	11,361	(74,037)	21,355
Total Liabilities	**$ 146,227**	**$ 11,364**	**$ (74,037)**	**$ 83,554**
Unexpended Appropriations	$ 22,855	$ 79	$ -	$ 22,934
Cumulative Results of Operations	252,493	10,479	-	262,972
Total Liabilities and Net Position	**$ 421,575**	**$ 21,922**	**$ (74,037)**	**$ 369,460**
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 717,153	$ (2,586)	$ (142)	$ 714,425
Less: Exchange Revenues	100,322	8,683	(131)	108,874
Net Cost of Operations	**$ 616,831**	**$ (11,269)**	**$ (11)**	**$ 605,551**
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 276,993	$ (2,033)	$ -	$ 274,960
Nonexchange Revenue	278,884	374	-	279,258
Other Financing Sources	336,302	948	(11)	337,239
Net Cost of Operations	(616,831)	11,269	11	(605,551)
Change in Net Position	$ (1,645)	$ 12,591	$ -	$ 10,946
Net Position End of Period	**$ 275,348**	**$ 10,558**	**$**	**$ 285,906**

Note 19. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides health care to approximately 2.6 million American Indians and Alaska Natives who belong to 573 federally recognized tribes in 37 states. Health services are provided on tribal/reservation trust land that was transferred to IHS by the DOI for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

The table below presents stewardship land held by HHS:

Indian Trust Land by Locations and Number of Sites

IHS Area	2019	2018
Albuquerque	4	4
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	36
Oklahoma City	1	1
Phoenix	10	10
Portland	3	3
Tucson	5	5
Total	**77**	**77**

Note 20. Budget and Accrual Reconciliation (in Millions)

2019	Intragovernmental	With the Public	Total
Net Cost of Operations	**$ 3,599**	**$ 1,219,250**	**$ 1,222,849**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation	-	(809)	(809)
Property, Plant, and Equipment Disposal & Reevaluation			
Other	-	580	580
	-	**(231)**	**(231)**
Increase/(Decrease) in Assets:			
Accounts Receivables	(339)	(2,652)	(2,991)
Investment	17	-	17
Other Asset – Regulatory Assets	(76)	(249)	(325)
	(398)	**(2,901)**	**(3,299)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	301	(11,168)	(10,867)
Salaries and Benefits	(12)	(47)	(59)
Environmental and Disposal Liabilities	-	3	3
Other Liabilities (Unfunded leave, Unfunded FECA, Actuarial FECA)	(39)	(3,007)	(3,046)
	250	**(14,219)**	**(13,969)**
Other Financing Sources:			
Federal Employee Retirement Benefit Costs Paid by OPM and Imputed to the Agency	(548)	-	(548)
Transfers out (in) Without Reimbursement	2,802	-	2,802
	2,254	**-**	**2,254**
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	7	407	414
Acquisition of Inventory	1	1,001	1,002
Acquisition of Other Assets	140	-	140
Other	8	5,346	5,354
	156	**6,754**	**6,910**
Net Outlays	**$ 5,861**	**$ 1,208,653**	**$ 1,214,514**
Federal Share of Child Support Collections and Other[8]			(892)
Net Outlays, Net			**$ 1,213,622**
Related Amounts on Combined Statement of Budgetary Resources			
Outlays, Net			1,706,314
Distributed Offsetting Receipts			(492,692)
Agency Outlays, Net			**$ 1,213,622**

[8] This amount is included in the HHS SBR, Distributed Offsetting Receipts but does not have an impact on Net Cost.

2018	Intragovernmental	With the Public	Total
Net Cost of Operations	**$ 3,897**	**$ 1,139,374**	**$ 1,143,271**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation	-	(751)	(751)
Property, Plant, and Equipment Disposal & Reevaluation	-	(2)	(2)
Other	-	(16)	(16)
	-	**(769)**	**(769)**
Increase/(Decrease) in Assets:			
Accounts Receivables	141	(6,282)	(6,141)
Investment	44	-	44
Other Asset – Regulatory Assets	24	(28,420)	(28,396)
	209	**(34,702)**	**(34,493)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	(194)	8,805	8,611
Salaries and Benefits	(4)	(103)	(107)
Environmental and Disposal Liabilities	-	(11)	(11)
Other Liabilities (Unfunded leave, Unfunded FECA, Actuarial FECA)	(766)	(2,942)	(3,708)
	(964)	**5,749**	**4,785**
Other Financing Sources:			
Federal Employee Retirement Benefit Costs Paid by OPM and Imputed to the Agency	(742)	-	(742)
Transfers out (in) Without Reimbursement	3,289	-	3,289
	2,547	**-**	**2,547**
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	10	246	256
Acquisition of Inventory	1	740	741
Other	189	4,351	4,540
	200	**5,337**	**5,537**
Net Outlays	**$ 5,889**	**$ 1,114,989**	**$ 1,120,878**
Federal Share of Child Support Collections and Other[9]			(615)
Net Outlays, Net			**$ 1,120,263**
Related Amounts on Combined Statement of Budgetary Resources			
Outlays, Net			1,589,140
Distributed Offsetting Receipts			(468,877)
Agency Outlays, Net			**$ 1,120,263**

[9] This amount is included in the HHS SBR, Distributed Offsetting Receipts but does not have an impact on Net Cost.

Note 21. Combined Schedule of Spending (in Millions)

The Combined Schedule of Spending presents an overview of how departments or agencies spend (i.e., obligating) money. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Combined Statement of Budgetary Resources.

Additional efforts to improve the transparency of spending activity in the federal government have recently come to fruition in the implementation of the *Digital Accountability and Transparency Act of 2014* (DATA Act). This legislation makes available to the public, at no cost, a searchable website that provides award and financial information on contracts and financial assistance awards (including grants). While the underlying obligation data used to generate both the Combined Schedule of Spending and the DATA Act submission are the same, there is a fundamentally different purpose behind each, which should be taken into account when comparing the two. The Combined Schedule of Spending presents total budgetary resources, total new obligations, and upward adjustments for the reporting entity. The website displaying the DATA Act submission, USAspending.gov,[10] collects the same data as well as recoveries. Additional differences include the definition of key attributes in each. Programs for the Combined Schedule of Spending are defined by the Treasury Account Symbol, whereas the DATA Act uses the Program and Financing lines from the President's budget. Object Classes are the criteria by which both group spending activity by type. However, the DATA Act requires granular-level object class assignments while the Combined Schedule of Spending groups object classes at a higher level for presentation purposes. Additionally, the DATA Act submission at the award-level data does not include certain obligations, such as personnel compensation, travel, utilities, leases, intra-departmental and interagency spending, and various other categories of financial awards. The Combined Schedule of Spending has no such exclusions and is similar to the program activity reporting file for DATA Act. Lastly, the DATA Act reporting responsibility for award-level activity in allocation accounts is always assigned to the child entity. This is not entirely consistent with allocation account reporting for the financial statements for which either the parent or child will report.

What Money is Available to Spend? This section presents resources that were available to spend, as reported in the Combined Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Combined Statement of Budgetary Resources and represents amounts approved for spending by law. Amount Available but Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the FY. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current FY. Total Amounts Agreed to be Spent represents spending actions taken by HHS – including contracts, purchase orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the New Obligations and Upward Adjustments line in the Combined Statement of Budgetary Resources.

Who did the Money Go To? This section identifies the recipient of the money by federal and non-federal entities. Amounts in this section reflect amount agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

How was the Money Spent/Issued? This section presents services or items that were purchased, categorized by program with spending greater than $1.0 billion are presented separately. Grants, Subsidies, & Contributions, Insurance Claims and Indemnities, Other Contractual Services and Personnel Compensation & Benefits are the object

[10] The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

classes that have a material impact on HHS reporting. HHS Medicare payments are reported under Insurance Claims and Indemnities based on the OMB A-11 object class definition.

Combined Schedule of Spending

For the Years Ended September 30, 2019 and 2018
(in Millions)

What Money is Available to Spend	2019	2018
Total Resources	$ 1,924,165	$ 1,757,780
Less Amount Available but Not Agreed to be Spent	50,528	43,696
Less Amount Not Available to be Spent	58,857	34,031
Total Amounts Agreed to be Spent	**$ 1,814,780**	**$ 1,680,053**

Who Did the Money Go To	2019	2018
Federal	$ 10,522	$ 9,133
Non-Federal	1,804,258	1,670,920
Total Amounts Agreed to be Spent	**$ 1,814,780**	**$ 1,680,053**

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2019

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 454,050	$ 1	$ 1	$ -	$ -	$ 454,052
Federal Supplementary Medical Insurance Trust Fund	-	366,285	115	1	5,152	371,553
Payments to Trust Funds	272,784	-	-	-	76,403	349,187
Federal Hospital Insurance Trust Fund	-	326,789	12	-	4,686	331,487
Medicare Prescription Drug Account	-	87,548	-	1	654	88,203
Taxation on OASDI Benefits, HI	23,781	-	-	-	-	23,781
State Children's Health Insurance Fund	17,598	-	7	-	-	17,605
Temporary Assistance for Needy Families	16,609	-	93	10	2	16,714
Children and Families Services Programs	12,137	-	355	152	11	12,655
Payments for Foster Care and Permanency	8,886	-	29	1	2	8,918
Risk Adjustment Program Payments	-	7,397	-	-	-	7,397
National Cancer Institute	3,718	-	1,645	569	114	6,046
CMS Program Management	34	-	5,074	679	156	5,943
Indian Health Services	2,570	16	968	1,484	899	5,937
National Institute of Allergy and Infectious Diseases	3,502	-	1,690	355	109	5,656
FDA Salaries and Expenses	303	3	2,277	2,606	460	5,649
Primary Health Care	5,203	-	251	76	9	5,539
Payment to States for the Child Care and Development Block Grant	5,151	-	106	2	1	5,260
Payments to States for Child Support Enforcement and Family Support Programs	4,064	-	543	-	-	4,607
Vaccines for Child Program	102	-	106	19	3,934	4,161
Substance Abuse Treatment	3,735	-	99	8	1	3,843
Low Income Home Energy Assistance	3,653	-	3	-	-	3,656
National Heart Lung and Blood Institute	2,815	-	516	159	33	3,523
Refugee and Entrant Assistance	2,380	-	764	16	11	3,171
National Institute on Aging	2,778	-	260	80	32	3,150
Public Health and Social Services Emergency Fund	299	-	1,202	180	1,347	3,028
Child Care Entitlement to States	2,951	-	31	-	-	2,982
National Institute of General Medical Sciences	2,696	-	104	32	3	2,835
National Institute of Neurological Disorders and Stroke	2,038	-	286	98	31	2,453
Ryan White HIV/AIDS Program	2,216	-	91	29	4	2,340
Aging and Disability Services Programs	2,158	-	49	30	5	2,242
National Institute of Diabetes and Digestive and Kidney Diseases	1,728	-	242	124	29	2,123
NIH Office of the Director	1,487	-	411	133	11	2,042
Health Care Fraud and Abuse Control Program	-	-	1,324	94	612	2,030
NIH Service and Supply Fund	-	-	1,333	291	378	2,002
National Institute of Mental Health	1,509	-	250	107	19	1,885
National Institute on Drug Abuse	1,362	-	272	70	10	1,714
Social Services Block Grant	1,666	-	10	1	-	1,677
Mental Health	1,502	-	77	4	2	1,585
National Institute of Child Health and Human Development	1,082	-	338	105	24	1,549
PSC Service and Supply Fund	-	-	1,247	161	94	1,502
Chronic Disease Prevention and Health Promotion	768	1	292	129	8	1,198
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	744	1	195	180	15	1,135
Health Workforce	1,026	-	74	25	9	1,134
Other Agency Budgetary Accounts	13,076	1,099	8,278	4,460	2,718	29,631
Total Amounts Agreed to be Spent	**$ 884,161**	**$ 789,140**	**$ 31,020**	**$ 12,471**	**$ 97,988**	**$ 1,814,780**

