CMS Financial Report

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AT A GLANCE

The Centers for Medicare & Medicaid Services (CMS) is an operating division within the Department of Health and Human Services (HHS). The CMS Agency Financial Report for fiscal year (FY) 2025 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

1. **Management's Discussion & Analysis**

   This section gives an overview of our organization, programs, performance goals, and overview of financial data.

2. **Financial Section**

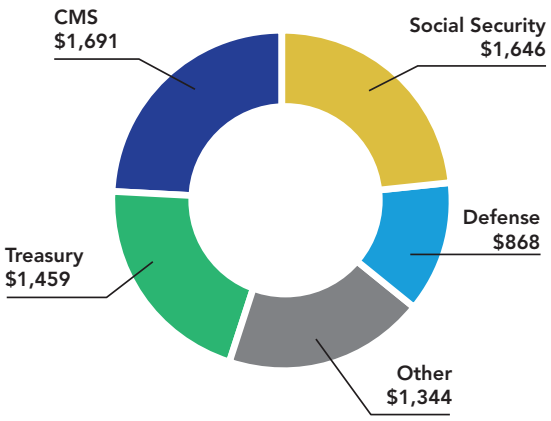
   This section contains the message from our Chief Financial Officer, financial statements and notes, required supplementary information, and audit reports.

3. **Other Information**

   This section includes Other Financial Information, Summary of the Federal Managers' Financial Integrity Act Report and the Office of Management and Budget (OMB) Circular A-123 Management Responsibility for Enterprise Risk Management and Internal Control.

2025 Federal Outlays

CMS has outlays of approximately $1,691 billion (net of offsetting receipts and Payments to the Healthcare Trust Funds) in fiscal year (FY) 2025, 24 percent of total Federal outlays. CMS employs approximately 5,900 Federal employees, but does most of its work through third parties. CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. CMS also assures the safety and quality of medical facilities, provides health insurance protection to workers changing jobs, and maintains the largest collection of health care data in the United States (U.S.).

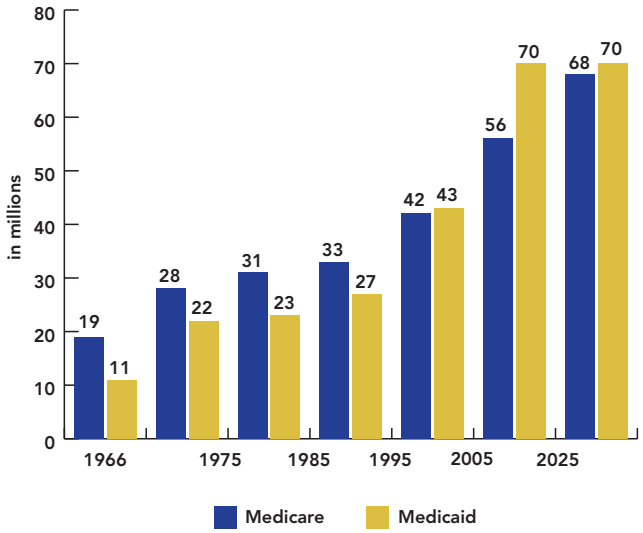


$ in billions

Source: U.S. Department of the Treasury

2025 Program Enrollment

CMS is one of the largest purchasers of health care in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to roughly 68 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 70 million beneficiaries.



A Message from the Administrator

I am proud to present the Centers for Medicare & Medicaid Services' (CMS) annual Agency Financial Report for fiscal year (FY) 2025. Since assuming the position of Administrator in April of this year, CMS has made meaningful progress on our mission of ensuring high value, quality health care for the most vulnerable among us.

Our number one priority at CMS is to preserve Medicare, Medicaid, and CHIP for those who need it by crushing fraud, waste and abuse, so we have launched a new era of integrity with modern tools, tighter oversight, and unrelenting enforcement. Our first act was to launch a CMS Fraud Defense Operations Center (FDOC) pilot, also known as the Fraud War Room, and we have now made this pilot program permanent. In part due to the efforts of the Fraud War Room, we have successfully prevented over $4 billion from being paid in response to false and fraudulent claims by using advanced data analytics, real-time monitoring, and swift administrative actions. Additional outcomes from our fraud crushing efforts include:

- Revoked Medicare billing privileges: 4,075 providers and suppliers
- Suspended Medicare payments: 441 Medicare payment suspensions preventing $3.4 billion of potentially fraudulent payments from going out of the door
- Stopped overpayments: $2.01 billion in overpayments through medical review

Another way we are further crushing waste, fraud, and abuse is by supporting the implementation of prior authorization only for items and procedures at high risk for fraud and abuse. The prior authorization system is broken, with patients often waiting much too long for coverage decisions. CMS has successfully secured pledges from health insurers to help fix the system through six reforms aimed at cutting red tape, accelerating care decisions, and enhancing transparency for patients and providers.

When used properly, and limitedly, prior authorization can be a valuable tool. But it is hardly ever utilized in fee-for-service Medicare. Our new Center for Medicare and Medicaid Innovation Wasteful and Inappropriate Service Reduction (WISeR) model, launching in 2026, is a model test program using enhanced technology, such as artificial intelligence (AI), in fee-for-service Medicare to help beneficiaries avoid harmful medical procedures that historically have had a higher risk of waste, fraud and abuse and also inflate healthcare costs. AI will help process authorizations more quickly, but appropriately licensed clinicians will always review any request not automatically affirmed and make the final decision. AI will never deny services on its own.



In Medicare Advantage (MA), the Department of Health and Human Services (HHS) recognizes the critical importance of Risk Adjustment Data Validation (RADV) audits in ensuring the accuracy and integrity of Medicare Advantage payments and oversight. As part of our ongoing commitment to safeguarding the Medicare program and ensuring data accuracy of risk adjusted payments, we have designated RADV audits a top priority. The implementation of RADV is essential for identifying MA overpayments, promoting accurate data submissions by MA organizations, and maintaining the financial sustainability of the Medicare program. By prioritizing RADV, we aim to enhance accountability of MA organizations, underscore its commitment to rigorous oversight, and uphold the highest standards of accuracy and fairness of the Medicare program.

We are also committed to lowering prescription drug costs and ensuring Medicare beneficiaries have access to necessary medications at lower, agreed-upon prices. We negotiated and reached agreement with the manufacturers of all 15 drugs covered under Part D selected for the second cycle of the Medicare Drug Price Negotiation Program. By establishing better prices for high-cost drugs, CMS ensures patients experience financial relief at the pharmacy counter.

Additionally, we are actively testing enhancements for Medicare Open Enrollment. These include giving beneficiaries the ability to search for plans based on the providers they see and select plans that include their providers in-network; an AI drug search that will provide conversational search experience that gives accurate and actionable drug cost and coverage information; and Passkeys to log into a Medicare account.

In other ways to help Medicare beneficiaries, CMS is issuing a request for information to gather recommendations on improving wellness, prevention, and chronic disease management—all "Make America Healthy Again" goals. This includes input on nutrition counseling and physical activity. We added five new outcome measures that focus on the prevention of chronic disease, including prescreening for diabetes, in the 2026 Medicare Physician Fee Schedule. We are also planning augmentations to the Medicare Diabetes Prevention Program (MDPP) Model, broadening eligibility and access to the MDPP Model—offering coaching, peer support, and proven strategies to delay or prevent Type 2 diabetes at no cost to beneficiaries with prediabetes. The CMS Innovation Center also is exploring evidence-based prevention strategies and lifestyle modification for women, children, and seniors in the coming months.

We are also working to specifically help Medicaid beneficiaries. For example, we are developing guidance for states on expectations for providing healthy, nutritious, medically tailored meals for Medicaid enrollees.

Our Medicaid status quo is particularly harming rural residents. Our rural healthcare infrastructure is collapsing. With Public Law 119-21, which CMS refers to as the Working Families Tax Cuts Legislation, President Trump and Congress are delivering unprecedented investments to rebuild our rural health care infrastructure. Thanks to this law, CMS has been entrusted with stewardship of $50 billion to transform rural health care delivery. All 50 states applied to receive funds, and CMS will announce approved awardees by December 31, 2025. CMS will partner with states on transformation plans that must be designed to: improve health care access and outcomes for rural residents; strengthen partnerships between rural hospitals and other health care providers; leverage data- and tech-driven solutions to advance rural health care delivery and outcomes; and manage long-term financial solvency of rural hospitals.

Across CMS, we are also working to help beneficiaries by creating a culture of patient safety. Our new final rules will not allow hospitals in the lowest quartile of the Safety of Care measure groups to receive five star ratings from CMS. With medical errors being one of the leading causes of death in the U.S., we have also strengthened and improved the quality measures that track the most common preventable harms and how often they are occurring in facilities. These measures include: health care-acquired conditions; health care-associated infections; medication events, maternal morbidity and mortality; and diagnostic errors.

Additionally, we are working to protect our vulnerable nursing home patients. There is a shortage of nursing staff in every state in America, impacting the quality of care for nursing home residents across the country. I sent a letter to the governors of all 50 states introducing a great opportunity to take bold action and tackle nursing home staff shortages. CMS is investing over $75 million in a new campaign to augment the supply of nurses and nursing aides, to train and retain them for nursing home residents. This campaign is funded by dollars collected from a portion of civil monetary penalties imposed against nursing homes that are found to be out of compliance with federal requirements. The money will fund programs that benefit residents and protect or improve their quality of care and life, such as programs to support certain recruiting incentives like tuition reimbursement and stipends. States may also use the funds to streamline their state-approved nursing aide training and competency evaluation programs. States can bolster the campaign by investing a portion of their civil monetary penalty funds, and CMS will proportionately match each state's contribution.

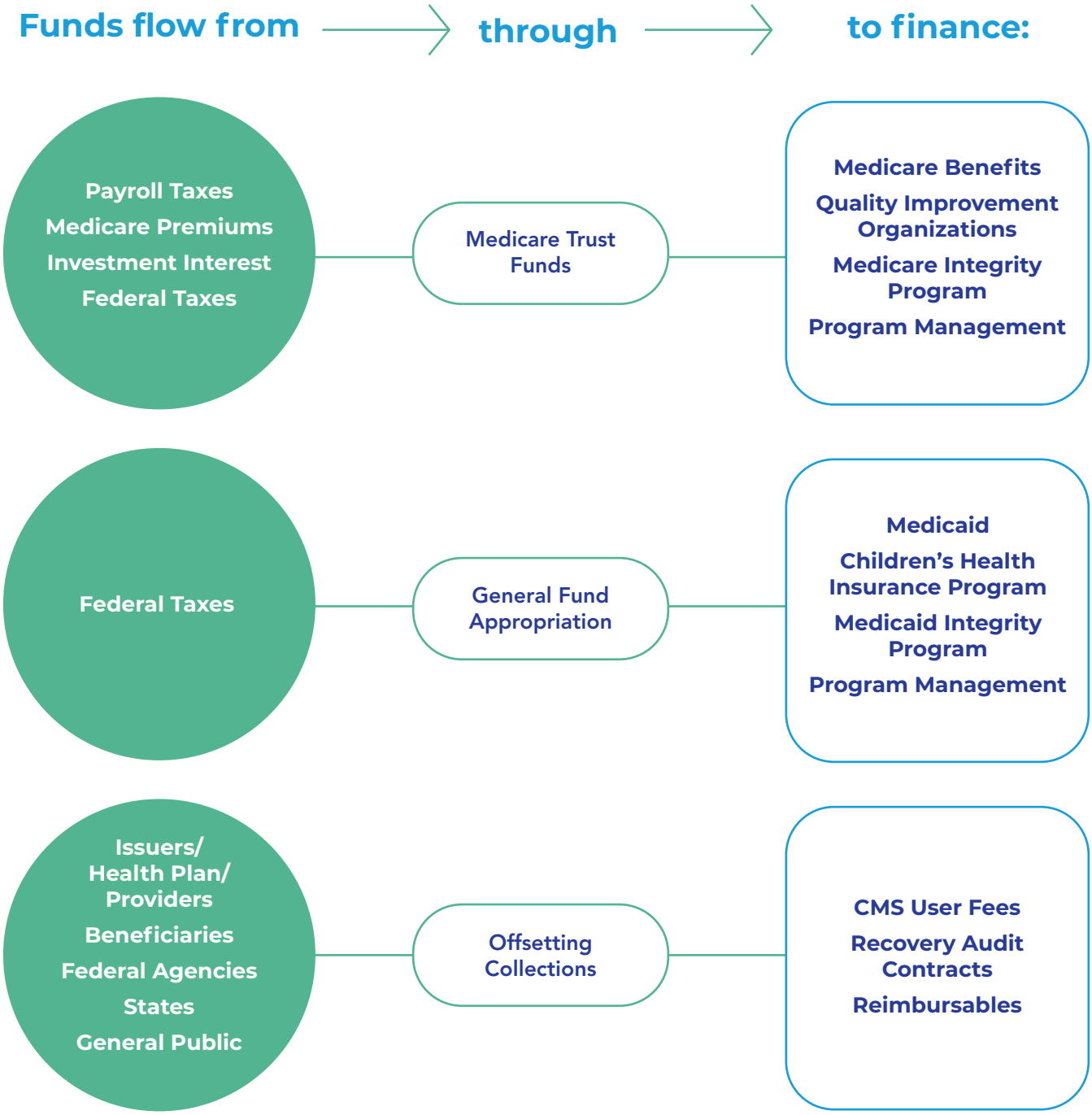
We are also working to aid healthcare providers by creating the necessary apps and services that will do away with repetitive forms, clipboards, and faxing, making healthcare solutions that are smart and secure. We are building a dynamic, interoperable national provider directory; bringing modern identity verification to Medicare.gov to streamline credentials across the healthcare system; expanding CMS's Blue Button 2.0 API; transitioning CMS's Data at the Point of Care pilot to general availability; and enhancing CMS's participation in trusted data exchange.

To help hospital and outpatient facilities better serve patients, we are freeing them from unnecessary red tape. In our FY 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, we have removed four outdated quality measures from the Hospital Inpatient Quality Reporting Program. We are also implementing policies that encourage appropriate care delivery while expanding patient choice. Specifically, in our Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center payment system Final Rule, we are making payments the same for drug administration services provided at a hospital or physician office; strengthening hospital price transparency; and improving the Hospital Star Rating System.

We have accomplished so much in a short period of time, but there is still so much more to do. I am grateful for the dedication of our fantastic CMS team, all working hard together to realize our goals of ensuring high value, quality health care for the most vulnerable among us and achieving better health for all Americans.

Dr. Mehmet Oz
Administrator

Financing of CMS Programs & Operations



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Our Organization

CMS, a division of the Department of Health and Human Services (HHS), employs approximately 5,900 federal employees in Maryland, Washington, DC, and many other states throughout the country. CMS provides direct services to state agencies, health care providers and suppliers, individuals with Medicare, sponsors of group health plans, Medicare health and prescription drug plans, and the general public.

CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from improper payments including fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. In addition, CMS's staff provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

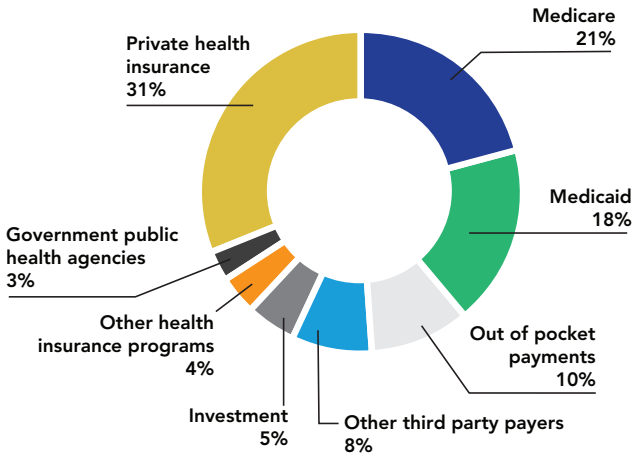
CMS also contracts and/or partners with third parties to operate many of its important activities. Each state administers a Medicaid program and a Children's Health Insurance Program (CHIP). States inspect hospitals, nursing homes, and other facilities to ensure health and safety standards are met. The Medicare Administrative Contractors (MACs) process claims, provide technical education to providers, review medical records, enroll providers, perform a host of financial audit and overpayment recovery services, adjudicate first level appeals, and answer inquiries from Medicare providers. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care is provided to individuals with Medicare. The CMS Tribal Technical Advisory Group (TTAG) assists the agency to optimize Tribal Health Care working with QIOs and the priorities set forth by the TTAG, and with the Center for Clinical Standards and Quality's ongoing quality engagement.

Overview

As the largest single health payer in the U.S., CMS administers Medicare, Medicaid, CHIP, the Federally Facilitated Exchange, and the *Clinical Laboratory Improvement Act of 1988* (CLIA) program. CMS now maintains the nation's largest collection of health care data.

According to 2025 projections[1], Medicare and Medicaid (including state funding) represent 39 cents of every dollar spent on health care in the U.S.— or looked at from three different perspectives: 51 cents of every dollar spent on nursing homes, 43 cents of every dollar received by U.S. hospitals, and 38 cents of every dollar spent on physician services.

The Nation's Health Care Dollar, 2025



[1] CMS, National Health Expenditure Projections, 2024-2033. CMS.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

Medicare

Title XVIII of the *Social Security Act* established Medicare in 1965. It was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program expanded to cover people with disabilities and people with End-Stage Renal Disease (ESRD). The *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA) further expanded the Medicare program, which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006. Medicare routinely processes over one billion fee-for-service (FFS) claims a year and accounts for approximately 14.6 percent of total federal outlays. Medicare is a combination of four programs: Hospital Insurance (HI), Supplementary Medical Insurance (SMI), Medicare Advantage (MA), and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to roughly 68 million individuals.

Hospital Insurance

Hospital Insurance, also known as HI, is provided to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most people entitled to Social Security or Railroad Retirement benefits. Most people do not pay a premium for HI because they or their spouse already paid for it through their payroll taxes while working (generally at least 10 years). The HI program pays for inpatient hospital, skilled nursing facility (SNF), certain home health, and hospice care, and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current individuals with Medicare.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI, is voluntary and available to nearly all people aged 65 and over, people with disabilities, and people with ESRD who are entitled to HI benefits. Medicare SMI pays for doctors' services and outpatient care, certain home health care, laboratory tests, ambulance services, durable medical equipment, designated therapy, and certain drugs. SMI pays for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and individuals who elect SMI are subject to monthly premium payments.

Medicare Advantage

The *Balanced Budget Act of 1997* established the Medicare+Choice program, now known as the Medicare Advantage (MA) program, to provide more health care coverage choices for individuals with Medicare. Those who are eligible because of age (65 or older) or disability may choose to join a MA commercial plan servicing their area if they are entitled to HI and enrolled in SMI. Those who are eligible for Medicare because of ESRD could join a MA plan beginning January 1, 2021. Medicare beneficiaries have the option to choose to enroll in health care plans that contract with CMS instead of receiving services under FFS arrangements offered under original Medicare. Many MA plans offer supplemental benefits such as prescription drugs, vision, and dental benefits, and offer different out-of-pocket cost sharing arrangements. MA plans assume full financial risk for care provided to their Medicare enrollees. Individuals with Medicare can also enroll in cost plans where they can receive services through the cost plan's network or original Medicare.

Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit is an optional prescription drug benefit created by the MMA for individuals with Medicare. Eligible individuals have the opportunity to enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dually eligible) are automatically enrolled in the Medicare Prescription Drug Benefit program; assistance with premiums and cost sharing is available to full-benefit dually eligible and other qualified low-income individuals.

Medicaid

Title XIX of the *Social Security Act* established the Medicaid program in 1965. Medicaid is administered by CMS in partnership with the states. Although the federal government establishes certain parameters for all states to follow, each state administers its Medicaid program differently, resulting in variations in Medicaid coverage across the country. States have flexibility in determining Medicaid eligibility and benefit packages within federal guidelines; however, all states' Medicaid programs are required to cover certain mandatory eligibility groups and benefits. States have additional options for coverage and may choose to cover other groups, such as covering home and community-based services (HCBS) or providing eligibility to children with state-funded adoption assistance. States and the federal government jointly fund the Medicaid program. CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs.

Medicaid provides access to comprehensive health coverage that may not be affordable otherwise for millions of Americans, including eligible low-income adults, children, pregnant women, older adults, and people with disabilities. Medicaid is the primary source of health care for over 70 million individuals. Over 12 million people are dually eligible for both Medicare and Medicaid. Medicaid is also the largest payer across the nation for long-term care.

CHIP

CHIP was created through the *Balanced Budget Act of 1997* and provides health coverage to low-income uninsured children and pregnant women whose income is too high to qualify for Medicaid. Title XXI of the *Social Security Act* outlines the program's structure and establishes a partnership between federal and state governments. States administer CHIP according to federal requirements while working closely with CMS, and other federal agencies. CMS ensures state programs meet statutory requirements designed to ensure meaningful coverage. CMS provides extensive guidance and technical assistance so states can further develop their CHIP state plans and use federal funds to provide health care coverage. CHIP funds cover the cost of health care services, reasonable costs for administration, and outreach services to enroll children.

States are given broad flexibility in designing their programs, such as choosing to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. In addition, states can create or expand their own separate CHIP programs, expand Medicaid, or combine both approaches. Over seven million individuals are enrolled in CHIP.

CLIA

CLIA legislation expanded the survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes, regardless of location. CMS regulates all laboratory testing on patients, including those performed in physicians' offices, for approximately 304,000 facilities.

The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS divisions: CMS, the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). CMS manages the overall CLIA program, including its regulatory and financial aspects. This includes enrollment, regulation, and policy development; approval of accrediting organizations and exempt states; proficiency testing and certification of providers; and enforcement. CDC provides research, technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while FDA performs test categorization.

Private Health Insurance and Health Insurance Exchanges

CMS oversees compliance with private health insurance reforms and works with health insurance issuers to increase industry transparency. CMS also facilitates access to private health insurance through the oversight of the Health Insurance Exchange (Exchanges) where health insurance issuers compete based on price and quality. Through these activities, CMS expands access to quality, affordable health coverage and care.

CMS works with states to ensure issuers comply with market reforms through policies like the federal prohibition on denying coverage for pre-existing conditions, the prohibition on annual and lifetime dollar limits on essential health benefits, and rating requirements. CMS also implements a process for states or CMS to review rates of non-grandfathered health insurance products in the individual and small group markets to determine compliance with federal health insurance rating rules. CMS is also responsible for enforcing compliance with a federal minimum Medical Loss Ratio (MLR) requiring health insurance issuers to spend a predetermined portion of premium revenues on clinical services and quality improvement or provide a rebate to policyholders if the MLR standard is not met. By ensuring issuer compliance with specific market reforms, CMS is expanding consumers' access to quality, affordable health coverage and care.

Performance Management

Performance measures provide valuable information on the success of CMS's programs and activities. CMS uses these measures to identify improvement opportunities and to shape its programs. Performance measures clearly communicate CMS's programmatic objectives to the public and our partners, such as states and national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term.

The *Government Performance and Results Act of 1993* (GPRA) mandates that cabinet-level agencies have strategic plans, annual performance goals, and annual performance reports that encourage accountable stewardship of public programs.

As required by the *GPRA Modernization Act of 2010*, HHS released the **FY 2026 Agency Performance Plan** in May 2025, which features key CMS performance measures. Consistent with GPRA principles, the CMS GPRA performance goals reinforce the mission, goals, and objectives of the Administration. We look forward to the challenges represented by our performance goals and are optimistic in our ability to meet them.

Our FY 2025 performance measures track progress in our major program areas, including crushing fraud, waste, and abuse across CMS programs. In addition, we measure quality improvement initiatives geared toward the most vulnerable patients and taxpayers who are served by the Medicare, Medicaid, CHIP, and QIO programs. Detailed CMS performance measure information and available results are included in the **CMS Budget**. Progress on our measures has been reported through the FY 2026 President's Budget process.

The *Foundations for Evidence-based Policymaking Act of 2018* (also referred to as the *Evidence Act*) was established to advance evidence-building in the federal government by improving access to data and expanding evaluation capacity. The *Evidence Act* requires changes to how the federal government manages and uses the information it collects, emphasizing strong agency coordination for the strategic use of data.

In 2025, HHS streamlined the number of *Evidence Act* reports by consolidating the 4-year Evidence-Building Plans (also known as Learning Agendas) with the annual Evaluation Plans into one annual document known as the Evidence Plan. The Evidence Plan is an annual report that will outline evidence-building priorities, priority questions, and the methods and data required to answer them. The Evidence Plan will include evaluations and analyses agencies aim to undertake to answer the priority questions. Additionally, CMS coordinates with HHS on the **FY 2023-2026 HHS Capacity Assessment** which is a four-year agency evaluation of evidence-building capacity and functions. While the Capacity Assessment is conducted every four years, updates are made on an annual basis and submitted in conjunction with the Annual Performance Plan.

CMS's FY 2025 Mission Statement and Overarching Goals

CMS's mission is straightforward. For FY 2025 and beyond, **our mission is to ensure our most vulnerable receive high-value care by leading all payors and supporting providers.**

CMS aims to achieve this mission through the work of thousands of dedicated individuals who are committed to improving people's lives through public policy aimed at making the U.S. health care system work better for everyone under the presidential vision—**Make America Healthy Again (MAHA).**

Leading Payor
Establish the CMS team as the indisputable leading payor in the country.

Crush Fraud
Crush fraud and reduce inappropriate spending.

Empower Beneficiaries
Empower beneficiaries with personalized, actionable health tools to support informed decision making and care navigation.

Incentivize Providers
Incentivize providers to maximize focus on delivering their best, data-driven care possible.

Align Spending & Value
Partner intentionally with CMS stakeholders to better align spending and value.

Strategic Objectives (Themes/Pillars)

Our work is organized and managed along five CMS strategic objectives that promote the establishment of broad programmatic goals. All of CMS's centers and offices are actively developing and implementing projects to collaboratively advance these strategic objectives across the agency. The following pages provide examples of some of the initiatives we have taken to achieve these strategic objectives under the overall vision of MAHA.