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2018

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 437,108	$ -	$ 101	$ 19	$ 4,164	$ 441,392
Federal Supplementary Medical Insurance Trust Fund	-	322,244	88	1	5,146	327,479
Payments to Trust Funds	251,278	-	-	-	70,309	321,587
Federal Hospital Insurance Trust Fund	-	298,861	10	-	4,056	302,927
Medicare Prescription Drug Account	-	81,100	-	1	426	81,527
Taxation on OASDI Benefits, HI	24,192	-	-	-	-	24,192
State Children's Health Insurance Fund	17,484	-	5	-	-	17,489
Temporary Assistance for Needy Families	16,612	-	90	11	3	16,716
Children and Families Services Programs	11,244	-	384	149	13	11,790
Payments for Foster Care and Permanency	8,185	-	33	-	2	8,220
National Cancer Institute	3,678	-	1,683	555	132	6,048
Indian Health Services	2,571	10	888	1,455	821	5,745
Primary Health Care	5,118	-	240	74	12	5,444
National Institute of Allergy and Infectious Diseases	3,297	-	1,582	344	116	5,339
Payment to States for the Child Care and Development Block Grant	5,128	-	102	2	-	5,232
Payments to States for Child Support Enforcement and Family Support Programs	3,805	-	624	-	-	4,429
Risk Adjustment Program Payments	-	3,865	-	-	11	3,876
Substance Abuse Treatment	3,640	-	112	9	-	3,761
Low Income Home Energy Assistance	3,638	-	3	-	-	3,641
National Heart, Lung, and Blood Institute	2,715	-	508	160	33	3,416
Child Care Entitlement to States	2,955	-	18	-	2	2,975
National Institute of General Medical Sciences	2,653	-	113	30	1	2,797
National Institute on Aging	2,281	-	220	76	22	2,599
Refugee and Entrant Assistance	2,070	-	360	15	6	2,451
Ryan White HIV/AIDS Program	2,240	-	96	26	4	2,366
Public Health and Social Services Emergency Fund	338	-	1,291	157	453	2,239
Aging and Disability Services Programs	2,124	-	48	30	6	2,208
National Institute of Diabetes and Digestive and Kidney Diseases	1,673	-	239	121	28	2,061
Health Care Fraud and Abuse Control Account	1	-	1,371	59	588	2,019
National Institute of Neurological Disorders and Stroke	1,603	-	254	96	26	1,979
NIH Service and Supply Fund	-	-	1,310	287	350	1,947
PSC Service and Supply Fund	-	-	1,655	157	84	1,896
National Institute of Mental Health	1,421	-	232	105	18	1,776
Social Services Block Grant	1,661	-	10	1	-	1,672
Mental Health	1,445	-	89	5	1	1,540
National Institute of Child Health and Human Development	1,042	-	329	104	20	1,495
National Institute on Drug Abuse	955	-	238	66	12	1,271
Public Health Preparedness and Response	630	-	258	122	162	1,172
Chronic Disease Prevention and Health Promotion	758	-	275	129	8	1,170
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	742	-	187	176	19	1,124
Other Agency Budgetary Accounts	14,418	1,185	14,368	7,573	3,502	41,046
Total Amounts Agreed to be Spent	**$ 840,703**	**$ 707,265**	**$ 29,414**	**$ 12,115**	**$ 90,556**	**$ 1,680,053**

Note 22: Reclassification of Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position for FR Compilation Process

Reclassification of Balance Sheet to Line Items Used for the Government wide Balance Sheet as of September 30, 2019 (in Millions)			
Financial Statement Line	**Amounts**	**Amounts***	**Reclassified Financial Statement Line**
ASSETS			**ASSETS**
Intra-Governmental Assets			**Intra-Governmental Assets**
Fund Balance with Treasury	$ 296,257	$ 296,257	Fund Balance with Treasury
		307,302	*Federal Investments*
		2,047	*Interest Receivable – Investments*
Investments, Net	309,349	309,349	Total Reclassified Investments, Net
		223	*Accounts Receivable*
		589	*Transfers Receivable*
Accounts Receivable, Net	812	812	Total Reclassified A/R
Advances	180	180	Advances to Others and Prepayments
Total Intra-Governmental Assets	**606,598**	**606,598**	**Total Intra-Governmental Assets**
Accounts Receivable, Net	24,156	24,156	Accounts and Taxes Receivable, Net
Inventory and Related Property, Net	10,781	10,781	Inventory and Related Property, Net
General PP&E, Net	6,544	6,544	PP&E, Net
Advances	2,452	2,452	Other Assets
		187	*Loans Receivable, Net*
		9	*Other Assets*
Other Assets	197	196	*Total Reclassified Other Assets*
Total Assets	**$ 650,728**	**$ 650,727**	**Total Assets**
LIABILITIES			**LIABILITIES**
Intra-Governmental Liabilities			**Intra-Governmental Liabilities**
		$ 163	*Accounts Payable*
		989	*Transfers Payable*
Accounts Payable	$ 1,153	1,152	Total Reclassified Accounts Payable
		332	*Liability to General Fund for Custodial and Other Non-Entity Assets*
		29	*Liability to the GF for Custodial and Other Non-Entity Assets*
		1,209	*Accounts Payable*
		124	*Benefit Program Contributions Payable*
		520	*Advances from Other & Deferred Credits*
		3,359	*Loans Payable*
Other Liabilities	5,573	5,573	*Total Reclassified Other – Miscellaneous Liabilities*
Total Intra-Governmental Liabilities	**6,726**	**6,725**	**Total Intra-Governmental Liabilities**
Accounts Payable	1,221	1,221	Accounts Payable
Federal Employee and Veteran Benefits	14,826	14,827	Federal Employee and Veteran Benefits Payable
Benefits Due and Payable	110,100	110,101	Benefits Due and Payable
Contingent Liabilities	17,083	17,083	Other Liabilities
Accrued Liabilities	15,543	15,543	Other Liabilities
		1	*Loan Guarantee Liabilities*
		220	*Environmental and Disposal Liabilities*
		3,472	*Other Liabilities*
Other Liabilities	3,695	3,693	*Total Reclassified Miscellaneous Liabilities*
Total Liabilities	**$ 169,194**	**$ 169,193**	**Total Liabilities**
NET POSITION			
Unexpended Appropriations – Funds from Dedicated Collections	$ 57,968	$ 57,968	Net Position – Funds from Dedicated Collections
Unexpended Appropriations – All Other Funds	170,438	170,438	Net Position – Funds Other than those from Dedicated Collections
Cumulative Results of Operations – Funds from Dedicated Collections	258,392	258,392	Net Position – Funds from Dedicated Collections
Cumulative Results of Operations – All Other Funds	(5,264)	(5.264)	Net Position – Funds Other than those from Dedicated Collections
Total Net Position	**481,534**	**481,534**	**Total Net Position**
Total Liabilities & Net Position	**$ 650,728**	**$ 650,727**	**Total Liabilities & Net Position**

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Net Cost to Line Items Used for the Government wide Statement of Net Cost For the Year Ending September 30, 2019 (in Millions)			
Financial Statement Line	**Amounts**	**Amounts***	**Reclassified Financial Statement Line**
		$ 1,338,407	***Non-Federal Costs***
			Intragovernmental Costs
		1,666	*Benefit Program Costs*
		548	*Imputed Costs*
		2,405	*Buy/Sell Costs*
		148	*Purchase of Assets*
		10	*Borrowing and Other Interest Expense*
		579	*Other Expenses (w/o Reciprocals)*
		5,355	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,201,630		
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	141,984		
Total Gross Costs	**$ 1,343,614**	**$ 1,343,762**	***Total Reclassified Gross Costs***
		(119,117)	**Non-Federal Earned Revenue**
			Intragovernmental Earned Revenue
		(1,604)	*Buy/Sell Revenue*
		(5)	*Borrowing and Other Interest Revenue*
		(148)	*Purchase of Assets Offset*
		(1,756)	**Total Intragovernmental Earned Revenue**
CMS: Exchange Revenue	(114,723)		
Other Segments: Exchange Revenue	(6,015)		
Total Exchange Revenue	**$ (120,738)**	**$ (120,874)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes	(27)	(27)	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost	**$ 1,222,849**	**$ 1,222,861**	**Net Cost**

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Changes in Net Position to Line Items Used for Government wide Statement of Operations and Changes in Net Position For the Year Ending September 30, 2019 (in Millions)			
Financial Statement Line	**Amounts**	**Amounts***	**Reclassified Financial Statement Line**
UNEXPENDED APPROPRIATIONS			
Unexpended Appropriations, Beginning Balance	$ 186,601	$ 186,601	Net Position, Beginning of Period
Appropriations Received	1,059,390	964,048	Appropriations Received as Adjusted
Other Adjustments	(95,342)		
		10	*Non-Expenditure Transfers-In of Unexpended Appropriations and Financing Sources (Federal)*
		(7)	*Non-Expenditure Transfers-Out of Unexpended*
Appropriations Transferred In/Out	3	3	Total Reclassified Appropriations Transferred In/Out
Appropriations Used	(922,246)	(922,246)	Appropriations Used (Federal)
Total Unexpended Appropriations	**$ 228,406**	**$ 228,406**	
CUMULATIVE RESULTS OF OPERATIONS			
Cumulative Results, Beginning Balance	$ 260,594	$ 260,594	Net Position, Beginning of Period
Other Adjustments	(8)	(8)	Revenue and Other Financing Sources – Cancellations
Appropriations Used	922,246	922,246	Appropriations Expended
			Intragovernmental Non-Exchange Revenues
Nonexchange Revenue – Tax Revenue	281,441	281,441	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	9,771	9,771	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange)
		2,717	*Other Taxes and Receipts (RC 45)*
		817	*Other Taxes and Receipts*
Nonexchange Revenue – Other	3,533	3,534	Total Other Taxes and Receipts
	294,745	**294,746**	***Total Intragovernmental Non-Exchange Revenues***
Donations and Forfeitures of Cash and Cash Equivalents	69	69	Other Taxes and Receipts
		804	*Expenditure Transfers-In of Financing Sources*
		(3,024)	*Expenditure Transfers-Out of Financing Sources*
Transfers-In/Out Without Reimbursement (+/-) – Budgetary	(2,220)	(2,220)	Total Reclassified Transfers-In/Out w/o Reimbursement – Budgetary
Total Budgetary Financing Sources	**1,214,832**	**1,214,833**	**Total Budgetary Financing Sources**
Other Financing Sources			
Donations and Forfeitures of Property	7	7	Other Taxes and Receipts
Imputed Financing	548	548	Imputed Financing Sources (Federal)
		(1,947)	*Other Taxes and Receipts*
		1,943	*Collections transferred into a TAS Other Than the General Fund of the U.S. Government –Non-Exchange*
Other (+/-)	(4)	(4)	
Total Other Financing Sources	551	551	Total Reclassified Other
Total Financing Sources	**1,215,383**	**1,215,384**	**Total Financing Sources**
		2	*Interest Revenue - Other*
		2,805	*Other Taxes and Receipts*
		(1,090)	*Non-Entity Collections Transferred to the General Fund*
		(1,718)	*Other Taxes and Receipts*
		11	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund*
		1	*Other Non-Budgetary Financing Sources*
		11	
Net Cost of Operations	**1,222,849**	**1,222,861**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 253,128**	**$ 253,128**	**Net Position – Ending Balance**
Total Net Position	**$ 481,534**	**$ 481,534**	**Total Net Position**

*Subtotals and totals may not equal due to rounding.