Leading Payor

CMS will continue to position itself as one of the largest purchasers of health care in the world. As a trusted steward of public funds, this will be achieved by continuously maintaining the strongest organizational foundation, being more innovative, and attracting the best talent into our organization. To continue maintaining our position as a leading payor, CMS implemented the following initiatives in FY 2025:

- Executed President Trump's Executive Order, "Establishing the President's Make America Healthy Again Commission." Six in ten Americans have at least one chronic disease, and four in ten have two or more chronic diseases. As such, focusing on the prevention and management of chronic disease is a top priority for CMS. The Administration is directing our focus toward understanding and drastically lowering chronic disease rates, including thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. In the calendar year (CY) 2026 Medicare Physician Fee Schedule, CMS has broadly solicited feedback to better understand how to enhance and support the prevention and management of chronic disease, thereby committing to its overall strategic objective of becoming a leading payor.
- Continued to expand the Program for All Inclusive Care for the Elderly (PACE) programs. CMS developed comprehensive heat maps and proposed innovative approaches to program expansion, contributing to strategic planning that supports CMS's position as the leading payor for specialized populations requiring coordinated care services. Additionally, in pursuit of becoming a leading payor, CMS completed 20 Medicare Advantage/PACE program audits to ensure continued program integrity and sustainability.
- Continued to demonstrate exceptional operational excellence by maintaining comprehensive oversight of 99 Marketplace issuers serving 14 million consumers on the federal platform in calendar year 2025, while successfully processed Qualified Health Plans (QHP) applications with 100 percent compliance.
- Published the Medicare Advantage Risk Adjustment Data Validation Level II Appeals guidance in July 2025; a key document in the process of ensuring Medicare Advantage Plans are paid correctly based on the health status and expected medical costs of their enrollees.
- Completed documentation of Medicare premium payment business rules**.** These payment rules automated Income Related Monthly Adjusted Amount-Part D refunds, reducing manual actions and enabling faster disbursement of refunds to beneficiaries. These updated processes will reduce the number of interactions between the Social Security Administration and CMS, resulting in payments being applied to beneficiary records more quickly.

Crush Fraud

Crushing fraud by working tirelessly to eliminate the incidents of waste, abuse, and fraudulent activities in our health care system remains a cornerstone of CMS. This strategic objective will help ensure CMS has advanced detection, robust oversight, preventative policies, and collaborative actions to recover funds. In our unwavering commitment to crush fraud, CMS implemented the following notable initiatives in FY 2025:

- Integrated Veterans Health Administration (VHA) data into the Integrated Data Repository (IDR), enabling a first-of-its-kind data sharing and analysis process to address long-standing program integrity risks. Medicare and VHA have faced the potential for duplicate payments to providers serving dually entitled beneficiaries. As a result of this integration and new dataset, CMS now has an operational process and data-driven capability to detect and recover duplicate payments in collaboration with the VHA. The initial analysis identified $101 million in recoverable Medicare payments, with recovery efforts beginning summer 2025. This milestone strengthens CMS's Program Integrity mission, safeguards Medicare Trust Funds, and sets the foundation for ongoing cross-agency collaboration.
- Finalized the Marketplace Integrity and Affordability rule to stabilize the individual market risk pool, lower premiums, and reduce improper enrollments. This rule finalizes additional safeguards to protect consumers from improper enrollments and unauthorized changes to their health care coverage, as well as establishing standards to strengthen the integrity of the *Affordable Care Act Exchanges*.
- Permanently established the Fraud Defense Operation Center (FDOC) that delivers a dynamic, real-time response to suspected Medicare fraud. FDOC is supported by a specialized team of fraud investigators, data analysts, policy experts, legal advisors, and law enforcement personnel, who leverage advanced artificial intelligence and machine learning technologies to detect and respond to suspected fraudulent activity swiftly.
- Improved CMS's information security footprint through implementation of a capability to flow all CMS contractors through "one front door" and onward to be logged in a central roster and appropriately vetted.
- Served as a key mechanism for protecting beneficiaries by swiftly resolving reports of inappropriate Medicare beneficiary hospice enrollment via the Hospice Enrollment Rapid Response Team. As of July 2025, the team has reversed 358 hospice elections for Medicare beneficiaries who were fraudulently enrolled, thereby restoring their access to medical services under traditional Medicare.
- Continued our Major Case Coordination (MCC) initiative, with representation from HHS's Office of Inspector General (OIG), Department of Justice, and HHS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, and fraud investigators to collaborate before, during, and after the development of fraud leads and investigations. This collaboration contributed to several successfully coordinated law enforcement actions. It also helped CMS better identify national fraud trends and program vulnerabilities, and better apply applicable administrative actions, when appropriate. In FY 2025, CMS reviewed 1,178 cases at Medicare MCC meetings, and law enforcement partners made 512 requests for CMS to refer reviewed cases. Additionally in FY 2025, CMS reviewed 88 cases at Medicaid MCC meetings, and law enforcement partners made 50 requests for CMS to refer reviewed cases from 17 different states.

Empower Beneficiaries

Our beneficiaries are important to us. CMS is the nation's largest insurer providing health care to millions of Americans through Medicare, Medicaid, CHIP, and the Exchanges. This strategic objective will help CMS to digitally activate beneficiaries while providing valuable Medicare interactive tools, a thriving health tech ecosystem, practical interoperability, and continuous transparency and feedback. Empowering our beneficiaries to access health care remains one of the core strategic objectives of CMS. In FY 2025, CMS:

- Embedded prevention, wellness, and person-centered care directly into quality measures. Through the integration of MAHA preventive approaches, including nutrition, fitness, and shared decision-making, into the Measures Under Consideration list, beneficiaries gain access to personalized, actionable tools that better support informed decision-making and care navigation. New measures, such as those focused on advanced care planning, patient life goals, and shared decision-making tools, ensure patients' voices are central to their care journey. By aligning measures across programs and emphasizing prevention and wellness, CMS is helping patients receive clearer, more tailored information to guide their health decisions.
- Enhanced consumer protection efforts in the Marketplace by implementing new oversight and accountability measures to address Marketplace consumer needs. CMS timely processed over 145,000 complaints, while ensuring consumers had consistent access to information and assistance. Transparency improvements were realized through comprehensive integrated dashboards that provided real-time monitoring and updates for Marketplace operations staff, thereby enhancing the consumer experience through more accurate and timely information availability.
- Developed provider complaint portals specifically designed for Medicare Advantage Organizations to address denial of services and payment disputes. CMS conducted comprehensive provider directory accuracy monitoring that resolved beneficiary confusion and provider access issues, coordinated corrective action that resulted in accurate provider directory posting and issued Notice of Non-Compliance to ensure future compliance. These efforts directly improved Medicare beneficiary access to care and provider network transparency. CMS achieved exceptional customer service performance by resolving tens of thousands of complaints with 98.7 percent closed timely, while maintaining a 99 percent Questions and Answers rating.

- Implemented measures to expand access to more affordable catastrophic health coverage through the new hardship guidance in order to ensure more Americans have a pathway to coverage. The guidance streamlines access to more affordable catastrophic coverage for consumers who are ineligible for advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs). Under new guidance, consumers may qualify for a hardship exemption to purchase a catastrophic plan on or off the Exchange if they are determined ineligible or expect to be ineligible for APTC or CSRs based on their projected annual household income. Catastrophic plans, which generally have lower monthly premiums, are designed to protect consumers from very high medical costs in the event of serious illness or injury, and are required to cover three primary care visits pre-deductible. Through these efforts, more Americans will qualify for catastrophic health coverage based on need, making it easier for individuals experiencing hardship and seeking catastrophic plans to access the full range of catastrophic coverage options available to them.
- Implemented measures that will use tools, information, and processes that better connect people to their health data and empower them to make informed health decisions through the patient-provider relationship. Current and future innovation models will unlock data access, align financial incentives and health outcomes, increase beneficiary access to information and tools, and publish data about providers and services.
- Launched three new features on Medicare.gov leveraging data to create personalized and actionable health care and coverage steps for beneficiaries with Medicare accounts.
- Launched an automated, one-stop-shop, statewide centralized directory for a test state that allows QHPs and providers to submit and access pre-populated provider data to improve accuracy and reduce burden.
- Continued to expand the self-service capabilities of the Marketplace Eligibility Appeals Portal by providing consumers with access to requests for information related to their appeals and offering the opportunity to upload that information directly to their appeals record via the portal.
- Engaged beneficiaries and stakeholders by attending 33 regional health fairs and hosting 54 presentations since July 15, 2025, to share CMS messaging across all initiatives.

Incentivize Providers

Our providers continue to be strong partners in health care delivery. These providers, when equipped with invaluable incentives, will continue partnering with CMS in fulfilling our mission. For CMS to address this objective, we will engage our providers and ensure there is real-time data as a standard of care, emphasize quality excellence and safety, focus on patients over paperwork, and develop innovative payment models. Some initiatives implemented in FY 2025 for this strategic objective include:

- Established a regular cadence of regulations aimed at advancing administrative simplification, as intended under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA),* through finalizing the Modifications to the National Council for Prescription Drug Programs Retail Pharmacy Standards Final Rule (CMS-0056) to reduce administrative burdens for all U.S. covered entities.
- Completed a proof-of-concept directory pilot to assess potential methods to improve data accuracy to incentivize and reduce burden on QHP issuers and providers. CMS successfully launched the QHP Directory Pilot in collaboration with the Oklahoma Insurance Department in FY 2025. This project established the first-of-its-kind automated, statewide provider directory and represents significant progress toward CMS's strategic objective to incentivize providers through innovative solutions that improve information exchange and create efficiencies. This milestone demonstrates CMS's commitment to reducing administrative burden, improving data accuracy, lowering administrative costs, and ultimately enhancing patient and provider experiences through streamlined, single-location data submission processes.
- Held the 2025 Quality Conference to enhance our meaningful engagement with providers. This conference brought together over 6,000 health care leaders, clinicians, researchers, and patient advocates from across the country to explore practical strategies for reducing harm, improving outcomes, and modernizing care delivery. CMS officials led powerful discussions on using data, strengthening accountability, and expanding proven interventions to build a safer and more efficient health care system.

- Established collaborative partnerships across our components to address provider complaints efficiently, expand professional networks, and improve collaborative capabilities. Quarterly trend reviews with regional partners were implemented to raise awareness of provider issues, identify systemic challenges, and implement coordinated solutions that benefit providers across both Marketplace and Medicare programs.
- Proposed the Ambulatory Specialty Model (ASM), which is designed to improve care for high-cost chronic conditions like heart failure and low back pain. ASM incentivizes specialists to detect early signs of disease progression, reduce avoidable procedures, and coordinate with primary care.
- Streamlined and aligned quality measures across Medicare FFS, MA, Accountable Care Organization, and Merit-based incentive payment system (MIPS) programs, reducing redundancy while sharpening focus on high-value, data-driven care. The consolidation of measures into the Universal Foundation for primary care, coupled with the removal of over 300 redundant or low-value measures since 2019, reduces provider reporting burden by over $228 million annually, freeing up resources to focus on delivering high-quality care. At the same time, providers are being supported in the transition to electronic clinical quality measures (eCQMs) built on FHIR (Fast Health Care Interoperability Resources) standards, which enable real-time, interoperable data exchange across care settings. These modernized digital measures not only reduce manual reporting but also empower providers with standardized, actionable insights that enhance timely follow-up, close care gaps, and strengthen equity-focused care delivery.

Align Spending & Value

CMS is committed to ensuring that every dollar spent creates economic value. Taxpayers expect us to ensure our expenditures are linked to creating value in all aspects of our operations in order to protect the nation's purse. This strategic objective will help CMS focus on Medicaid outcomes and efficiencies, sustaining MA growth, ensuring a thriving Marketplace, and prescription drug value. CMS implemented the following notable initiatives in FY 2025:

- Implemented policies that support rural providers, improve access to care in rural areas, and support the transformation of the rural health delivery system. CMS is improving workforce training in underserved areas through Graduate Medical Education (GME) allocations. CMS continues to allocate 1,200 GME slots, phased in over multiple years, to enhance the physician workforce and fund additional residencies in hospitals serving underserved communities. CMS has prioritized training slots in areas that demonstrate the greatest need for additional providers geared towards focusing on aligning spending and value. Clinicians who train in residency programs in underserved areas are more likely to continue their practice nearby after graduation.
- Implemented the CMS Acquisition Lifecycle Modernization (CALM) system as CMS's primary acquisition system, migrating 99.8 percent of data and documents from the legacy Comprehensive Acquisition Management System (CAMS), training and onboarding over 1,700 acquisition and financial staff members, and enabling data interoperability across previously closed CMS systems. CALM is a unified platform designed to modernize the agency's acquisition processes. It centralizes acquisition activities from planning to contract closeout, enhancing transparency and visibility across all workstreams and stakeholders. It features real-time communication, document management and standardized workflows, and integrates acquisition compliance. Additionally, with CMS now having full ownership and control of acquisition data throughout the entire lifecycle, deeper analysis of contracts, including cross-contract AI-driven comparisons, are now possible allowing for better identification of duplicate effort and opportunities for consolidation, leading to potential cost savings. This modernization effort exemplifies CMS's strategic commitment to aligning spending and value while positioning the agency as the leading health care payor through innovative federal acquisition process improvements, enhanced operational efficiency, and superior data analysis capabilities.

- Implemented cost efficiency initiatives in Marketplace operations, which contributed to contract savings through strategic insourcing initiatives that eliminated costly external contractor dependencies while maintaining service quality. Process improvements reduced plan request processing times by 58 percent, from 12 minutes to 5 minutes, while implementing comprehensive cost-efficiency measures that enhanced rather than diminished operational capabilities for Marketplace oversight.
- Engaged in ongoing dialogue with stakeholders, including those representing medical specialty societies, device/drug manufacturers, digital health companies, and patient care organizations, to improve payment accuracy for physician services and better align payment incentives with high-value care. In FY 2025, CMS successfully calculated and implemented the Internal Revenue Service (IRS) Branded Prescription Drug Fee, equitably allocating the $2.8 billion statutory aggregate fee among all covered entities based on government program sales data. All proceeds were credited to the Medicare Part B Trust Fund, reinforcing the program's long-term sustainability. The Branded Prescription Drug Fee, established under Section 9008 of the *Affordable Care Act* and codified at 26 U.S.C. § 4001, together with implementing regulations at 26 CFR Part 51, is an annual fee imposed on manufacturers and importers of branded prescription drugs. Covered entities are assessed proportionally according to their share of branded prescription drug sales to federal programs such as Medicare, Medicaid, the Department of Veterans Affairs, and the Department of Defense. This statutory fee ensures manufacturers benefiting from participation in federal health care programs contribute to their long-term financial solvency and offset federal expenditures on prescription drugs.
- Continued to implement the Medicare Shared Savings Program (MSSP) ACOs, which are critical in helping MAHA by supporting high-quality coordinated care that addresses prevention, chronic illness, and the root causes of disease. The MSSP's unique design means ACOs are held accountable for saving money and improving health care quality, delivering a win for both patients and the Medicare Trust Funds. The MSSP is one of the largest value-based programs in the country that aims to reduce overall costs of care while ensuring Medicare beneficiaries receive high quality care. During 2025, the MSSP expanded to include 476 ACOs with over 650,000 health care providers and organizations. These ACOs are providing traditional Medicare to over 11.2 million people, marking a 3.7 percent increase in individuals from the previous year. The MSSP continued to work with CMS stakeholders to address the impacts of significant, anomalous, and highly-suspect billing activity which could, if not addressed, adversely impact the accuracy, fairness, and integrity of financial calculations under the MSSP.
- Continued to ensure financial integrity by increasing transparency and taking on financing reform. On May 15, 2025, CMS published a proposed rule (Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole Proposed Rule), which, if finalized, would save the federal government an estimated $33.2 billion over five years and strengthen the fiscal integrity of the Medicaid program.

Management's Assurances

Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls; (2) Office of Management and Budget (OMB) Circular A-123, Appendix A self-assessments; (3) OIG audits, and Government Accountability Office audits and High-Risk reports; (4) Statement on Standards for Attestation Engagements (SSAE) 18 internal control audits; (5) evaluations and tests of MACs' controls conducted pursuant to section 912 of the *Medicare Modernization Act*; (6) the annual Chief Financial Officers (CFO) Act audit; (7) security assessment; and authorization of systems; and (8) Department Enterprise Risk Management efforts. As of September 30, 2025, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) were achieved with the exception of two instances of non-compliance described below.

OMB Circular A-123 Statement of Assurance

CMS management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the FMFIA. These objectives are to ensure: (1) effective and efficient operations, (2) reliable reporting, and (3) compliance with applicable laws and regulations.

CMS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, CMS provides a modified statement of reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2025, except for the following material non-compliance items: the *Payment Integrity Information Act of 2019* (PIIA), and Section 6411 of the *Patient Protection and Affordable Care Act* (PPACA).

PIIA Noncompliance

PIIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. PIIA defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Improper payments also include payments to ineligible recipients, payments for ineligible services, duplicate payments, and payments for services not received, as well as payments that are missing sufficient documentation to determine if proper.

CMS has instituted comprehensive processes that measure improper payments for the Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug (Medicare Part D), Medicaid, CHIP, and APTC programs.

Although CMS has calculated and reported an improper payment estimate for the Federally Facilitated Exchange of the Advance Premium Tax Credits program, CMS's noncompliance stems from not calculating and reporting an improper payment estimate for the State-based Exchanges. CMS continues to develop the improper payment measurement methodology for the State-based Exchanges and will continue to update the AFR with the measurement program development status.

It is noteworthy to state that CMS is committed to strengthening corrective action plans (CAPs) to address the root causes of improper payments, particularly those related to insufficient documentation and medically unnecessary services. CMS will continue evaluating and documenting critical and feasible action steps to strengthen CAPs, improve reduction targets, and demonstrate measurable improvements in payment integrity, while also expanding provider outreach and education efforts following policy changes.

Section 6411 of the PPACA

CMS did not fully comply with Section 6411 of the PPACA regarding the development of the Medicare Part C Recovery Audit Contractor (RAC) program.

Assurance for the Federal Financial Management Improvement Act of 1996

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, CMS provides reasonable assurance that its overall financial management systems substantially comply with FFMIA and substantially conform to the objectives of FMFIA, Section 4.

System Compliance

CMS is substantially compliant with Section 803(a) of the FFMIA and has noted no lack of compliance.

Overview of Financial Data

Sound financial management is an integral part of CMS's efforts to deliver services and administer our programs. CMS maintains strong financial management operations and continues to improve its financial management and reporting processes to provide timely, reliable, and accurate financial information. CMS management and other decision makers use this information to make appropriate and accurate program and administrative decisions.

The basic financial statements in this report are prepared pursuant to the requirements of the *Government Management Reform Act of 1994*, the *Chief Financial Officers Act of 1990*, and other requirements, including the OMB Circular A-136, *Financial Reporting Requirements*. CMS management is responsible for the integrity of the financial information in these statements. The OIG selects an independent certified public accounting firm to audit CMS's financial statements and related notes.

Consolidated Balance Sheet

The Consolidated Balance Sheet presents, as of September 30, 2025, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A Consolidating Balance Sheet by Major Program is provided as Other Financial Information. CMS's Consolidated Balance Sheet reported assets of $902.8 billion. A major asset is Investments totaling $409.7 billion, which are invested in Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The largest asset is the Fund Balance with Treasury of $442.3 billion, most of which is used for Medicaid, CHIP, and Payments to Health Care Trust Funds. Liabilities of $191.6 billion consist primarily of the Entitlement Benefits Due and Payable of $164.0 billion. CMS's Net Position totals $711.2 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost presents the actual net cost of CMS's operations by major program for the year ended September 30, 2025. The four major programs that CMS administers are Medicare HI, Medicare SMI, Medicaid, and CHIP. The majority of CMS's net costs are in these programs. Medicare and Medicaid program integrity and fraud and abuse funding are included under the HI trust fund. The net cost of operations under "Other" includes State Grants and Demonstrations and Other Health.

Program Management expenses are allocated and shown separately under each major program. A Consolidating Statement of Net Cost shows the Medicare funds as Dedicated Collection versus Other Fund components of net cost as Other Information. In FY 2025, CMS's total Net Cost of Operations was $1,691.2 billion encompassing gross benefit/program costs of $1,859.5 billion and operating costs of $8.7 billion.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position presents the change in net position (i.e., difference between assets and liabilities) for the year ended September 30, 2025. Changes in the Cumulative Results of Operations and Unexpended Appropriations affect CMS's net position balance. Funds From Dedicated Collections are shown in a separate column from Other Funds. The bulk of the change pertains to Appropriations Used of $1,302.1 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the Health Care Trust Funds to HI and SMI, and State Grants and Demonstrations and general fund-financed Program Management appropriations. Medicaid and CHIP are financed by general fund appropriations provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the *Federal Insurance Contributions Act* and the *Self Employment Contributions Act for the HI trust fund* and totaled $400.6 billion.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as the status for the year ended September 30, 2025. A supplementary Combining Statement of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. In this statement, Program Management is shown separately and Other includes State Grants and Demonstrations, Other Health and Medicare and Medicaid program integrity, and fraud and abuse activities. Also, there are no intra-CMS eliminations in these statements.

CMS total budgetary resources were $2,889.1 billion. New obligations of $2,595.4 billion leave unobligated balances of $293.7 billion. Total outlays, net of collections, were $2,478.4 billion. When offset by $785.9 billion relating to collection of premiums and general fund transfers from the Payments to the Health Care Trust Funds, as well as refunds of MAC overpayments, the CMS net outlays were $1,692.5 billion.

Overview of Social Insurance Data

Statement of Social Insurance

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

Actuarial present values are computed under the intermediate set of assumptions specified in the 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. With two exceptions, the projections are based on the *Social Security Act*'s current-law provisions[2] as of the date of the release of the Medicare Trustees Report.

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

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

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

The SOSI presents the following actuarial estimates:

- The present value of future income (excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future expenditures of providing benefits to those same individuals;

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[2] Because it was enacted after the release of the 2025 Medicare Trustees Report, the projections do not reflect the impact of the Medicare provisions in the *One Big Beautiful Bill Act* of 2025 (OBBBA: Public Law 119-21). Three provisions affect the Medicare program directly, with a negligible estimated impact on spending. The combined net effect of the income tax provisions in the OBBBA results in less overall tax liability for Social Security beneficiaries, meaning the HI trust fund is projected to receive less revenue from income taxation of Social Security benefits for all years beginning in 2025, and the timing for reserve depletion is accelerated by roughly one year. The 2026 Trustees Report will reflect updated economic and demographic assumptions that incorporate the effects of the OBBBA as well as other factors and experience into the projections. As a result, the status of the HI trust fund that will be reported in the 2026 Medicare Trustees Report is uncertain at this time.

Similarly, the projections do not reflect the impact of the Medicare provisions in the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37), which was enacted on November 12, 2025. The provisions included were temporary extensions of prior policies, a reduction in the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through February of 2033. The estimated impact is negligible over the next few years and there is no impact beyond 2033.

Lastly, the projections do not reflect the impact of the skin substitute policies finalized in the Calendar Year 2026 Physician Fee Schedule final rule, which was published on November 5, 2025. These policies significantly reduce spending for skin substitute services provided under Part B. Based on the projections reflected in the 2025 Medicare Trustees Report, the estimated impact on total Part B expenditures is a reduction of roughly 3.4 percent, including the reduction in fee-for-service spending and the associated impact on payments to Medicare Advantage plans, beginning in 2026.

- The present value of future income (excluding interest) to be received from or on behalf of current participants who have not yet attained eligibility age and the future expenditures of providing benefits to those same individuals;
- The present value of future income (excluding interest) less expenditures for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;
- The present value of future income (excluding interest) to be received from or on behalf of future participants and the expenditures of providing benefits to those same individuals;
- The present value of future income (excluding interest) less expenditures for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and
- The present value of future income (excluding interest) less expenditures for all current and future participants over the next 75 years (open group measure) (deficit) increased from $(2.6) trillion, determined as of January 1, 2024, to $(3.3) trillion, determined as of January 1, 2025.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2025, the actuarial present value of estimated future income (excluding interest) less expenditures plus HI and SMI trust fund assets for all current and future participants is estimated to be a $(2.9) trillion deficit for the 75-year valuation period. The comparable metric for the closed group of participants is estimated to be a $(14.1) trillion deficit for the 75-year valuation period.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive HI trust fund assets. The following table shows the HI trust fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio declines slightly from 40 percent at the beginning of FY 2021 to 39 percent at the beginning of FY 2022, after which it rises in 2023 through 2025. The ratio is estimated to increase in 2025 as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

TRUST FUND RATIO

Beginning of Fiscal Year[3]

	2021	2022	2023	2024	2025
HI	40%	39%	45%	48%	53%

Short-Term Financing

The HI trust fund is deemed adequately financed for the short term when actuarial estimates of HI trust fund assets for the beginning of each CY are at least as large as program obligations for the year. Under the intermediate assumptions of the 2025 Medicare Trustees Report, after 2025 the HI trust fund ratio is estimated to steadily decrease for the rest of the projection period until the fund is depleted in CY 2033. The assets were $237.5 billion at the beginning of 2025, representing about 53 percent of expenditures projected for 2025, which is below the Trustees' minimum recommended level of 100 percent. The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003.

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

Long-Term Financing

This year's short-range financial outlook for the HI trust fund is less favorable than what was projected last year. After 2025, the trust fund ratio declines until the fund is depleted in CY 2033, three years earlier than projected in 2024. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program expenditures are expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to be 89 percent in 2033 (year of exhaustion), 86 percent in 2049 (25th projection year), and then about 100 percent in 2099 (end of the projection period).