To prepare the Financial Report of the U.S. Government (FR), Treasury requires agencies to submit an adjusted trial balance, which is a listing of amounts by U.S. Standard General Ledger account that appears in the financial statements. Treasury uses the trial balance information reported in Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) to develop a Reclassified Balance Sheet, Reclassified Statement of Net Cost,

and a Reclassified Statement of Changes in Net Position for each agency, which are accessed using GTAS. Treasury eliminates all intragovernmental balances from the reclassified statements and aggregates lines with the same title to develop the FR statements. This note shows the HHS financial statements and the HHS reclassified statements prior to elimination of intragovernmental balances and prior to aggregation of repeated FR line items.

The Statement of Net Cost and Statement of Changes in Net Position have immaterial differences primarily due to the presentations between HHS's financial statements and the reclassified financial statements. There is a difference of $12 million for the Statements of Net Cost and $11 million for the Statement of Changes in Net Position due to custodial activities. The remainder of the differences are due to rounding.

Note 23. Statement of Social Insurance (Unaudited)

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

Actuarial present values are computed under the intermediate set of assumptions specified in the *2019 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on April 22, 2019, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

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

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

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

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on April 22, 2019, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, 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 following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2019 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2019. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website at http://www.cms.hhs.gov/CFOReport/.[11]

[11]The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2019

					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]
2019	1.75	1,409,000	785.9	2.19	4.02	1.83	2.8	3.5	5.5	-1.5	1.0
2020	1.76	1,413,000	779.9	2.08	4.71	2.63	2.4	3.8	5.0	3.5	0.7
2030	2.00	1,329,000	716.5	1.29	3.89	2.60	2.0	4.2	5.6	4.9	2.5
2040	2.00	1,280,000	657.7	1.20	3.80	2.60	2.0	4.5	4.4	4.7	2.5
2050	2.00	1,251,000	606.0	1.25	3.85	2.60	2.1	4.0	4.0	4.7	2.5
2060	2.00	1,236,000	560.6	1.25	3.85	2.60	2.0	3.7	3.8	4.5	2.5
2070	2.00	1,227,000	520.6	1.19	3.79	2.60	2.0	3.8	3.7	4.4	2.5
2080	2.00	1,221,000	485.1	1.16	3.76	2.60	2.1	3.9	3.8	4.5	2.5
2090	2.00	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5

[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, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4] Difference between percentage increases in wages and the CPI.
[5] Average annual wage in covered employment.
[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance FY 2019-2015

					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]
2019	2.0	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5
2018	2.0	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7
2017	2.0	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
2015	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2027.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. (Beginning with FY 2018 legal immigration is referred to as lawful permanent resident (LPR) immigration, and other, non-legal, immigration is referred to as other-than-LPR immigration.) The ultimate level of net legal immigration is 788,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[4]Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in Table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[5]Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[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. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016 - 2019.

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

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

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

Certain features of current law may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity although these health providers have historically achieved lower levels of productivity growth. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The gap will continue to widen throughout the projection, and the Trustees estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028 to 2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the 5 percent bonuses for qualified physicians in advanced alternative models (advanced APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2025.[12] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

The table on the next page contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

[12]The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the enactment of MACRA in 2015 replaced the SGR with specified physician updates.

Medicare Present Value

(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$ 24,359	$ 24,420
Part B	39,652	46,342
Part D	11,232	11,232
Expenditures		
Part A	29,843	34,890
Part B	39,652	46,342
Part D	11,232	11,232
Income less expenditures		
Part A	(5,484)	(10,470)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2019 Trustees Report.

[2]At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the 5-percent bonuses paid to qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A and Part B expenditures would each be higher than the current-law projections by roughly 17 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 17 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are the same under each projection because the services are not affected by the productivity adjustments or the physician updates.

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

Note 25. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future

participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2018 to the period beginning on January 1, 2019, and the reconciliation from the period beginning on January 1, 2017 to the period beginning on January 1, 2018. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

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

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

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

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

Assumptions Used for the Statement of Changes in Social Insurance Amounts

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

Period beginning on January 1, 2018 and ending January 1, 2019

Present values as of January 1, 2018 are calculated using interest rates from the intermediate assumptions of the 2018 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2019. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2018 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2019 Trustees Report.

Period beginning on January 1, 2017 and ending January 1, 2018

Present values as of January 1, 2017 are calculated using interest rates from the intermediate assumptions of the 2017 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2018. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2017 Trustees Report. Since interest rates are an economic estimate and all

estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2018 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2018-92) to the current valuation period (2019-93) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2018, replaces it with a much larger negative net cash flow for 2093, and measures the present values as of January 1, 2019, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2018-92 to 2019-93. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2018 are realized. The change in valuation period resulted in a slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $193 billion.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2017-91) to the current valuation period (2018-92) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2017, replaces it with a much larger negative net cash flow for 2092, and measures the present values as of January 1, 2018, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2017-91 to 2018-92. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2017 are realized. The change in valuation period resulted in a very slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $168 billion.

Change in Projection Base

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

Actual income and expenditures in 2018 were different than what was anticipated when the 2018 Trustees Report projections were prepared. Part A income in 2018 was lower and expenditures were higher than anticipated based on actual experience. For both Part B and Part D, total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is a decrease of $193 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2018 and January 1, 2019 is incorporated in the current valuation and is more than projected in the prior valuation.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

Actual income and expenditures in 2017 were different than what was anticipated when the 2017 Trustees Report projections were prepared. Part A payroll tax income in 2017 was lower attributable to lowered wages and expenditures were higher than anticipated based on actual experience. Part B total income and expenditures were

higher than estimated based on actual experience. For Part D, actual income and expenditures were both lower than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease of $926 billion in the present value of the estimated future net cash flow including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2017 and January 1, 2018 is incorporated in the current valuation and is less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

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

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2019) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed. The numbers of new lawful permanent residents (LPR) for calendar years 2018 and 2019 were assumed to be slightly lower than projected in the prior valuation period, due to recent lower annual refugee ceilings set by the Administration.

- The current valuation incorporated a gradual rise in 2017 and 2018 of other-than-LPR immigrants, reaching the ultimate assumed level in 2019. In contrast, the prior valuation incorporated a surge in the number of other-than-LPR immigrants for years 2016 through 2021.
- Final birth rate data for 2017 indicated slightly lower birth rates than were assumed in the prior valuation.
- Incorporating 2016 mortality data obtained from the National Center for Health Statistics (NCHS) for ages under 65 and 2016 and preliminary 2017 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.

There were two notable changes in demographic methodology:

- Improved the method for projecting fertility rates by better incorporating detailed provisional birth rate data available from NCHS.
- Incorporated more comprehensive Medicare mortality data from CMS.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in a slight increase in the estimated future net cash flow. The present value of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $27 billion.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

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

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2018), with the exception of a small decrease of 10,000 lawful-permanent-resident (LPR) immigrants per annum in the future, are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2016 indicated slightly lower birth rates than were assumed in the prior valuation.

- Recent fertility data suggests that the short-term increase in the total fertility rate used in the prior valuation to account for an assumed deferral in childbearing (resulting from the recent economic downturn) was no longer warranted. The observed persistent drop in the total fertility rate in recent years is now assumed to be a loss of potential births rather than just a deferral for this period.
- Incorporating 2015 mortality data obtained from the National Center for Health Statistics for ages under 65 and preliminary 2015 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- More recent LPR and other-than-LPR immigration data and historical population data were included.

There was one notable change in demographic methodology:

- Improved the method for projecting mortality rates by marital status by utilizing recent data from NCHS and the American Community Survey.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present value of estimated income and expenditures are both lower for Part A and Part B but higher for Part D. Overall, these changes increased the present value of the estimated future net cash flow by $434 billion.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

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

For the current valuation (beginning on January 1, 2019), there were four changes to the ultimate economic assumptions.

- The ultimate annual rate of change in total-economy labor productivity was lowered from 1.68 percent in the prior valuation to 1.63 percent in the current valuation, reflecting an expected slower rate of productivity growth in the long term.
- The difference between the ultimate growth rates for the Consumer Price Index for Urban Wage Earners and Clerical Workers and the GDP implicit price deflator (the "price differential"), was decreased from 0.40 percentage point in the prior valuation to 0.35 percentage point in the current valuation.
- The ultimate average real-wage differential was increased from 1.20 percentage points in the prior valuation to 1.21 percentage points in the current valuation.
- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.7 percent in the prior valuation to 2.5 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include the July 2018 revisions in historical GDP estimated by the Bureau of Economic Analysis (BEA) of the Department of Commerce. This and other smaller changes in starting values and near-term growth assumptions combined to increase the present value of estimated future net cash flows.

There was one notable change in economic methodology:

- Incorporated more recent projections of disability prevalence in the labor force participation model.

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

- Lower assumed growth in economy-wide productivity, which results in higher payment updates for certain providers.
- Faster projected spending growth for physician-administered drugs under Part B.
- Higher projected drug manufacturer rebates and slower overall drug price increases assumed in the short-range period.

The net impact of these changes resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and also income). Overall, these changes decreased the present value of the estimated future net cash flow by $402 billion.

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

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

The ultimate economic assumptions for the current valuation (beginning on January 1, 2018) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The estimated level of potential GDP was reduced by about 1 percent in 2017 and throughout the projection period, primarily due to the slow growth in labor productivity for 2010 through 2017 and low unemployment rates in 2017. This lower estimated level of potential GDP means that cumulative growth in actual GDP is 1 percent less over the remainder of the projected recovery than was assumed in the prior valuation.
- Near-term interest rates were decreased, reflecting a more gradual path for the rise to the ultimate real interest rate than was assumed in the prior valuation.
- New data from the Bureau of Economic Analysis (BEA) indicated lower-than-expected ratios of labor compensation to GDP for 2016 and 2017, while new data from the Internal Revenue Service (IRS) indicated lower-than-expected ratios of taxable payroll to GDP for 2016 and 2017. This new data led to assumed extended recoveries in these ratios to the unchanged ultimate ratios.

There was one notable change in economic methodology:

- Improved the method for projecting educational attainment among women in age groups 45-49 and 50-54 in the labor force participation model.

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

- Utilization rate assumptions for inpatient hospital were decreased.
- Utilization rate and case mix for skilled nursing facilities services were decreased.
- Payment rates to private health plans are higher than projected in last year's report primarily due to higher risk scores and increased coding by plans.
- Higher projected drug manufacturer rebates.

The net impact of these changes resulted in a small increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, these changes decreased the present value of estimated expenditures (and also income). Overall, these changes increased the present value of the estimated future net cash flow by $14 billion.

Changes in Law

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The provisions enacted as part of Medicare legislation since the prior valuation date had no measurable impact on program expenditures. For more information on the legislation please see section V.A of the 2019 Medicare Trustees Report.