The primary reason for the projected long-term inadequacy of financing under current law relates to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 2.8 in 2024 to about 2.2 by 2099. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.1 trillion, which is 0.4 percent of taxable payroll and 0.2 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information: Social Insurance disclosures required by the Federal Accounting Standards Advisory Board (FASAB).

SMI Trust Fund Solvency

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

While differences between the two accounts exist, the SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and government contributions for Parts B and D—which are contributions of the federal government that the law authorizes to be appropriated and transferred from the general fund of the Treasury—are reset each year to cover projected program costs and ensure a reserve for Part B to provide a contingency for unexpected program variation.

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

Therefore, in this financial statement, the present value of estimated future excess of income over expenditure for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(57.0) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percentage of GDP. In 2024, SMI incurred expenditures were 2.4 percent of GDP. By 2099, SMI expenditures are projected to grow to 4.8 percent of the GDP.

Financial Challenges

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

The following table presents key amounts from our basic financial statements for FY 2025.

TABLE OF KEY MEASURES[4]

Dollars in billions

	2025
NET POSITION (END OF FISCAL YEAR)	
Assets	$902.8
Less Total Liabilities	$191.6
Net Position (assets net of liabilities)	$711.2
COSTS (END OF FISCAL YEAR)	
Net Costs	$1,691.2
Total Financing Sources	$1,716.5
Net Change in Cumulative Results of Operations	$25.3
STATEMENT OF SOCIAL INSURANCE (CALENDAR YEAR BASIS)	
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$(3,301)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	$(2,618)
Change in present value	$(683)

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

Statement of Changes in Social Insurance Amounts

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

The present value as of January 1, 2025, decreased as follows: (i) by $97 billion as a result of advancing the valuation date by 1 year and including the additional year 2099; (ii) by $627 billion because of changes in the projection base; and (iii) by $236 billion because of changes in economic and health care assumptions. However, changes in the demographic assumptions increased the present value by $275 billion. The net overall impact of these changes is a decrease in the present value of $683 billion.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, *Accounting for Social Insurance* (as amended by *SFFAS 37*, *Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), CMS has included information about the HI and SMI Medicare Trust Funds. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to individuals with Medicare (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the *SFFAS 17* requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The principal financial statements are prepared to report the financial position, financial condition, and results of operations, pursuant to the requirements of 31 U.S.C. § 3515(b). The statements are prepared from records of Federal entities in accordance with Federal generally accepted accounting principles (GAAP) and the formats prescribed by OMB. Reports used to monitor and control budgetary resources are prepared from the same records. Users of the statements are advised that the statements are for a component of the U.S. Government.

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Financial Section

- A Message from the Chief Financial Officer
- Financial Statements
- Notes to the Financial Statements
- Required Supplementary Information
- Audit Reports

A Message from the Chief Financial Officer

I am pleased to present the Centers for Medicare & Medicaid Services fiscal year (FY) 2025 Agency Financial Report (AFR). For the 27th consecutive FY, we received an unmodified opinion on four of the six principal financial statements; however, as in previous years, the auditors were not able to express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to uncertainty in the long-range assumptions applied in our projection models. Nonetheless, CMS remains assured that our projections are fairly presented and properly disclose the purpose of the projections.

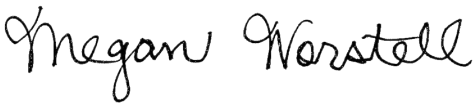
In FY 2025 and beyond, CMS remains committed and resolute as responsible financial stewards, promoting fiscal excellence in all aspects of our operations by seeking innovative ways to manage our ever-changing complex programs. The following highlights some of our FY 2025 accomplishments:

- **Reductions in Improper Payments and Increase Program Integrity Efforts –** As part of our strategic plan initiatives to protect our programs, we continue to achieve success in our program integrity efforts that led to reductions in improper payments. The Medicare Fee-for-Service (FFS) estimated improper payment rate for FY 2025 was 6.55 percent, or $28.83 billion, decreased from 7.66 percent, or $31.70 billion in FY 2024; representing a decrease of $2.88 billion. The FY 2025 estimate marks the ninth consecutive year the Medicare FFS estimated improper payment rate was below the 10 percent compliance threshold. In addition, CMS saw a significant reduction in skilled nursing facility projected improper payments from FY 2024 to FY 2025, representing a decrease of $1.57 billion. Furthermore, while CMS continues to support state activities through our Medicaid Integrity Program, CMS's Medicare Recovery Audit Program also resulted in the recovery of overpayments.
- **Medicare Secondary Payer (MSP) Savings –** CMS reported MSP savings of approximately $8.7 billion for the current fiscal year. MSP savings are recognized through cost avoidance and recovery. Medicare Trust Fund cost avoidance savings occur when Medicare pays secondary on a medical claim versus paying primary because an identified MSP occurrence prevented payment as primary. Recovery savings reflect actual monies returned to CMS because Medicare incorrectly paid the claim when another entity had primary payer responsibility. The total savings reflect pre-pay (cost avoidance) savings of $5.9 billion and post-pay (recovery) savings of $2.8 billion.
- **Recovery of Duplicate Payments Made by CMS and Veterans Administration (VA) –** CMS continued working on an initiative to identify and recover duplicate payments made by both Medicare and the VA. This fiscal year, CMS automated the recovery process and is projected to recover approximately $101 million in duplicate payments.

- **Automation and Artificial Intelligence (AI) –** In FY 2025, CMS accelerated the adoption of automation and AI across financial operations, deploying more than 10 AI solutions, eight RPA processes, and thirty three automations that collectively saved 6,522 mission hours and over $610,000. Major system automations generated more than 2,800 hours of annual efficiency, with improvements reaching 97 percent Within Healthcare Integrated General Ledger Accounting System, automation reduced Medicare bankruptcy portfolio case processing time by 95 percent, enabling the re-referral of $140 million and preserving the trust funds. Program and payment integrity automations prevented $44 million in high-risk payments, automated accounts payable liability cancellations delivered $107 million in direct trust fund savings, and a new duplicate payment recovery system now systematically identifies and recovers duplicate payments across Medicare and VA, strengthening CMS's role as a key payor and advancing the Crush Fraud initiative. CMS successfully completed its fifth consecutive annual Disaster Recovery event in three hours and thirty five minutes, exceeding the 4-hour return-to-operations requirement and sustaining full operational recovery for more than six months. This achievement demonstrates a well-established, proven disaster recovery capability that safeguards HIGLAS, CMS's financial system of record, and ensures the continuity and integrity of critical national financial operations.

Investing in our people, processes and myriad number of invaluable stakeholders ensures that CMS operates more efficiently and effectively as we continue to pursue our core mission of ensuring the most vulnerable receive high-value care. We will relentlessly continue our work of managing and safeguarding taxpayer dollars by developing processes, such as implementing technology that crushes fraud or improper payments, waste, and abuse.

I am proud of the work we have accomplished this year which demonstrates that we continue to take the responsibility for stewardship of the Medicare Trust Funds very seriously and our commitment remains unwavered.



Megan Worstell
Director & CMS Chief Financial Officer

Consolidated Balance Sheet

As of September 30, 2025

(in millions)

	FY 2025 Consolidated Totals
ASSETS	
Intragovernmental:	
Fund Balance with Treasury (Note 2)	$442,316
Investments (Note 3)	409,738
Accounts Receivable, Net (Note 4)	681
Other Assets	6
Total Intragovernmental	**852,741**
Other than intragovernmental:	
Accounts Receivable, Net (Note 4)	48,333
General Property, Plant and Equipment, Net	1,323
Advances and Prepayments	1
Other Assets	408
Total Other than intragovernmental	**50,065**
TOTAL ASSETS	**$902,806**
LIABILITIES	
Intragovernmental:	
Accounts Payable	$1,450
Debt	452
Other Liabilities (Note 7)	96
Total Intragovernmental	**1,998**
Other than intragovernmental:	
Accounts Payable	461
Entitlement Benefits Due and Payable (Note 5)	163,952
Other Liabilities	
Contingencies and Commitments (Note 6)	8,244
Other (Note 7)	16,969
Total other than intragovernmental	**189,626**
TOTAL LIABILITIES (Note 8)	**$191,624**
NET POSITION	
Unexpended Appropriations-Funds from Dedicated Collections (Note 10)	$236,903
Unexpended Appropriations-Funds from Other than Dedicated Collections	103,628
Total Unexpended Appropriations	**340,531**
Cumulative Results of Operations-Funds from Dedicated Collections (Note 10)	366,202
Cumulative Results of Operations-Funds from Other than Dedicated Collections	4,449
Total Cumulative Results of Operations	**370,651**
TOTAL NET POSITION	**$711,182**
TOTAL LIABILITIES AND NET POSITION	**$902,806**

The accompanying notes are an integral part of these statements.

Consolidated Statement of Net Cost

For the Year Ended September 30, 2025

(in millions)

NET PROGRAM/ACTIVITY COSTS GPRA PROGRAMS	FY 2025 Totals	Intra-CMS Eliminations	FY 2025 Consolidated Totals
Medicare HI			
Gross Costs	**$434,713**	**$21**	**$434,734**
Less: Earned Revenues	(6,146)		(6,146)
Net Cost Medicare HI	**$428,567**	**$21**	**$428,588**
Medicare SMI			
Gross Costs	**$722,105**	**$32**	**$722,137**
Less: Earned Revenues	(154,814)		(154,814)
Net Cost Medicare SMI	**$567,291**	**$32**	**$567,323**
Medicaid			
Gross Costs	**$670,716**		**$670,716**
Less: Earned Revenues	(1)		(1)
Net Cost Medicaid	**$670,715**		**$670,715**
CHIP			
Gross Costs	**$23,142**		**$23,142**
Less: Earned Revenues			
Net Cost CHIP	**$23,142**		**$23,142**
Other			
Gross Costs	**$17,409**		**$17,409**
Less: Earned Revenues	(15,898)	$(53)	(15,951)
Net Cost Other	**$1,511**	**$(53)**	**$1,458**
NET COST OF OPERATIONS (Note 9)	**$1,691,226**		**$1,691,226**

The accompanying notes are an integral part of these statements.

Consolidated Statement of Changes in Net Position

For the Year Ended September 30, 2025

(in millions)

	Funds from Dedicated Collections *(Note 10)*	Funds from Other than Dedicated Collections	FY 2025 Consolidated Total
Unexpended Appropriations			
Beginning Balances	**$263,916**	**$105,661**	**$369,577**
Appropriations Received	657,934	761,111	1,419,045
Appropriations Transferred-in/out		(5,943)	(5,943)
Other Adjustments	(75,239)	(64,803)	(140,042)
Appropriations Used	(609,708)	(692,398)	(1,302,106)
Change in Unexpended Appropriations	**(27,013)**	**(2,033)**	**(29,046)**
Total Unexpended Appropriations: Ending Balance	**$236,903**	**$103,628**	**$340,531**
Cumulative Results of Operations			
Beginning Balances	**$340,801**	**$4,520**	**$345,321**
Appropriations Used	609,708	692,398	1,302,106
Nonexchange Revenue:			
FICA and SECA Taxes	400,622		400,622
Interest on Investments	12,521	886	13,407
Other	3,224		3,224
Transfers-in/out without Reimbursement	(5,804)	1,716	(4,088)
Imputed Financing	1,296	14	1,310
Other		(25)	(25)
Net Cost of Operations (Note 9)	**996,166**	**695,060**	**1,691,226**
Net Change in Cumulative Results of Operations	**25,401**	**(71)**	**25,330**
Cumulative Results of Operations: Ending Balance	**$366,202**	**$4,449**	**$370,651**
Net Position	**$603,105**	**$108,077**	**$711,182**

The accompanying notes are an integral part of these statements.

Combined Statement of Budgetary Resources (Note 11)

For the Year Ended September 30, 2025

(in millions)

	FY 2025 Combined Totals Budgetary
Budgetary Resources:	
Unobligated balance from prior year budget authority, net (discretionary and mandatory) (Note 11)	$340,872
Appropriations (discretionary and mandatory)	2,520,260
Spending authority from offsetting collections (discretionary and mandatory)	27,921
Total Budgetary Resources	**$2,889,053**
Status of Budgetary Resources:	
New Obligations and upward adjustments	$2,595,375
Unobligated balance, end of year	
Apportioned, unexpired accounts	45,256
Exempt from Apportionment, unexpired accounts	962
Unapportioned, unexpired accounts	13,762
Unexpired unobligated balance, end of year	$59,980
Expired unobligated balance, end of year	233,698
Unobligated balance, end of year (total)	$293,678
Total Budgetary Resources	**$2,889,053**
Outlays, net	
Outlays, net (discretionary and mandatory)	$2,478,441
Distributed offsetting receipts	(785,967)
Agency Outlays, Net (discretionary and mandatory)	**$1,692,474**
Disbursements, Net	**$(134)**

The accompanying notes are an integral part of these statements.

Statement of Social Insurance

75-Year Projection as of January 1, 2025 and Prior Base Years

(in billions)

		Estimates from Prior Years			
	2025 (unaudited)	2024 (unaudited)	2023 (unaudited)	2022 (unaudited)	2021 (unaudited)
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 12 and 13)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$16,554	$16,189	$15,360	$14,767	$13,029
SMI Part B	47,167	40,323	39,008	39,039	34,467
SMI Part D	6,910	7,097	6,865	7,372	6,881
Have attained eligibility age (age 65 or over)					
HI	1,042	953	862	793	664
SMI Part B	9,517	8,181	7,683	7,447	6,536
SMI Part D	1,592	1,517	1,315	1,164	1,061
Those expected to become participants					
HI	15,537	15,360	15,046	14,603	13,017
SMI Part B	11,845	10,161	9,934	10,131	9,010
SMI Part D	2,231	2,393	2,372	3,094	2,921
All current and future participants					
HI	33,133	32,502	31,268	30,163	26,710
SMI Part B	68,530	58,665	56,625	56,618	50,013
SMI Part D	10,733	11,008	10,551	11,630	10,863
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 12 and 13)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$23,964	$22,970	$23,622	$23,211	$20,940
SMI Part B	46,832	39,853	38,539	38,605	34,075
SMI Part D	6,910	7,097	6,865	7,372	6,881
Have attained eligibility age (age 65 and over)					
HI	8,045	7,357	7,215	7,010	6,230
SMI Part B	9,980	8,508	8,038	7,825	6,892
SMI Part D	1,592	1,517	1,315	1,164	1,061
Those expected to become participants					
HI	4,426	4,794	5,061	5,036	4,597
SMI Part B	11,717	10,304	10,048	10,188	9,046
SMI Part D	2,231	2,393	2,372	3,094	2,921
All current and future participants:					
HI	36,435	35,120	35,897	35,257	31,767
SMI Part B	68,530	58,665	56,625	56,618	50,013
SMI Part D	10,733	11,008	10,551	11,630	10,863
Actuarial present value for the 75-year projection period of estimated future excess of income excluding interest) over expenditures (Notes 12 and 13)					
HI	$(3,301)	$(2,618)	$(4,630)	$(5,094)	$(5,057)
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 12 and 13)					
HI	$(3,301)	$(2,618)	$(4,630)	$(5,094)	$(5,057)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$237	$209	$198	$177	$198
SMI Part B	152	172	194	163	133
SMI Part D	19	16	18	20	10
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 12 and 13)					
HI	$(3,064)	$(2,410)	$(4,432)	$(4,917)	$(4,859)
SMI Part B	152	172	194	163	133
SMI Part D	19	16	18	20	10

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements. 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.

Statement of Social Insurance
(continued)

75-Year Projection as of January 1, 2025 and Prior Base Years

(in billions)

Medicare Social Insurance Summary	2025 (unaudited)	Estimates from Prior Years: 2024 (unaudited)	2023 (unaudited)	2022 (unaudited)	2021 (unaudited)
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)	**$12,152**	$10,651	$9,860	$9,404	$8,261
Expenditures	**19,617**	17,383	16,567	15,998	14,184
Income less expenditures	**(7,465)**	(6,731)	(6,707)	(6,595)	(5,922)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	**70,631**	63,609	61,232	61,178	54,377
Expenditures	**77,706**	69,920	69,026	69,188	61,895
Income less expenditures	**(7,075)**	(6,310)	(7,794)	(8,010)	(7,519)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	**(14,540)**	(13,042)	(14,501)	(14,605)	(13,441)
Combined Medicare Trust Fund assets at start of period	**408**	397	410	360	341
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	**(14,132)**	(12,645)	(14,091)	(14,244)	(13,100)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	**$29,613**	$27,914	$27,352	$27,828	$24,948
Expenditures	**18,374**	17,491	17,480	18,318	16,564
Income less expenditures	**11,239**	10,423	9,871	9,510	8,384
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	**(3,301)**	(2,618)	(4,630)	(5,094)	(5,057)
Combined Medicare Trust Fund assets at start of period	**408**	397	410	360	341
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	**$(2,893)**	$(2,222)	$(4,220)	$(4,734)	$(4,716)

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements. 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.

Statement of Changes in Social Insurance Amounts (Unaudited)
Medicare Hospital and Supplementary Medical Insurance

January 1, 2024 to January 1, 2025

(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 14)*					
As of January 1, 2024	$102,175	$104,793	$(2,618)	$397	$(2,222)
Reasons for change					
Change in the valuation period	3,319	3,416	(97)	22	(75)
Change in projection base	1,737	2,364	(627)	(11)	(638)
Changes in the demographic assumptions	(1,361)	(1,637)	275		275
Changes in economic and health care assumptions	6,487	6,723	(236)		(236)
Changes in law	39	37	2		2
Net changes	10,221	10,904	(683)	11	(672)
As of January 1, 2025	$112,396	$115,697	$(3,301)	$408	$(2,893)
HI – Part A *(Note 14)*					
As of January 1, 2024	$32,502	$35,120	$(2,618)	$209	$(2,410)
Reasons for change					
Change in the valuation period	962	1,059	(97)	24	(73)
Change in projection base	62	689	(627)	5	(622)
Changes in the demographic assumptions	(304)	(579)	275		275
Changes in economic and health care assumptions	(89)	147	(236)		(236)
Changes in law		(2)	2		2
Net changes	632	1,315	(683)	29	(654)
As of January 1, 2025	$33,133	$36,435	$(3,301)	$237	$(3,064)
SMI – Part B *(Note 14)*					
As of January 1, 2024	$58,665	$58,665		$172	$172
Reasons for change					
Change in the valuation period	2,025	2,025		(3)	(3)
Change in projection base	1,614	1,614		(18)	(18)
Changes in the demographic assumptions	(675)	(675)			
Changes in economic and health care assumptions	6,861	6,861			
Changes in law	40	40			
Net changes	9,864	9,864		(21)	(21)
As of January 1, 2025	$68,530	$68,530		$152	$152
SMI – Part D *(Note 14)*					
As of January 1, 2024	$11,008	$11,008		$16	$16
Reasons for change					
Change in the valuation period	333	333			
Change in projection base	61	61		3	3
Changes in the demographic assumptions	(383)	(383)			
Changes in economic and health care assumptions	(285)	(285)			
Changes in law					
Net changes	(275)	(275)		3	3
As of January 1, 2025	$10,733	$10,733		$19	$19

Totals do not necessarily equal the sum of the rounded components.

The accompanying notes are an integral part of these financial statements.

Statement of Changes in Social Insurance Amounts (Unaudited) Medicare Hospital and Supplementary Medical Insurance (continued)

January 1, 2023 to January 1, 2024

(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 14)*					
As of January 1, 2023	$98,444	$103,074	$(4,630)	$410	$(4,220)
Reasons for change					
Change in the valuation period	2,839	2,983	(144)	(13)	(157)
Change in projection base	944	197	747	(1)	746
Changes in the demographic assumptions	(34)	664	(698)		(698)
Changes in economic and health care assumptions	(3)	(2,109)	2,106		2,106
Changes in law	(16)	(16)			
Net changes	3,731	1,719	2,011	(13)	1,998
As of January 1, 2024	$102,175	$104,793	$(2,618)	$397	$(2,222)
HI – Part A *(Note 14)*					
As of January 1, 2023	$31,268	$35,897	$(4,630)	$198	$(4,432)
Reasons for change					
Change in the valuation period	815	959	(144)	4	(140)
Change in projection base	413	(334)	747	7	755
Changes in the demographic assumptions	(561)	137	(698)		(698)
Changes in economic and health care assumptions	567	(1,539)	2,106		2,106
Changes in law					
Net changes	1,234	(777)	2,011	11	2,023
As of January 1, 2024	$32,502	$35,120	$(2,618)	$209	$(2,410)
SMI – Part B *(Note 14)*					
As of January 1, 2023	$56,625	$56,625		$194	$194
Reasons for change					
Change in the valuation period	1,728	1,728		(9)	(9)
Change in projection base	115	115		(13)	(13)
Changes in the demographic assumptions	129	129			
Changes in economic and health care assumptions	84	84			
Changes in law	(16)	(16)			
Net changes	2,040	2,040		(22)	(22)
As of January 1, 2024	$58,665	$58,665		$172	$172
SMI – Part D *(Note 14)*					
As of January 1, 2023	$10,551	$10,551		$18	$18
Reasons for change					
Change in the valuation period	296	296		(7)	(7)
Change in projection base	416	416		4	4
Changes in the demographic assumptions	398	398			
Changes in economic and health care assumptions	(653)	(653)			
Changes in law					
Net changes	456	456		(3)	(3)
As of January 1, 2024	$11,008	$11,008		$16	$16

Totals do not necessarily equal the sum of the rounded components.

The accompanying notes are an integral part of these financial statements.

NOTE 1:

Summary of Significant Accounting Policies

Basis of Accounting and Presentation

The financial statements were prepared from CMS's accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, *Financial Reporting Requirements.* GAAP for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, CMS has included all consolidation entities for which it is accountable in this general purpose federal financial report.

The financial statements have been prepared to report the financial position, net cost, changes in net position, and budgetary resources for all programs administered by CMS. CMS's fiscal year (FY) ends September 30. These financial statements reflect both accrual and budgetary accounting transactions. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when incurred, without regard to the receipt or payment of cash. Budgetary accounting is designed to recognize the obligation of funds according to legal requirements that, in many cases, is made prior to the occurrence of an accrual-based transaction. Budgetary accounting is essential for compliance with legal constraints and controls over the use of federal funds. 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.

Use of Estimates

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 in understanding the effect of changes in assumptions to the related information.

Parent/Child Reporting

CMS is a party to allocation transfers with other federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. Financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived. CMS allocates funds as the parent to the Centers for Disease Control and Prevention for children's vaccines. CMS has a child relationship with the Internal Revenue Service for the Advance Premium Tax Credit and Basic Health Program payments; these payments are not included in CMS's financial statements.

Funds from Dedicated Collections

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

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

CMS's major funds from dedicated collections include:

Federal Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Federal Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage (MA) plans are also charged to this trust fund. The CMS financial statements include HI trust fund activities administered by the Department of the Treasury (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 *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration (SSA) records of wages established and maintained by SSA in accordance with wage information reports.

Federal Supplementary Medical Insurance Trust Fund – Part B

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

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

Federal Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003* (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 *Patient Protection and Affordable Care Act* (PPACA) provided that beneficiary cost sharing in the Part D coverage gap be reduced for brand-name and generic drugs to a 25 percent coinsurance. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program at Section 1893 of the *Social Security Act*. HIPAA Section 201 also established the Healthcare Fraud and Abuse Control Account (HCFAC), 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.

Payments to the Healthcare Trust Funds Appropriation

The *Social Security Act* provides for payments to the HI and SMI trust funds for SMI (e.g., appropriated funds to provide for federal matching of SMI premium collections) and HI (e.g., for the Federal Uninsured Payments). The *Social Security Act* prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the states, and Transitional Assistance benefits be transferred from the general fund to the SMI trust fund; this occurs via the Payments to the Healthcare Trust Funds account. The *Social Security Act* also prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the HCFAC account of the HI trust fund as well as payments to support the Federal Bureau of Investigation activities related to health care fraud and abuse activities. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust fund. In addition, funds are provided by the Payments to the Healthcare Trust Funds account to cover CMS's administrative costs that are not related to the Medicare program. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

There is permanent indefinite authority for the transfer of general funds to the HI trust fund in amounts equal to SECA tax credits and receipts from taxation of Old Age Survivors and Disability Insurance (OASDI) beneficiaries. The *Social Security Act Amendments of 1994*, provided for additional tax payments from Social Security OASDI benefits and Tier 1 Railroad Retirement beneficiaries.

The Health (Other Funds) programs managed by CMS include:

Medicaid

Medicaid is funded through annual appropriations from Congress and is administered via grant awards, which limit the funds that can be drawn by the states and territories to cover current expenses. Beginning January 1, 2014, the PPACA expanded eligibility (based upon a state's choice) for Medicaid to certain low-income adults with the federal government paying 90 percent of claims for those newly eligible under Medicaid expansion for calendar year 2020 and beyond.

CHIP

CHIP is administered via grant awards, which limit the funds that can be drawn by the states and territories to cover current expenses.

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

State Grants and Demonstrations

Several grant programs have been established through the 75-0516 State Grants and Demonstrations appropriation fund group. With the passage of the PPACA, several new grants were included in the account and the availability of funds for other grants was extended.

The *Deficit Reduction Act* Section 6201 provided Federal payments for several projects, including the Money Follows the Person demonstration, the Medicaid Integrity Program, and the establishment of alternative non-emergency providers.

CHIPRA provided for transition grants to provide funding to states to assist them in transitioning to a prospective payment system and grants to improve outreach and enrollment.

Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, Exchange, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. Medicare Advantage plans are required to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The *Clinical Laboratory Improvement Amendments of 1988* (CLIA) marked the first comprehensive effort by the federal government to regulate medical laboratory testing. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Beginning January 1, 2014, the PPACA requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Exchange to offset operating costs. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys, for coordination of benefits for the Part D program, and for new providers of medical or other items or services. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Healthcare Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs. User fees collected from Medicare Advantage plans seeking federal qualification and funds received from other federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated based on the CMS cost allocation system. It is reported under the Program Management (administrative) and Other (user fees) columns in the Other Financial Information section. Both of these activities are reported as dedicated collections.