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

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

- The *Disaster Tax Relief and Airport and Airway Extension Act of 2017* (Public Law 115-63, enacted on September 29, 2017) included one provision that affects the HI and SMI Part B programs.
    - The funding amount of $270 million previously provided to the Medicare Improvement Fund, for services provided during and after fiscal year 2021, is decreased to $220 million. (This fund was intended to be available for improvements to the original fee-for-service program under Parts A and B.)
- An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (Public Law 115-97, enacted on December 22, 2017, and also referred to as the *Tax Cuts and Jobs Act of 2017*) included three provisions that affect the HI program.
    - Federal income tax rates for individuals are reduced, effective for taxable years beginning after December 31, 2017 and ceasing to apply after December 31, 2025. In addition, the inflation index applied to the tax bracket thresholds and standard deductions is changed, effective for taxable years beginning after December 31, 2017, such that these amounts will permanently grow more slowly than under prior law.
    - The requirement that most individuals be covered by a health insurance plan or pay a financial penalty, commonly referred to as the individual mandate, is repealed, effective January 1, 2019. Accordingly, the percentage of people without health insurance is expected to increase. Because the change in this percentage is a factor used in determining payments to Medicare disproportionate share hospitals for uncompensated care, these payments are expected to increase as well. In addition, in light of this repeal, it is expected that some individuals will drop their employer-sponsored health insurance, thereby slightly increasing HI covered wages and taxable payroll.
    - Temporary tax changes for certain small businesses are made that will affect reported self-employment income and, in turn, HI covered wages and taxable payroll.
- An Act Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes (Public Law 115-120, enacted on January 22, 2018) included one provision that affects the HI and SMI programs.
    - A moratorium for calendar year 2019 is placed on the annual fee to be paid by health insurance providers. This fee is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D.

- The *Bipartisan Budget Act of 2018* (BBA 2018; Public Law 115-123, enacted on February 9, 2018) included provisions that affect the HI and SMI programs.
    - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines, as described in previous annual reports, is extended by 2 years, through fiscal years 2026 and 2027.
    - The Independent Payment Advisory Board (IPAB) and all related provisions are repealed, effective upon enactment. (The IPAB was established by the *Affordable Care Act* to develop and submit proposals aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries.)
    - For Medicare Advantage plans and stand-alone Part D plans that undergo a contract consolidation approved on or after January 1, 2019, the star rating (and any quality bonus payment) for the surviving contract is to reflect an enrollment-weighted average of the ratings for the continuing and closed contracts.
    - The authority for Medicare Advantage Special Needs Plans (SNPs), which was due to expire on December 31, 2018, is permanently extended. A number of reforms to dual-eligible SNPs and chronic-condition SNPs are also mandated.
    - For Medicare Advantage plans, certain provisions are enacted, effective January 1, 2020, which permit plans to offer to chronically ill enrollees (i) a broader range of supplemental benefits (which may include services that are not primarily health care services), as long as the benefit offers a reasonable expectation of improving or maintaining health or overall function, and (ii) expanded telehealth services as supplemental benefits, subject to certain specified requirements. In addition, the Value-Based Insurance Design (VBID) Model, which is a pilot program allowing certain plans to offer supplemental benefits or reduced cost sharing to enrollees with certain chronic conditions, is expanded, effective no later than January 1, 2020, to allow plans in all States the opportunity to participate in it. The VBID program is also made exempt, through December 31, 2021, from certain spending and quality-of-care testing to which it would otherwise be subjected.
    - For Medicare Accountable Care Organizations (ACOs), certain provisions are enacted to (i) provide more opportunities for beneficiaries to be assigned to, or voluntarily align with, ACOs; (ii) allow for the use of beneficiary incentive programs; and (iii) allow for expanded use of telehealth services. The specific types of ACOs to which each of these changes apply, as well as the effective dates, vary.
    - Funding for the National Quality Forum is provided from the HI and SMI trust funds for the remainder of fiscal year 2017 and for fiscal years 2018 and 2019.
    - Funding for certain low-income outreach and assistance programs is extended 2 years, through September 30, 2019.
    - Certain existing civil and criminal penalties are substantially increased for providers and suppliers who violate health care fraud and abuse laws, effective upon enactment.
    - For home health agencies serving beneficiaries in rural areas, the 3-percent add-on payment is extended 1 year, through December 31, 2018. Then, for services furnished in rural areas from 2019 through 2022, three separate tiers of add-on adjustments are established, based on Medicare home health utilization and low-population density; these adjustments diminish over varying periods of time (and become 0 percent no later than 2020). Also, for services furnished on or after January 1, 2019, home health agencies are required to report the county in which the services are furnished.
    - For the Medicare home health prospective payment system (PPS), the annual update for calendar year 2020 is set at 1.5 percent.

- Under the home health PPS, the unit of payment for home health services is changed from a 60-day to a 30-day episode of care, beginning in 2020. This change must be made in a budget-neutral manner, but adjustments to offset anticipated behavior changes that could result from the modified methodology are allowed. Also beginning in 2020, therapy thresholds are removed from the home health case mix adjustment.
- To demonstrate home-bound and medical-necessity status when determining if a patient is eligible for home health services, documentation in the medical records of home health agencies can be used as supporting material, in addition to documentation in the medical records of the certifying physician, effective January 1, 2019.
- For telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, the geographic restriction that limits originating sites to rural areas is eliminated, provided that all other Medicare telehealth coverage requirements are satisfied. In addition, no originating site facility fee is to be paid to sites that do not meet the current geographic and site type requirements. This provision is effective beginning on January 1, 2019.
- For the Medicare electronic health records incentive program, the provision requiring more stringent measures of meaningful use, over time, is eliminated, effective upon enactment.
- The funding amount of $220 million previously provided for the Medicare Improvement Fund (as noted above) is eliminated.
- The Medicare-Dependent Hospital (MDH) program is extended for 5 fiscal years, through September 30, 2022. In addition, the program is extended to certain rural hospitals that are located in all-urban States and that otherwise meet the MDH criteria.
- Medicare inpatient hospital add-on payments for low-volume hospitals are extended for 5 fiscal years, through September 30, 2022. In addition, for fiscal years 2019 through 2022, changes are made to the qualifying criteria (which are to be based on total discharges or Medicare discharges, depending on the year, and on the distance from another inpatient hospital) and to the add-on adjustments (which are to be based on a sliding scale ranging from 25 percent to 0 percent).
- Two changes are made to the long-term care hospital (LTCH) site-neutral provision. First, the originally mandated 2-year transition period is extended for 2 additional years, covering fiscal years 2018 and 2019. Second, the inpatient hospital PPS comparable amount used in the site-neutral payment rate calculations for fiscal years 2018 through 2026 is to be reduced by 4.6 percent.
- For the inpatient hospital diagnosis-related groups (DRGs) subject to the post-acute care transfer policy, hospice is added as a setting of care, effective October 1, 2023.
- For the Medicare skilled nursing facility PPS, the annual update for fiscal year 2019 is set at 2.4 percent.
- Physician assistants are added to the types of providers who may serve as attending physicians for the purposes of hospice care, effective January 1, 2019. (Previously, only physicians and nurse practitioners could serve.) Like nurse practitioners, physician assistants are not permitted to provide the written certification of terminal illness required for hospice services.
- A new income-related premium threshold is established. Specifically, beginning in calendar year 2019, individuals with incomes at or above $500,000 (and couples with incomes at or above $750,000) will pay premiums covering 85 percent (rather than 80 percent) of the average program cost for aged beneficiaries. These new threshold levels will not be inflation-adjusted until 2028 and later.
- The 1.00 floor on the geographic index for physician work is extended for 2 additional years, through December 31, 2019.

- The physician fee schedule update for 2019, which had been set at 0.5 percent, is decreased to 0.25 percent.
- A number of changes are made to the merit-based incentive payment system (MIPS) for physicians, including that it be applied only to covered professional services instead of to items and services (thereby excluding, most prominently, physician-administered Part B drugs) and that its transition period be extended by 3 years (such that the post-transition period now begins in 2022, not 2019). Certain additional changes to the system are mandated for the extended transition period, and others are mandated for the period thereafter. Effective dates vary.
- The annual payment limits on therapy services are permanently repealed, beginning on January 1, 2018. The threshold for the targeted manual medical review process is lowered, from $3,700 to $3,000, effective as of the same date and until 2028, after which the threshold is to be increased by a specified formula.
- Outpatient physical and occupational therapy services furnished by a therapy assistant are paid at 85 percent of the amount that otherwise would have been paid under the fee schedule, effective January 1, 2022.
- The freeze on coding and valuation of certain radiation therapy services reimbursed under the fee schedule, in place for 2017 and 2018, is extended through 2019.
- For qualified home infusion therapy suppliers, a temporary transitional payment for administering home infusion therapy is established, beginning on January 1, 2019. Payment rates in three categories will apply during the transition period, which will end on December 31, 2020, after which a new payment methodology will begin.
- Certain ground ambulance add-on payments are extended 5 additional years, through December 31, 2022. (These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.) The development of a system to collect certain data from providers and suppliers of ground ambulance services is also mandated.
- For non-emergency ground ambulance transports of beneficiaries with end-stage renal disease (ESRD) to and from renal dialysis services, the reduction in payments is increased from 10 percent to 23 percent for transports furnished on or after October 1, 2018.
- For beneficiaries with ESRD who receive home dialysis, all monthly physician visits can be provided via telehealth, beginning on January 1, 2019, as long as the beneficiary receives one in-person visit monthly for the initial 3 months and at least one every 3 months thereafter. (Previously, at least one in-person visit per month was required.) Also, the originating site requirements are modified in several ways, and no site facility fee is to be paid if the beneficiary's home is the originating site.
- Conditions are added to those that allow a beneficiary who qualifies for cardiac rehabilitation services to qualify for the more intensive set of services, effective upon enactment. Also, the supervision requirements for cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation are changed to allow physician assistants, nurse practitioners, and clinical nurse specialists (in addition to physicians) to supervise these programs, effective January 1, 2024.
- A provision of the *Steve Gleason Act of 2015*, requiring that Medicare payment for rental or lump-sum purchase of speech-generating devices and accessories be made without a cap on the amount, is made permanent.
- Enforcement is delayed an additional year, through December 31, 2017, for the instruction that, for outpatient therapeutic services provided in critical access and small rural hospitals, a physician or non-physician practitioner must provide direct supervision throughout the performance of a procedure. (In the 2018 outpatient hospital PPS rule, CMS extended these non-enforcement instructions for 2018 and 2019 and noted that, for 2017, while there was not a non-enforcement

instruction in place, Medicare administrative contractors were directed not to prioritize enforcement of this requirement for these hospitals. This legislation provides the non-enforcement instruction that had been lacking for 2017.)

- Under the Part D standard benefit structure, the coverage gap closes 1 year earlier than previously scheduled for brand-name drugs only; that is, for brand-name drugs, beneficiaries in the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies) will pay 25 percent of drug costs beginning on January 1, 2019 (instead of 30 percent in 2019 and 25 percent thereafter). Also beginning on that date, these beneficiaries will receive a 70-percent manufacturer discount (instead of 50 percent) and a 5-percent benefit (instead of 20 percent in 2019 and 25 percent thereafter) from their Part D plans for applicable prescription drugs. (For purposes of drug discounts while beneficiaries are in the Part D coverage gap, applicable drugs are generally covered brand-name Part D drugs, while non-applicable drugs are generally covered generic Part D drugs.) For generic drugs, the law remains the same, with beneficiaries paying 37 percent of drug costs in 2019 and 25 percent thereafter.
- For purposes of drug discounts while beneficiaries are in the Part D coverage gap, the definition of applicable drugs is expanded to include biosimilars, effective January 1, 2019. (Applicable drugs previously included biologics but not biosimilars.)

Overall these provisions resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and a slight decrease to the present value of estimated future income, with an overall net decrease of $535 billion in the present value of the estimated future net cash flow. For Part B and Part D, these changes increased the present value of estimated future expenditures (and also income).