The PPACA provides additional funding for Program Management to address activities such as Medicaid adult health quality measures, a nationwide program for national and state background checks on long-term care employees, evaluations of community prevention and wellness programs, quality measurements, state health insurance programs, the Medicare Independence at Home Demonstration program, and the complex diagnostic laboratory tests demonstration project.

Description of Concepts Unique to CMS and/or the Federal Government

Fund Balance with Treasury are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from the states and third parties.

Investments consist of trust fund (Dedicated collections) investments, which are investments (plus the accrued interest on investments) held by Treasury. SFFAS 27, *Identifying and Reporting Funds from Dedicated Collections*, prescribes certain disclosures concerning dedicated collections investments, such as the fact that cash generated from funds from dedicated collections is used by the U.S. Treasury for general government purposes and that, upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures. Additionally, investments consist of the CHIP Child Enrollment Contingency Fund investments (net of any accrued amortized or unrealized discounts) also held by Treasury (see Note 3).

Unexpended Appropriations include the portion of CMS's appropriations represented by undelivered orders and unobligated balances.

Benefit Payments are payments made by Medicare contractors, CMS, and state Medicaid agencies to health care providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement.

State Phased-Down Contributions are reimbursements to the SMI trust fund for the federal assumption of Medicaid prescription drug costs for dually eligible beneficiaries pursuant to the MMA. The MMA prescribes a formula for computing the states' contributions and allows states to make monthly payments. Amounts billed and collected under the State Phased-Down provision are recognized as a reduction to expense.

Medicare Premiums Collected are used to help finance benefits and administrative expenses. Premiums collected are for Part A, Part B, Medicare Advantage and Part D.

Budgetary Financing Sources (Other than Exchange Revenues) arise primarily from the exercise of the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other government entities, donations, and imputed financing. The major sources of Budgetary Financing Sources are as follows:

- **Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums Collected section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. Federal matching contributions consist of transfers of general funds to the HI trust fund in an amount equal to SECA tax credits made through the Payments to the Healthcare Trust Funds account.
- **Non-exchange Revenues** arise primarily from the exercise of the Government's power to demand payment from the public (e.g., taxes, duties, fines and penalties) but also include donations. Employment tax revenue is the primary source of financing for Medicare's HI program. Interest earned on HI and SMI trust fund investments, as well as on the Child Enrollment Contingency Fund investments, are also reported as non-exchange revenue.

Appropriations provide budget authority that permits government officials to incur obligations that result in immediate or future outlays of government funds.

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

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

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

Obligations are actions that create a legal liability to disburse funds, immediately or in the future. Budgetary resources must be available before obligating actions can be taken legally. In entitlement programs, obligations may arise under operation of law.

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

Obligations Incurred consists of expended authority and the change in undelivered orders. OMB exempted CMS from the Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133, Report on Budget Execution and Budgetary Resources. OMB issued a waiver mandating that CMS report all Medicare cash collections as an offsetting receipt.

Health Insurance Exchange 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.

Change in Presentation

Effective FY 2025, the principal statements and footnotes have been changed to a single-year presentation format.

NOTE 2:

Fund Balance with Treasury

(Dollars in Millions)

	FY 2025
Status of Fund Balance with Treasury:	
Unobligated Balance	$293,678
Obligated Balance not yet Disbursed	225,050
Non-Budgetary Fund Balance with Treasury	(76,412)
Total Fund Balance with Treasury	$442,316

The Unobligated Balance includes $54,629 million for CHIP, Program Management, the Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations which is not available for current use and is restricted for future use.

NOTE 3:

Investments

(Dollars in Millions)

Intragovernmental Investments as of September 30, 2025

Medicare Investments	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2026	4.250%	$19,289
Bonds	June 2027 to June 2038	2.250 – 4.625%	233,618
Accrued Interest			2,242
Total HI TF Investments			**$255,149**
SMI TF			
Certificates	June 2026	4.250 – 4.500%	$31,347
Bonds	June 2028 to June 2038	1.500 – 4.625%	122,497
Accrued Interest			745
Total SMI TF Investments			**$154,589**
Total Medicare Intragovernmental Investments			**$409,738**

Sections 1817 for HI and 1841 for SMI of the *Social Security Act* require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI trust fund or the SMI trust fund. The cash receipts collected from the public for a fund from dedicated collections are deposited in the U.S. Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI trust funds as evidence of their receipts. Treasury securities are an asset to the HI and SMI trust funds and a liability to the U.S. Treasury. Because the HI and SMI trust funds and the U.S. Treasury are both parts of the federal government, these assets and liabilities offset each other from the standpoint of the federal government as a whole. For this reason, they do not represent an asset or a liability in the U.S. government-wide financial statements.

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

Investment Summary

	Medicare (Dedicated Collections)			Consolidated Total
FY 2025	HI TF	SMI TF	Total	
Certificates	$19,289	$31,347	$50,636	$50,636
Bonds	233,618	122,497	356,115	356,115
Accrued Interest	2,242	745	2,987	2,987
Total Investments	$255,149	$154,589	$409,738	$409,738

NOTE 4:

Accounts Receivable, Net

(Dollars in Millions)

FY 2025	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Net Receivables
Intragovernmental					
Entity	**$681**		**$681**		**$681**
Total Intragovernmental	**$681**		**$681**		**$681**
Other than Intragovernmental					
Entity					
Medicare FFS	$14,250		$14,250	$(5,669)	$8,581
Medicare Advantage/Prescription Drug Program	23,195		23,195	(20)	23,175
Medicaid	7,917		7,917	(847)	7,070
CHIP	204		204		204
Other	10,709		10,709	(1,466)	9,243
Non-Entity	5	$169	174	(114)	60
Total Other than Intragovernmental	**$56,280**	**$169**	**$56,449**	**$(8,116)**	**$48,333**

Intragovernmental accounts receivable represents CMS claims for payment from other federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of the Fiscal Service (BFS) are eliminated against BFS's corresponding liabilities to CMS in the Consolidated Balance Sheets. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible.

Accounts receivable from other than intragovernmental are primarily composed of provider and beneficiary overpayments, Medicare Prescription drug overpayments, Medicare premiums, State phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, civil monetary penalties and restitutions, the recognition of Medicare secondary payer (MSP) accounts receivable, and Exchange activities. The accounts receivable is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable has been recorded to account for amounts due related to collections for Exchange activities.

NOTE 5:

Entitlement Benefits Due and Payable

(Dollars in Millions)

	FY 2025
Medicare FFS	$64,352
Medicare Advantage/Prescription Drug Program	40,343
Medicaid	57,979
CHIP	1,278
Totals	**$163,952**

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, 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.

The Medicare FFS 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, 2025 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 2025. 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, 2025.

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 based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded as of September 30, 2025; however, we believe these estimates to be reasonable.

NOTE 6:

Contingencies and Commitments

The contingencies balance as of September 30, 2025 is $8,244 million that consists of $5,994 million for audit and program disallowances and reimbursement of Medicaid state plan amendments along with $2,250 million for legal contingent liabilities. CMS 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. CMS accrues contingent liabilities where a loss is determined to be probable and the amount can be estimated. CMS may owe amounts to providers for previous years' disputed cost reports and claims adjustments. Additionally, other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. CMS does not record an accrual for a contingent liability if it is not estimable and probable, but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements.

NOTE 7:

Other Liabilities

(Dollars in Million)

The total Other than Intragovernmental Liabilities balance as of September 30, 2025 is $16,969 million. This consists primarily of the $9,809 million for liabilities not covered by budgetary resources for the Exchange Risk Adjustment programs.

	FY 2025
Intragovernmental	
Accrued Payroll and Benefits	$10
Custodial Liabilities	86
Total Intragovernmental	$96
Other than Intragovernmental	
Accrued Grant Liability	$4
Accrued Payroll and Benefits	112
Federal Employee and Veteran Benefits	13
Liability for Non-Fiduciary Deposit Funds and Un-Deposited Collections	538
Other Deferred Revenue	2,596
Other Liabilities With Related Budgetary Obligations	3,897
Other Liabilities Without Related Budgetary Obligations	9,809
Total Other than Intragovernmental	$16,969

NOTE 8:
Liabilities Not Covered by Budgetary Resources

(Dollars in Millions)

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. CMS recognizes such liabilities for debt, contingencies (see Note 6), employee annual leave earned but not taken, amounts billed by the Department of Labor for *Federal Employee's Compensation Act* (FECA) payments, and the Risk Adjustment program (reflected in the Other Line) below. For CMS revolving funds, all liabilities are funded as they occur.

	Medicare		Health						
FY 2025	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Program Management**	**Combined Total**	**Intra-CMS Eliminations**	**Consolidated Total**
Intragovernmental									
Debt		$94					$94		$94
Other					$85	$3	88		88
Total Intragovernmental		**94**			**85**	**3**	**182**		**182**
Other than Intragovernmental									
Federal Employee and Veterans Benefits	$7	1			18	64	90		90
Other					9,809		9,809		9,809
Contingencies	2,250		$5,994				8,244		8,244
Total Other than Intragovernmental	**2,257**	**1**	**5,994**		**9,827**	**64**	**18,143**		**18,143**
Total Liabilities Not Covered by Budgetary Resources	**2,257**	**95**	**5,994**		**9,912**	**67**	**18,325**		**18,325**
Total Liabilities Covered by Budgetary Resources	**76,323**	**148,588**	**57,981**	**1,278**	**4,438**	**245**	**288,853**	**(118,689)**	**170,164**
Total Liabilities Not Requiring Budgetary Resources	**193**	**2,403**			**539**		**3,135**		**3,135**
TOTAL LIABILITIES	**$78,773**	**$151,086**	**$63,975**	**$1,278**	**$14,889**	**$312**	**$310,313**	**$(118,689)**	**$191,624**

NOTE 9:
Net Cost of Operations

(Dollars in Millions)

FY 2025	Medicare		Health			Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other	
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$224,563	$252,607				$477,170
Medicare Advantage/Managed Care	206,829	315,113				521,942
Prescription Drug		150,136				150,136
Medicaid/CHIP			$670,393	$23,098		693,491
Other					$16,361	16,361
Bad Debt Expense and Write-offs	(71)	350	82		(7)	354
Total Benefit/Program Costs	**$431,321**	**$718,206**	**$670,475**	**$23,098**	**$16,354**	**$1,859,454**
OPERATING COSTS						
Medicare Integrity Program	$1,663					$1,663
Quality Improvement Organizations	558	$190				748
Program Management and Other Expenses	1,171	3,709	$241	$44	$1,055	6,220
Total Operating Costs	**3,392**	**3,899**	**241**	**44**	**1,055**	**8,631**
TOTAL COSTS	**$434,713**	**$722,105**	**$670,716**	**$23,142**	**$17,409**	**$1,868,085**
Less: Earned Revenues:						
Medicare Premiums	$6,143	$154,799				$160,942
Other Earned Revenues	3	15	$1		$15,898	15,917
Total Earned Revenues	**6,146**	**154,814**	**1**		**15,898**	**176,859**
Total CMS Eliminations	**21**	**32**			**(53)**	
TOTAL NET COST OF OPERATIONS	**$428,588**	**$567,323**	**$670,715**	**$23,142**	**$1,458**	**$1,691,226**

For purposes of financial statement presentation, non-CMS administrative costs included in the line of Program Management and Other Expenses that consist of the MAC administrative cost and the Bureau of the Fiscal Service administrative costs are considered expenses to the Medicare trust funds when outlaid by Treasury even though some funds may have been used to pay for assets, such as property and equipment. CMS administrative costs have been allocated to programs based on CMS's cost allocation system. Program Management costs allocated to the Medicare program include $2,255 million paid to Medicare contractors to carry out their responsibilities as CMS's agents in the administration of the Medicare program.

For reporting purposes, Medicare Part D expense has been reduced by actual and accrued reimbursements made by the states pursuant to the State Phased-Down provision. The FY 2025 Part D expense of $150,136 million is net of state reimbursements of $18,727 million. The gross expense would have been $168,863 million without these reimbursements.

NOTE 10:
Funds from Dedicated Collections

(Dollars in Millions)

CMS has designated as funds from dedicated collections the Medicare HI and SMI trust funds, which also include the Payments to the Healthcare Trust Funds appropriation and the HCFAC account. Other Non-Medicare includes user fees and program management (administrative) activities.