Required Supplementary Stewardship Information

Investment in Human Capital (in Millions)

For the Year Ended September 30, 2019

Responsibility Segment Program	2019	2018	2017	2016	2015
National Institutes of Health					
Research Training and Career Development	$ 943	$ 883	$ 1,807	$ 1,745	$ 1,631
Health Resources and Services Administration					
Health Workforce Grants, Scholarships and Loans	940	1,058	1,047	935	828
Other HRSA Training Investments	87	89	88	90	-
Other Investments in Human Capital					
Other	22	23	21	17	14
Totals	**$ 1,992**	**$ 2,053**	**$ 2,963**	**$ 2,787**	**$ 2,473**

Investments in Human Capital are expenses incurred by federal education and training programs for the public, intended to maintain or increase national productive capacity. The following OpDivs conduct education and training programs under this category:

National Institutes of Health

NIH has long recognized the importance of a sustainable and diverse workforce is key to achieving its mission. To this end, NIH remains committed to the development, support, and retention of our next generation of investigators. The NIH Research Training and Career Development Programs address the need for trained scientists to conduct biomedical and behavioral research. The primary goal of the support that NIH provides for research training and career development is to produce new, highly trained investigators who are likely to conduct research that will benefit public health. NIH's major research training and career development programs include: institutional research training grants for graduate students and post-doctoral scholars; individual pre- and post-doctoral fellowships; individual and institutional research career development awards for advanced post-doctorates and early-stage faculty; loan repayment programs; and research education awards that promote research experiences, curriculum development, and other related activities. In addition, as part of implementing the *21st Century Cures Act* (Cures Act), NIH launched the Next Generation Researchers Initiative (NGRI) in August 2017 to address the challenges faced by early career researchers trying to embark upon and sustain independent research careers. In FY 2019, NIH funded at least 1,287 early-stage investigators. Going forward, NGRI will continue to prioritize meritorious applications to support early-stage investigators that have never received an independent research award, as well as current NIH-funded researchers at risk of losing support.

Within the Intramural Research Program at NIH, investments in the next generation of researchers may offer the biggest dividends yet. NIH has enlarged its world-famous training program. We now have approximately 1,500 recent college graduates in the NIH Postbaccalaureate (Postbac) Program working in NIH labs across the country as they explore scientific career opportunities. Complementing the Postbac program is the Medical Research Scholars Program, in which 50 highly qualified medical, dental, and veterinary students pause their university studies to conduct basic, clinical, or translational research work at the NIH for a year.

Health Resources and Services Administration

HRSA's Bureau of Health Workforce (BHW) improves the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health care workforce. BHW programs support a diverse, culturally competent workforce by addressing components

including education, training, and financial support for students, faculty, practitioners, and supporting institutions. In FY 2019, BHW made more than 1800 awards worth a total of $1.1 billion to organizations and individuals for scholarships and grants. HRSA continues to invest in expanding access to substance use disorder treatment in rural and underserved areas. In Academic Year 2018-2019, BHW also supported more than 850 residents in 56 Teaching Health Centers through the Teaching Health Center Graduate Medical Education program. Teaching Health Centers trained more than 500 future Family Medicine physicians, 200 future Internal Medicine physicians, and 50 future Psychiatrists. For more information, visit HRSA Health Workforce.

Other HRSA human capital investments are primarily in the form of grants and cooperative agreements. HRSA Maternal and Child Health (MCH) Workforce Development awarded grants to educate and train the current and future generations of MCH professionals through interdisciplinary undergraduate, graduate, and post-graduate training programs, and through continuing education to practicing MCH professionals. AIDS Education and Training Centers Program supports a network of eight regional centers with more than 130 local affiliated sites, as well as two national centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people with HIV. The PHS Act family planning service program provided clinical and programmatic training and technical assistance to clinical providers, Title X family planning grantees, as well as to help support Title X clinical service sites.

Other Investments in Human Capital

Administered by ACL, Projects of National Significance grants and contracts are awarded to public and private nonprofit institutions to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. These monies also support the development of national and state policy to serve this community. As of September 30, 2019, 25 grants (totaling $9.1 million) and 8 contracts (totaling $2.3 million) were awarded in FY 2019. This program works to ensure that individuals with developmental disabilities and their families are able to fully participate in and contribute to all aspects of community life.

ACL's National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) administers the Advanced Rehabilitation Research and Training (ARRT) Program to increase capacity for high-quality rehabilitation research by supporting grants to institutions to provide advanced research training to individuals with doctorates or similar advanced degrees who have clinical or other relevant experience. As of September 30, 2019, ACL has awarded 19 ARRT grants (totaling $2.8 million). These grants were made to institutions to recruit qualified persons, including individuals with disabilities, and to prepare them to conduct independent research related to disability and rehabilitation, with particular attention to research areas that support the implementation and objectives of the Rehabilitation Act and that improve the effectiveness of services authorized under the Act.

In addition, AHRQ provides an array of pre-doctoral and postdoctoral educational and career development grants and opportunities in health services research training. Research training and career development activities are administered by the Division of Research Education in the Office of Extramural Research, Education, and Priority Populations.

Investment in Research and Development (in Millions)

For the Year Ended September 30, 2019

Responsibility Segments	Basic	Applied	Developmental	2019 Total	2018	2017	2016	2015	Grand Total
AHRQ	$ -	$ 189	$ -	$ 189	$ 187	$ 217	$ 213	$ 167	$ 973
CDC	60	334	76	470	424	509	502	490	2,395
FDA	193	-	7	200	188	142	170	129	829
NIH	19,020	17,909	217	37,146	35,468	29,465	28,258	28,093	158,430
Other	3	203	-	206	34	108	32	26	406
Totals	**$ 19,276**	**$ 18,635**	**$ 300**	**$ 38,211**	**$ 36,301**	**$ 30,441**	**$ 29,175**	**$ 28,905**	**$ 163,033**

The research and development programs in HHS include the following:

Agency for Healthcare Research and Quality

AHRQ is the leading federal agency charged with improving the safety and quality of America's health care system. AHRQ develops knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making. In FY 2019, AHRQ released a Question Builder mobile app to help prepare and organize questions and other helpful information prior to medical visits.

Centers for Disease Control and Prevention

Diseases, Occupational Safety and Health, Injury Prevention and Control, and Emerging and Zoonotic Diseases were the primary areas where CDC's research and development was invested. CDC works with partners around the country and world to protect Americans from infectious diseases; prevent the leading causes of disease, disability, and death; ensure global disease protection; keep Americans safe from environmental and work-related hazards; protect Americans from natural and bioterrorism threats; monitor health; and ensure laboratory excellence. CDC programs provide partners and Americans with the essential health information and tools they need to protect and advance their health.

CDC received appropriations of $168 million in FY 2019 for Antibiotic Resistance (AR). AR has the potential to impact all Americans at every stage of life. CDC is a leader in the fight against this global threat. Through its AR Solutions Initiative, CDC works with partners to drive aggressive action and empower the nation to comprehensively respond.

CDC's AR Solutions Initiative invests in national infrastructure to detect, respond, contain, and prevent resistant infections across healthcare settings, food, and communities. CDC funding supports all 50 state health departments, six local health departments, and Puerto Rico and the U.S. Virgin Islands. Through these investments, CDC is transforming how the nation and world combat and slow antibiotic resistance at all levels. For more information, visit AR Solutions Initiative.

Food and Drug Administration

FDA has two programs that meet the requirements of research and development investments: Orphan Products Designation (OPD) Program and FDA Research Grants Program. While the FDA's center components conduct

scientific studies, FDA does not consider this type of research as "research and development" because it supports FDA's regulatory policy and decision-making processes.

The OPD Program was established by the *Orphan Drug Act* with the purpose of identifying orphan products and facilitating their development. The *Orphan Drug Act* also created the Orphan Product Clinical Trials Grants Program to stimulate the development of promising products for rare diseases and conditions. Orphan product grants are a proven method of fostering and encouraging the development of new, safe, and effective medical products for rare diseases and conditions. Since Orphan Products Clinical Trials Grants Program's inception in 1983, FDA has received over 2,500 applications (generally, about 100 applications each year), reviewed over 2,200, and funded over 590 studies. In contrast, fewer than 10 such products supported by industry came to market between 1973 and 1983. The program has bought more than 60 products to marketing approval. Approximately 10 percent of the studies that received developmental support from the OPD Grants Program utilized to facilitate the marketing approval of those drugs, biologics, and medical devices. The Humanitarian Use Device Program has been the first step in approval of 70 Humanitarian Device Exemption approvals. For more information about the Orphan Products Clinical Trials Grants Program, including grants funded to date, visit Orphan Products Clinical Trials Grants Program.

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

National Institutes of Health

NIH supports research that seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. To push forward the frontier of knowledge and achieve this mission, NIH supports extramural and intramural activities that span the spectra of medical research, including fundamental, disease-oriented, pre-clinical laboratory animal, observational, population-based, behavioral, social science, and translational research. Moreover, NIH's clinical research activities aim to understand healthy and disease states, move laboratory findings into medical applications, as well as assess new treatments or compare different treatment approaches. NIH also regards the expeditious transfer of the results of its medical research for further development and commercialization of biomedical products as an important component to improve public health.

Congress passed and the President signed into law the Cures Act in December 2016 authorizing $1.8 billion in funding for the Cancer Moonshot℠ over 7 years. An initial $300 million has been appropriated in fiscal year (FY) 2017 to fund Moonshot initiatives. The law provides NIH with critical tools and resources to advance biomedical research across the spectrum, from foundational basic research studies to advanced clinical trials of promising new therapies. The Cures Act provides multiyear funding to four highly innovative scientific initiatives. The All of Us Research Program aims to collect one million or more volunteers' medical history, lifestyle information, and genetic information to support advances in medical research. The Brain Research through Advancing Innovative Neurotechnologies Initiative seeks to better understand how the brain encodes, stores, and retrieves information, which will transform the ability to diagnose and treat neurological/mental disorders. The Cancer Moonshot℠ to accelerate cancer research aims to make more therapies available to more patients, while also improving the ability to prevent cancer and detect it at an early stage. The Regenerative Medicine Innovation Project will support clinical research in coordination with the FDA using adult stem cells to further the field of regenerative medicine. For more information, visit the Cures Act.

NIH continues to implement provisions of the Cures Act relevant to the overall conduct of biomedical and behavioral research. This includes, but is not limited to, reducing administrative burdens for investigators, strengthening protections for participants involved with clinical research, bolstering the next generation of biomedical scientists,

enhancing the rigor of meritorious peer-reviewed research, ensuring persons across the lifespan are included in clinical research, and requiring sharing of data resulting from NIH funded clinical trials.

NIH continues the aggressive, trans-agency effort launched in 2018 to speed scientific solutions to stem the national opioid public health crisis. The HEAL (Helping to End Addiction Long-term) Initiative builds on extensive, NIH-supported research on understanding the complex neurological pathways involved in pain and addiction, developing and testing new treatment models, and integrating behavioral interventions with medication-assisted treatment.

The Accelerating Medicines Partnership (AMP) is a public-private partnership between the NIH, FDA, multiple biopharmaceutical and life science companies and non-profit organizations to transform the current model for developing new diagnostics and treatments. The ultimate goal is to increase the number of new diagnostics and therapies for patients and reduce the time and cost of developing them. Since its launch in 2014, AMP projects have focused on Alzheimer's disease, type 2 diabetes, rheumatoid arthritis, lupus, and Parkinson's Disease. For each project, scientists from NIH and industry developed research plans aimed at characterizing effective molecular indicators of disease, called biomarkers, and distinguishing biological targets most likely to respond to new therapies. NIH and industry partners are sharing expertise and resources — over $350 million, which includes in-kind contributions — in an integrated governance structure that enables the best-informed contributions to science from all participants. All partners have agreed to make the AMP data and analyses publicly accessible to the broad biomedical community.

For intramural research activities, investments in infrastructure, equipment, and talent have yielded significant dividends. NIH is one of the few institutions in the United States that houses gnotobiotic mice, which are born in germ-free conditions. NIH investigators can study the impact of the microbiome — benign microorganisms residing in and on our bodies — by inoculating these mice with specific microorganisms. As a result, we have learned, among many things that native microorganisms on our skin can help facilitate rapid healing through chemical signaling with immune cells called T cells. NIH investigators have found new connections between the microbiome and tumor development and obesity as well. Related to this, NIH investigators have created a new mouse model that utilizes "wildling," that is, exposing laboratory-bred genetically modified mice to a broad range of the microbes and pathogens of wild mice, which makes them even more useful for research.

Investments in imaging have opened new windows into organs such as the brain and into the microscopic, subcellular world. Research highlights include greater resolution of tissue imaging with less radiation and near-atomic-level resolution of proteins via cryo-electron microscopy. At the NIH Clinical Center, physician-investigators appear to have cured a major form of sickle cell disease through experimental gene therapy. To further advance such gene replacement therapies, as well as cancer immunotherapy and immunotoxin therapy, both also pioneered at the NIH Clinical Center, we soon will open the Center for Cellular Engineering and a tumor infiltrating lymphocytes facility, situated very close to the Clinical Center. The two facilities will immensely improve the capacity to safety and rapidly create cell-based medicines and will lead to future cures.

Other Investments in Research and Development

ACL, through the NIDILRR, conducts research to generate new knowledge and promote its effective use to improve the abilities of people with disabilities to perform activities of their choice in the community, and to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. One such NIDILRR research effort is the monthly analysis and reporting of national trends in the employment rates of people with disabilities, coinciding with the Monthly Jobs Report provided by the U.S. Bureau of Labor Statistics.

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

HRSA conducts health services research that will improve the quality of health care, increase capacity, and promote evidence-based decision-making. MCH research is to support the MCH field, improving the health and well-being of women, children, and families. The Federal Office of Rural Health Policy funds the Rural Health Research Center Program which supports policy oriented health services research on key rural health issues. Healthcare Systems Bureau (HSB) Division of Transplantation supports applied research to identify successful model interventions designed to increase deceased organ donation registration and family consent; to educate the public about living organ donation; and to remove financial barriers to living organ donation. The Division of Poison Control and Healthcare Facilities, also under HSB, conducts survey research to assess overall awareness and use of the Poison Help Phone Line, poison centers and the services they provide. HRSA's basic research supports the diagnosis, transmission, prevention, and treatment of Hansen's disease.

Required Supplementary Information

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2019

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Fund	Medicaid	Other Agency Accounts	Agency Combined Totals
Budgetary Resources						
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 11	$ 55	$ 18,722	$ 60,625	$ 41,436	$ 120,849
Appropriations (Discretionary and Mandatory)	331,476	371,498	402,347	406,923	265,446	1,777,690
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	5	5
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,182	24,439	25,621
Total Budgetary Resources	**$ 331,487**	**$ 371,553**	**$ 421,069**	**$ 468,730**	**$ 331,326**	**$ 1,924,165**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 331,487	$ 371,553	$ 373,052	$ 454,051	$ 284,637	$ 1,814,780
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	29,312	62	20,982	50,356
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	172	172
Unapportioned, Unexpired Accounts	-	-	-	14,617	16,359	30,976
Unexpired Unobligated Balance, End of Year	-	-	29,312	14,679	37,513	81,504
Expired Unobligated Balance, End of Year	-	-	18,705	-	9,176	27,881
Unobligated Balance, End of Year	-	-	48,017	14,679	46,689	109,385
Total Status of Budgetary Resources	**$ 331,487**	**$ 371,553**	**$ 421,069**	**$ 468,730**	**$ 331,326**	**$ 1,924,165**
Outlays, Net						
Outlays, Net (Discretionary and Mandatory)	$ 327,856	$ 367,587	$ 358,881	$ 404,899	$ 247,091	$ 1,706,314
Distributed Offsetting Receipts	(35,733)	(454,676)	-	-	(2,283)	(492,692)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 292,123**	**$ (87,089)**	**$ 358,881**	**$ 404,899**	**$ 244,808**	**$ 1,213,622**

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 65,152	$ 55,435
ACL	2,254	2,023
AHRQ	400	322
CDC	15,191	12,251
CMS	155,778	111,886
FDA	7,540	2,795
HRSA	12,896	11,569
IHS	9,912	5,455
NIH	45,970	34,815
OS	7,751	3,341
PSC	2,438	587
SAMHSA	6,044	4,329
Totals	**$ 331,326**	**$ 244,808**

Deferred Maintenance and Repairs

For the Years Ended September 30, 2019 and 2018

The FASAB issued SFFAS 42, *Deferred Maintenance and Repairs*: *Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32* effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repair activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service. Other factors under consideration are whether the asset meets applicable building codes, and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred.

CDC, NIH, and FDA use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. The landholding OpDivs prioritize their maintenance activities based on urgency and the best use of their limited resources, with life safety the top priority. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include Property, Plant and Equipment location, age, design etc. Equipment affixed to real property should be appropriately reflected in building and other structures.

Estimated Cost to Return to Acceptable Condition (in Millions)

Category of Asset	2019	2018
General PP&E		
Buildings	$ 2,533	$ 2,392
Other Structures	17	21
Total	**$ 2,550**	**$ 2,413**

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

Social Insurance

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

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

RSI material is generally drawn from the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this year's report are based on current law, certain features of which may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity[13] although these health providers have historically achieved lower levels of productivity growth. If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013); the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014); the *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015); and the *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2027 and by 4 percent from April 1, 2027 through September 30, 2027. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2027.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from specific provisions of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010* (referred to collectively as the *Affordable Care Act* or ACA) and the *Medicare Access and*

[13]For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

CHIP Reauthorization Act of 2015 (MACRA). These ACA and MACRA provisions lower increases in Medicare payment rates to most categories of health care providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting health care cost growth over time. The current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; (ii) the average physician payment updates would transition from current law to payment updates that reflect the Medicare Economic Index; and (iii) the 5-percent bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and the $500-million payments for physicians in the merit-based incentive payment system (MIPS) would continue indefinitely rather than expire in 2025. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA[14] and ACA[15] cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 24 in these financial statements, in section V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/.

[14]Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced APMs or MIPS, respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.2 percent per year in the long range.

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

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[16] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[17]

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

Prior to the ACA, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services.[18] To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the ACA were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall. The ACA requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range—a lower rate than that of 1.1 percent assumed in the 2018 report. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care provider services:

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

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 4.0 percent in 2043, or GDP plus 0.1 percent, declining gradually to 3.6 percent in 2093, or GDP minus 0.2 percent.[19]

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[16]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which the Trustees estimated separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

[17]The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel and with Finding 3-2 of the 2016-2017 Medicare Technical Review Panel. The Panels' final reports are available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdfand at https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf.

[18]Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices.

[19]These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

(ii) ***Physician services***

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year per capita growth rates for physician payments are assumed to be 3.4 percent in 2043, or GDP minus 0.5 percent, declining to 2.8 percent in 2093, or GDP minus 1.0 percent.

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

Such services include durable medical equipment that is not subject to competitive bidding,[20] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.2 percent in 2043, or GDP minus 0.7 percent, declining to 2.8 percent in 2093, or GDP minus 1.0 percent.

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

These Part B outlays constitute an estimated 21 percent of total Part B expenditures in 2027 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[21] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.7 percent in 2043, or GDP plus 0.8 percent, declining to 4.3 percent by 2093, or GDP plus 0.5 percent.

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

After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 3.7 percent per year for the last 50 years of the projection period, or GDP minus 0.2 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.8 percent over this same time period or GDP minus 0.1 percent, while the growth rate in 2093 is 3.7 percent or GDP minus 0.1 percent.

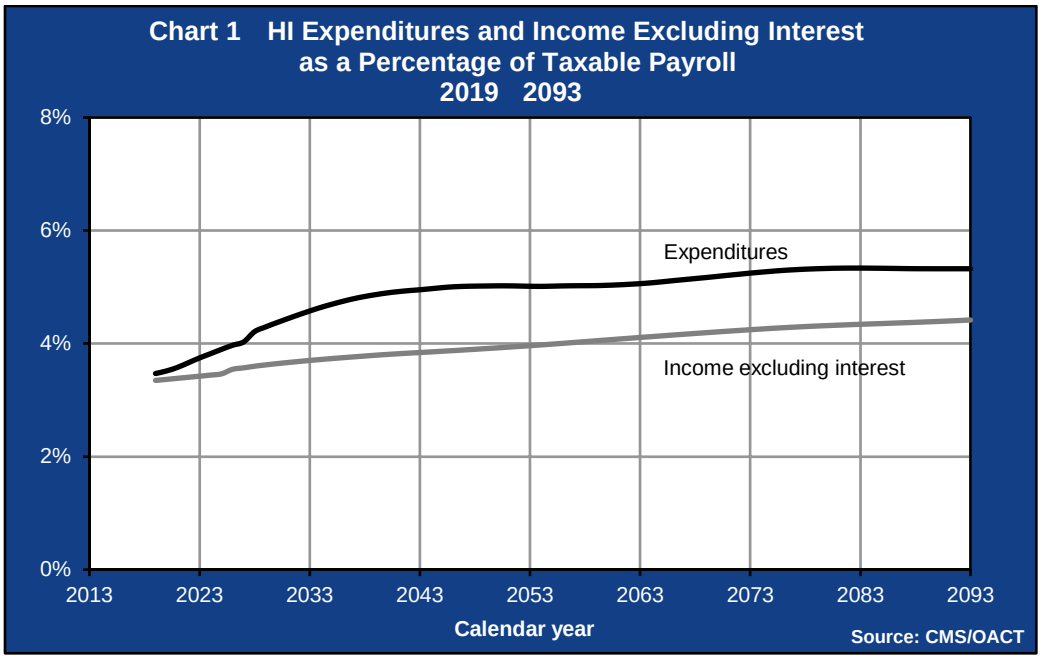
HI Cash Flow as a Percentage of Taxable Payroll

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

[20]The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process.

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2019 report are higher than those from the 2018 report for all years largely due to higher spending and lower taxable payroll in all projected years.



Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

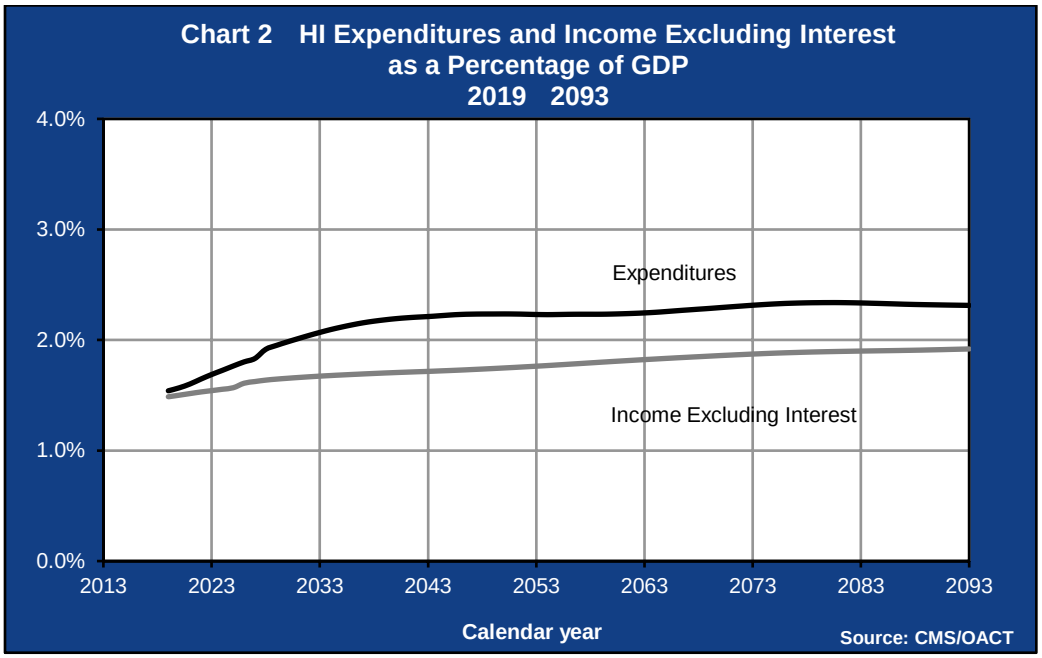
In 2019 and beyond, as indicated in Chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2028 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2044 and 7.9 percent in 2093.

HI and SMI Cash Flow as a Percentage of GDP

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

HI

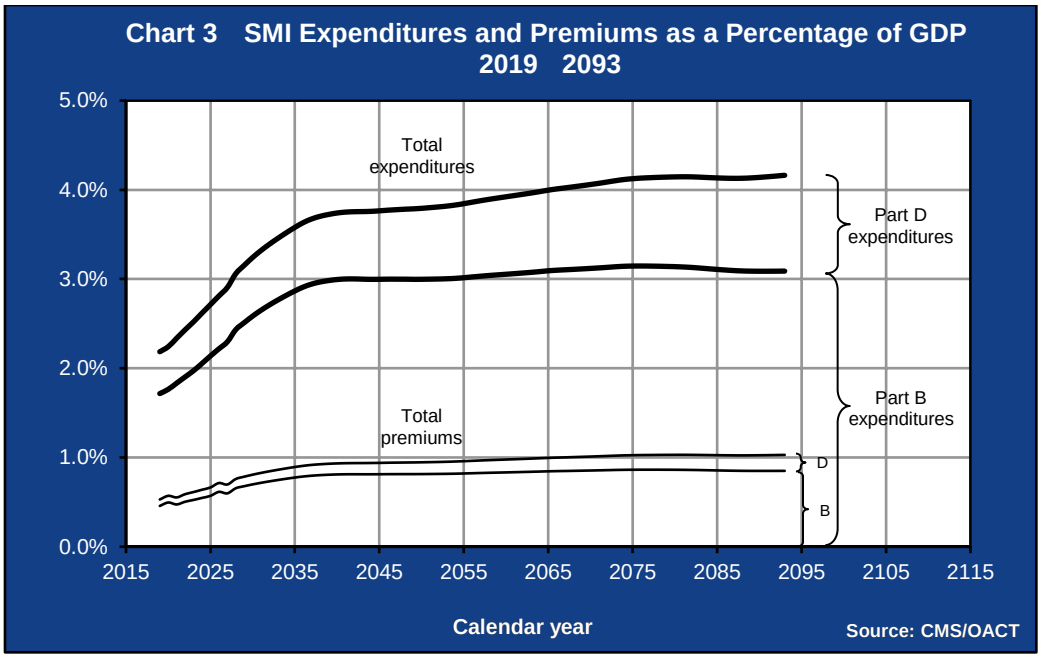
Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2018, the expenditures were $308.2 billion, which was 1.5 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.4 percent in 2093.



SMI

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

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



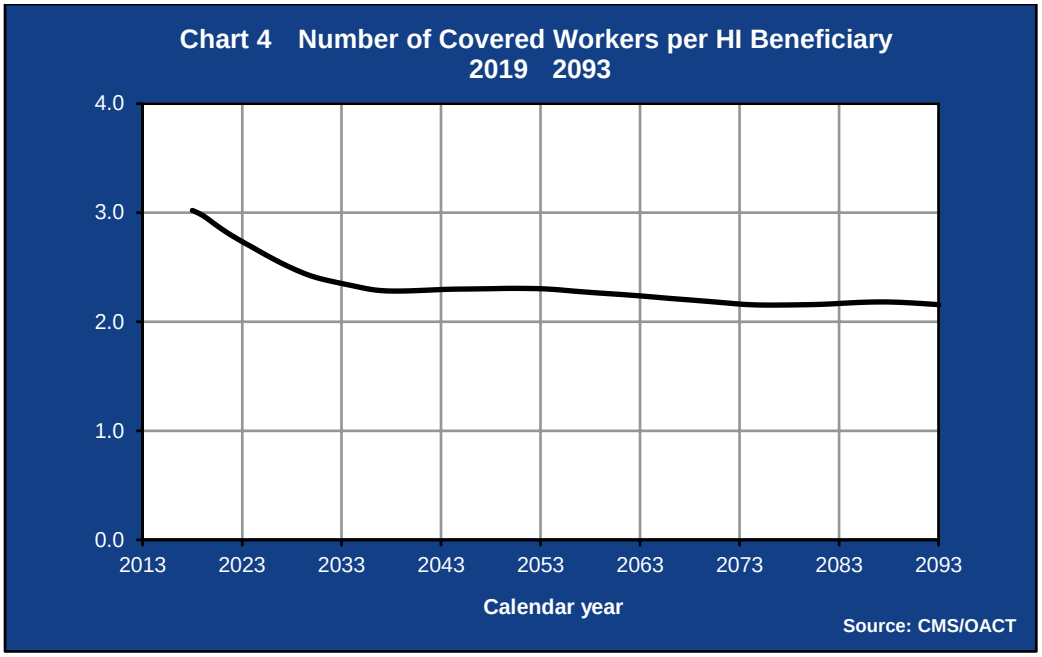
In 2018, SMI expenditures were $432.4 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.8 percent of GDP within 25 years and to 4.2 percent by the end of the projection period, as demonstrated in Chart 3. (Under the illustrative alternative, total SMI expenditures in 2093 would be 5.6 percent of GDP.)

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2018 by about 4.4 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

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



In 2018, every beneficiary had about 3.0 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 for each beneficiary, as indicated in Chart 4. The projected ratio continues to decline until there are only 2.2 workers per beneficiary by 2093.

Sensitivity Analysis

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

To illustrate the sensitivity of the long range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually. [22] The assumptions varied are the health care cost factors, real wage differential, CPI, real interest rate, fertility rate, and net immigration.[23]

For this analysis, the intermediate economic and demographic assumptions in the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund*s are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2019 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

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

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

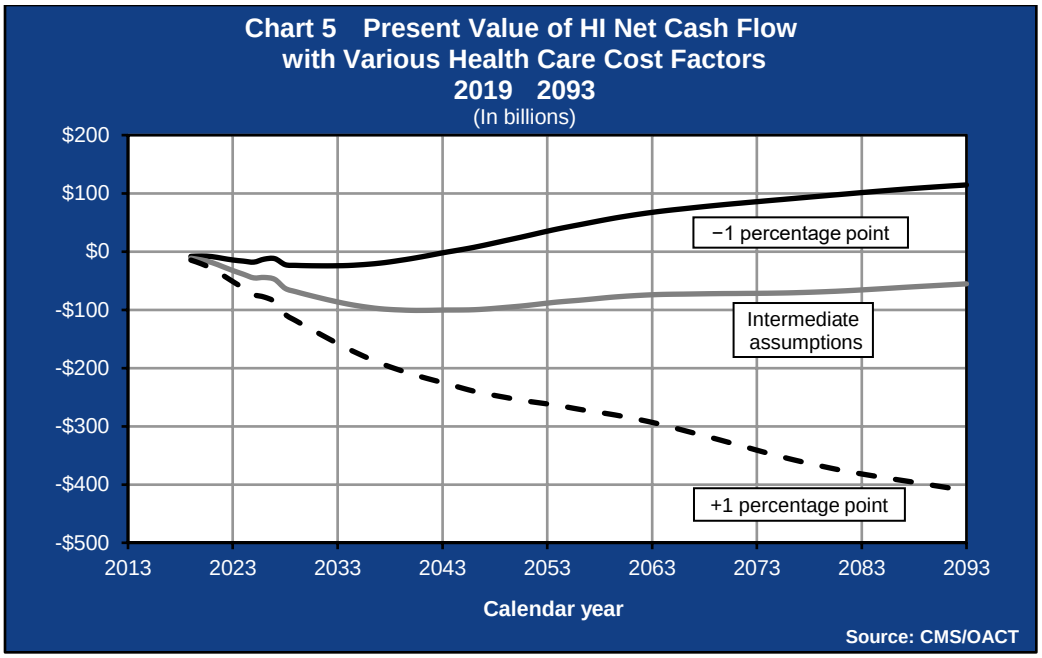
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$3,122	-$5,484	-$19,321

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,606 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $13,837 billion.

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

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

[23]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.



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus due to the improved financial outlook for the HI trust fund as a result of the ACA. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

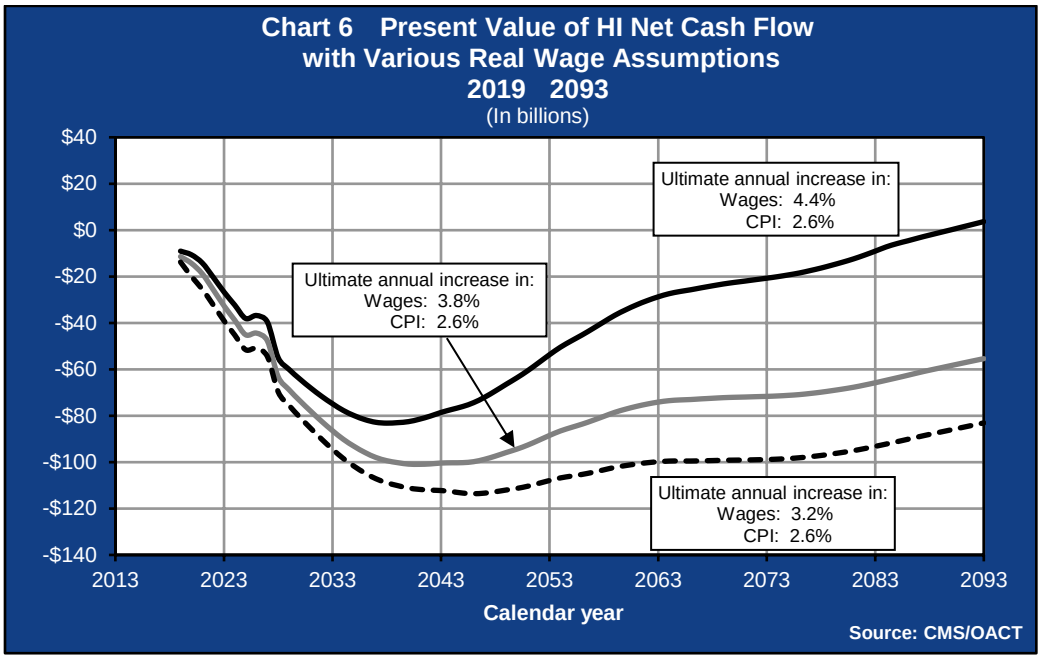
Table 2 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[24] In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.4 percent, respectively.

Table 2 Present Value of Estimated HI Income Less Expenditures under Various Real Wage Assumptions			
Ultimate percentage increase in wages - CPI	3.2 – 2.6	3.8 – 2.6	4.4 – 2.6
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	−$6,887	−$5,484	−$2,898

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,155 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,170 billion.

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

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



Faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars, as demonstrated in Chart 6. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the ACA and MACRA depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

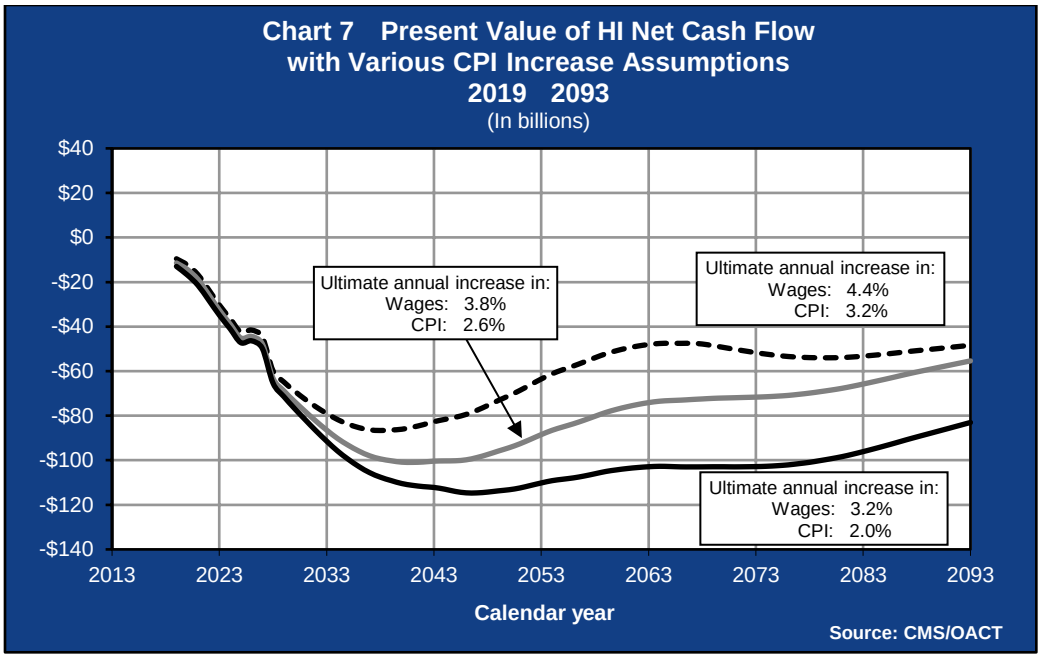
Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.2, 2.6, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.4, 3.8, and 3.2 percent, respectively.

Table 3 Present Value of Estimated HI Income Less Expenditures under Various CPI Increase Assumptions			
Ultimate percentage increase in wages - CPI	4.4 – 3.2	3.8 – 2.6	3.2 – 2.0
Income minus expenditures (in billions)	−$4,331	−$5,484	−$6,946

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.2 percent, the deficit decreases by $1,153 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,462 billion.

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



This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the ACA for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

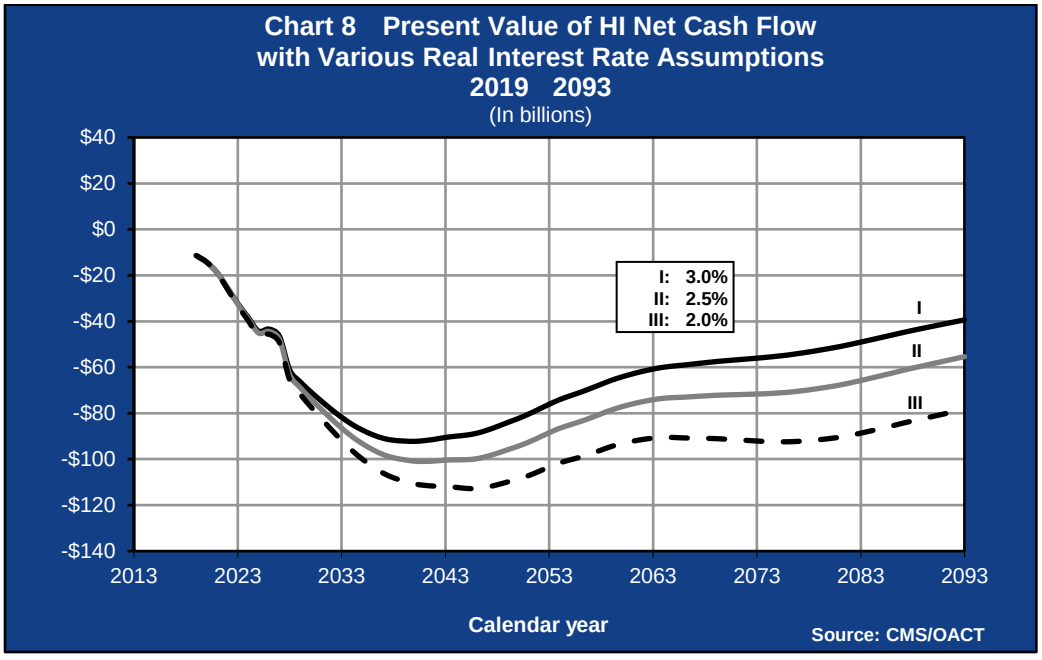
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.0, 2.5, and 3.0 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.6, 5.1, and 5.6 percent, respectively.

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

Ultimate real-interest rate	2.0 percent	2.5 percent	3.0 percent
Income minus expenditures (in billions)	-$6,534	-$5,484	-$4,664

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

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



The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in Chart 8. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

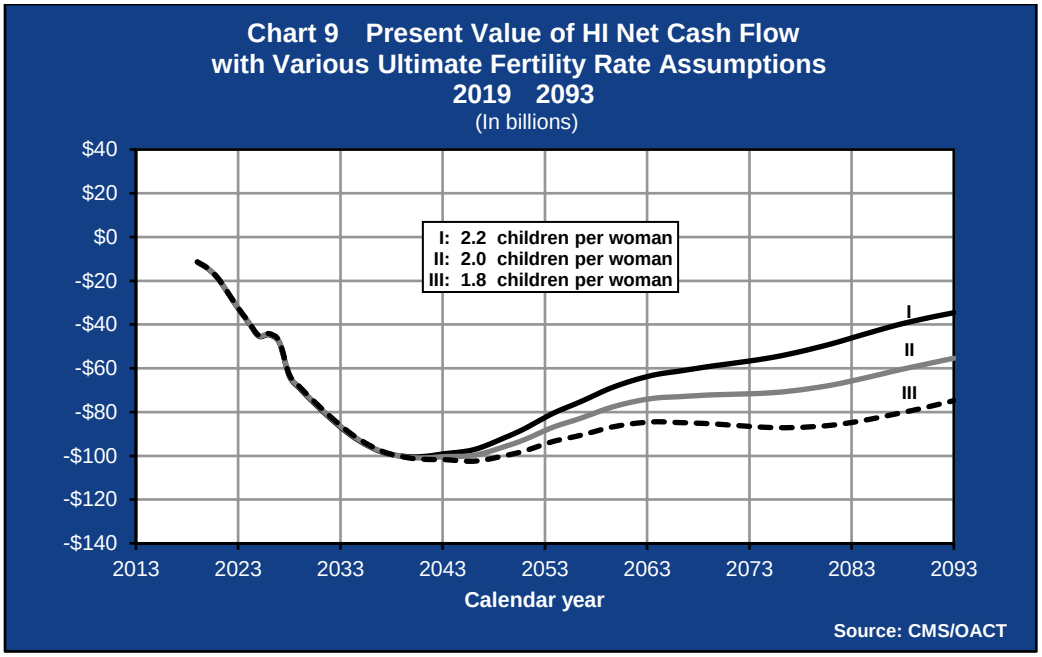
Table 5 Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.8	2.0	2.2
Income minus expenditures (in billions)	−$6,105	−$5,484	−$4,851

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

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $625 billion.

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



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

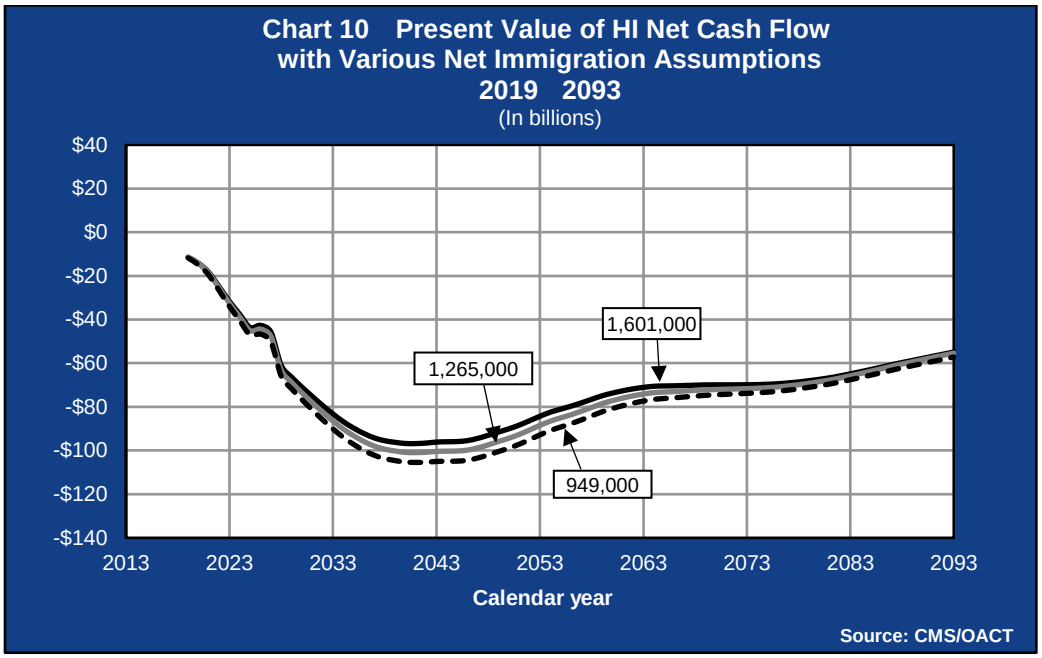
Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 949,000 persons, 1,265,000 persons, and 1,601,000 persons per year.

Table 6 Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions			
Average annual net immigration	949,000	1,265,000	1,601,000
Income minus expenditures (in billions)	−$5,705	−$5,484	−$5,299

As indicated in Table 6, if the average annual net immigration assumption is 949,000 persons, the deficit—expressed in present-value dollars—increases by $222 billion. Conversely, if the assumption is 1,601,000 persons, the deficit decreases by $185 billion.

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



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

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is similar to the projections in last year's annual report. The estimated depletion date for the HI trust fund is 2026, the same as in the 2018 report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI income is projected to be lower than last year's estimates due to lower payroll taxes and lower income from the taxation of Social Security benefits. HI expenditures are projected to be slightly higher than last year's estimates because of higher-than-projected 2018 spending and higher projected provider payment updates, factors that are mostly offset by the effect of lower assumed utilization of skilled nursing facility services.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, once again expenditures exceeded income, and there was a trust fund deficit of $1.6 billion. The Trustees project deficits in all future years until the trust fund becomes depleted in 2026. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

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

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

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[25] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2019-2025). For the 2019 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2021, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2021 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 report. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2019 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges."

[25]Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

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