Balance Sheet as of September 30, 2025	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from Dedicated Collections (Consolidated)
ASSETS					
Intragovernmental Assets:					
Fund Balance with Treasury	$262,493	$16,181	$278,674		$278,674
Investments	409,738		409,738		409,738
Accounts Receivable, Net	109,703	6,804	116,507	$(115,826)	681
Other Assets	1	4	5		5
Total Intragovernmental Assets	**781,935**	**22,989**	**804,924**	**(115,826)**	**689,098**
Other than Intragovernmental Assets:					
Accounts Receivable, Net	**31,756**	**9,208**	**40,964**		**40,964**
General Property Plant & Equipment, Net	**196**	**1,028**	**1,224**		**1,224**
Advances and Prepayments	**1**		**1**		**1**
Total Other than Intragovernmental Assets	**31,953**	**10,236**	**42,189**		**42,189**
TOTAL ASSETS	**$813,888**	**$33,225**	**$847,113**	**$(115,826)**	**$731,287**
LIABILITIES					
Intragovernmental Liabilities:					
Accounts Payable	$120,066	$47	$120,113	$(115,826)	$4,287
Debt	94		94		94
Other Liabilities	1	9	10		10
Total Intragovernmental Liabilities	**120,161**	**56**	**120,217**	**(115,826)**	**4,391**
Other than Intragovernmental Liabilities:					
Accounts Payable	143	289	432		432
Entitlement Benefits Due and Payable	104,695		104,695		104,695
Other Liabilities					
Contingencies and Commitments	2,250		2,250		2,250
Other	2,610	13,804	16,414		16,414
Total Other than Intragovernmental Liabilities	**109,698**	**14,093**	**123,791**		**123,791**
TOTAL LIABILITIES	**$229,859**	**$14,149**	**$244,008**	**$(115,826)**	**$128,182**
NET POSITION					
Unexpended Appropriations-Funds from Dedicated Collections	$233,517	$3,386	$236,903		$236,903
Cumulative Results of Operations-Funds from Dedicated Collections	350,512	15,690	366,202		366,202
TOTAL NET POSITION	**$584,029**	**$19,076**	**$603,105**		**$603,105**
TOTAL LIABILITIES AND NET POSITION	**$813,888**	**$33,225**	**$847,113**	**$(115,826)**	**$731,287**
Statement of Net Cost for the Year Ended September 30, 2025					
Benefit and Program Expenses	$1,149,527	$15,001	$1,164,528		$1,164,528
Operating Costs	1,928	6,559	8,487		8,487
Total Costs	**1,151,455**	**21,560**	**1,173,015**		**1,173,015**
Less: Earned Revenues	(160,942)	(15,907)	(176,849)		(176,849)
NET COST OF OPERATIONS	**$990,513**	**$5,653**	**$996,166**		**$996,166**

NOTE 10:

Funds from Dedicated Collections (continued)

(Dollars in Millions)

	Medicare	Other Non-Medicare	Total Funds from Dedicated Collections (Combined)	Eliminations	Total Funds from Dedicated Collections (Consolidated)
Statement of Changes in Net Position for the Year Ended September 30, 2025					
UNEXPENDED APPROPRIATIONS					
Beginning Balance	**$260,565**	**$3,351**	**$263,916**		**$263,916**
Budgetary Financing Sources:					
Appropriations Received	657,683	251	657,934		657,934
Other Adjustments	(75,235)	(4)	(75,239)		(75,239)
Appropriations Used	(609,496)	(212)	(609,708)		(609,708)
Change in Unexpended Appropriations	**(27,048)**	**35**	**(27,013)**		**(27,013)**
TOTAL UNEXPENDED APPROPRIATIONS: ENDING BALANCE	**$233,517**	**$3,386**	**$236,903**		**$236,903**
CUMULATIVE RESULTS OF OPERATIONS					
Beginning Balance	**$326,649**	**$14,152**	**$340,801**		**$340,801**
Appropriations Used	609,496	212	609,708		609,708
Non-exchange Revenue:					
Intragovernmental Non-exchange Revenue	415,938		415,938		415,938
Other than Intragovernmental Non-exchange Revenue	429		429		429
Transfers-in/out without Reimbursement	(11,497)	5,693	(5,804)		(5,804)
Imputed Financing	10	1,286	1,296		1,296
Total Financing Sources	**$1,014,376**	**$7,191**	**$1,021,567**		**$1,021,567**
Net Cost of Operations	**990,513**	**5,653**	**996,166**		**996,166**
NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS	**23,863**	**1,538**	**25,401**		**25,401**
CUMULATIVE RESULTS OF OPERATIONS: ENDING BALANCE	**$350,512**	**$15,690**	**$366,202**		**$366,202**
NET POSITION	**$584,029**	**$19,076**	**$603,105**		**$603,105**

NOTE 11:

Statement of Budgetary Resources Disclosures

(Dollars in Millions)

Net adjustments to unobligated balance, brought forward, October 1 as of September 30, 2025 consisted of the following:

Net Adjustments to Unobligated Balance, Brought Forward, October 1	FY 2025
Budgetary Resources:	
Unobligated balance, brought forward, October 1	$313,071
Recoveries of prior year unpaid obligations	55,099
Recoveries of prior year paid obligations	21,837
Canceled authority	(45,821)
Prior year adjustments	132
Other	(3,446)
Total Unobligated Balance Brought Forward, October 1	**$340,872**

Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources (SBR). 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. The excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the SBR and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and can become available for obligation as needed. The entire trust fund balances of $305,515 million are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2025 (in millions):

	FY 2025 Combined Balance
Trust Fund Balance, Beginning	**$294,385**
Receipts	**1,038,129**
Less: Obligations	**(1,026,999)**
Excess of Receipts over Obligations (+/-)	**11,130**
Trust Fund Balance, Ending	**$305,515**

Explanations of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2024

CMS reconciled the amounts of the FY 2024 column of the SBR to the actual amounts for FY 2024 from the Appendix in the FY 2026 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections). The Budget with the actual amounts for the current year (FY 2025) will be available at a later date.

FY 2024	Budgetary Resources	New Obligations & Upward Adjustments	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$2,618,308	$2,305,236	$699,790	$2,215,703
Expired Accounts	(255,438)			
Other	7,239	7,236		6,527
Budget of the US Govt (2024 Actual)	**$2,370,109**	**$2,312,472**	**$699,790**	**$2,222,230**

For the budgetary resources' reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. The Expired Accounts line included expired authority, recoveries and other amounts included in the Combined SBR that are not included in the President's Budget. The Other line, contained in the SBR and not in the President's Budget for budgetary resources, obligations incurred and net outlays, are CMS amounts reported on CDC and HHS statements and Government-wide Treasury Account Symbol Adjusted Trial-Balance System (GTAS) adjustments.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $55,539 million.

FY 2025	Federal	Non-Federal
Undelivered orders **(unpaid)**	$724	$54,809
Undelivered orders **(paid)**	5	1
Total	**$729**	**$54,810**

NOTE 12:

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 *2025 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016–2017 Technical Review Panel.

With two exceptions, the projections are based on the current-law provisions[1] of the *Social Security Act* as of the date of release of the Medicare Trustees Report. The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Medicare Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the Medicare HI trust fund to become depleted.

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

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

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[1] Because it was enacted after the release of the 2025 Medicare Trustees Report, the projections do not reflect the impact of the Medicare provisions in the *One Big Beautiful Bill Act* of 2025 (OBBBA: Public Law 119-21). Three provisions affect the Medicare program directly, with a negligible estimated impact on spending. The combined net effect of the income tax provisions in the OBBBA results in less overall tax liability for Social Security beneficiaries, meaning the HI trust fund is projected to receive less revenue from income taxation of Social Security benefits for all years beginning in 2025, and the timing for reserve depletion is accelerated by roughly one year. The 2026 Trustees Report will reflect updated economic and demographic assumptions that incorporate the effects of the OBBBA as well as other factors and experience into the projections. As a result, the status of the HI trust fund that will be reported in the 2026 Medicare Trustees Report is uncertain at this time.

Similarly, the projections do not reflect the impact of the Medicare provisions in the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37), which was enacted on November 12, 2025. The provisions included were temporary extensions of prior policies, a reduction in the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through February of 2033. The estimated impact is negligible over the next few years and there is no impact beyond 2033.

Lastly, the projections do not reflect the impact of the skin substitute policies finalized in the Calendar Year 2026 Physician Fee Schedule final rule, which was published on November 5, 2025. These policies significantly reduce spending for skin substitute services provided under Part B. Based on the projections reflected in the 2025 Medicare Trustees Report, the estimated impact on total Part B expenditures is a reduction of roughly 3.4 percent, including the reduction in fee-for-service spending and the associated impact on payments to Medicare Advantage plans, beginning in 2026.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

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

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

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

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

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2025 SOSI actuarial projections are drawn from the Medicare Trustees Reports for 2025. 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.[2]

TABLE 1:
Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2025

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[13]
2025	1.64	2,102,000	764.4	1.47	3.97	2.47	2.3	3.7[9]	5.4[10,11]	5.9[11,12]	1.8
2030	1.72	1,323,000	734.3	1.45	3.88	2.40	2.0	4.6	7.2	2.2	1.7
2040	1.87	1,289,000	676.1	1.22	3.65	2.40	1.9	4.2	5.5	2.8	2.2
2050	1.90	1,260,000	623.8	1.08	3.51	2.40	1.8	3.3	3.7	4.0	2.3
2060	1.90	1,251,000	577.6	1.10	3.53	2.40	1.9	3.3	3.9	4.0	2.3
2070	1.90	1,244,000	536.6	1.13	3.56	2.40	1.8	3.4	3.6	3.8	2.3
2080	1.90	1,240,000	500.1	1.13	3.55	2.40	1.8	3.4	3.7	3.9	2.3
2090	1.90	1,237,000	467.6	1.13	3.56	2.40	1.9	3.6	3.8	4.0	2.3

1 Average number of children per woman.

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

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

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

5 Average annual wage in covered employment.

6 The CPI represents a measure of the average change in prices over time in a fixed group of goods and services.

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

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

9 Reflects higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

10 Reflects higher projected spending for outpatient hospital and physician-administered drugs.

11 Reflects *Inflation Reduction Act of 2022*.

12 Reflects lower projected enrollment that is disproportionately lower for those eligible for low-income subsidies.

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

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

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 below 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 2025–2021

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
FY 2025	1.9	1,237,000	467.6	1.13	3.56	2.40	1.9	3.6	3.8	4.0	2.3
FY 2024	1.9	1,216,000	468.1	1.13	3.56	2.40	2.0	3.5	3.7	3.9	2.3
FY 2023	2.0	1,216,000	469.9	1.12	3.55	2.40	2.1	3.5	3.7	4.0	2.3
FY 2022	2.0	1,217,000	469.9	1.14	3.54	2.40	2.1	3.5	3.7	4.2	2.3
FY 2021	2.0	1,218,000	472.7	1.14	3.54	2.40	2.1	3.4	3.7	4.2	2.3

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

2 Includes lawful permanent resident (LPR) immigration, net of emigration, as well as temporary or unlawfully present immigration. The ultimate level of net LPR immigration is 788,000 persons per year, and the assumption for annual net temporary or unlawfully present immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

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

4 Beginning with the 2023 Trustees Report, for consistency with other growth rate measures, the real-wage growth is defined as the annual percentage change in average wages adjusted for the average percentage change in the CPI. In the 2022 and earlier Trustees Reports it is presented as the difference between percentage increases in wages and the CPI and referred to as real-wage differential. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

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 2090.

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

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

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 2090.

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

NOTE 13:

Alternative SOSI Projections (Unaudited)

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

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

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

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028–2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period.[3] 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.

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

Table 3 below 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.

TABLE 3:

Medicare Present Values

(in billions)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	$33,133	$33,218
Part B	68,530	76,922
Part D	10,733	10,732
Expenditures		
Part A	36,435	43,287
Part B	68,530	76,922
Part D	10,733	10,732
Income less expenditures		
Part A	(3,301)	(10,069)
Part B		
Part D		

[1] These amounts are not presented in the 2025 Trustees Report.

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

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly 36 percent of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-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 and the physician updates transitioned to the Medicare Economic Index, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 19 percent and Part B expenditures would be higher than the current-law projections by roughly 12 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 12 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

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

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

NOTE 14:

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 non-interest 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, 2024 to the period beginning on January 1, 2025, and the reconciliation from the period beginning on January 1, 2023 to the period beginning on January 1, 2024. The reconciliation identifies several significant components of the change and provides reasons for the change.

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

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

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

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

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the SCSIA are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Medicare Trustees Reports for those years. Table 1 of Note 12 summarizes these assumptions for the current year.

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

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

Period beginning on January 1, 2023 and ending January 1, 2024

Present values as of January 1, 2023 are calculated using interest rates from the intermediate assumptions of the 2023 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2024. 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 2023 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 2024 Trustees Report.

Change in the Valuation Period

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

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

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2023–97) to the current valuation period (2024–98) 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 2023, replaces it with a much larger negative net cash flow for 2098, and measures the present values as of January 1, 2024, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2023–97 to 2024–98. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2023 are realized. The change in valuation period resulted in a small decrease 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 $157 billion.

Change in Projection Base

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

Actual income and expenditures in 2024 were different from what was anticipated when the 2024 Trustees Report projections were prepared. For Part A, B, and D income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is a decrease of $638 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, 2024 and January 1, 2025 is incorporated in the current valuation and is less than projected in the prior valuation.

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024

Actual income and expenditures in 2023 were different from what was anticipated when the 2023 Trustees Report projections were prepared. Part A income was higher and expenditures were lower than estimated based on actual experience. For Part B and Part D, income and expenditures were both higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $746 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, 2023 and January 1, 2024 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, 2024 to the period beginning on January 1, 2025

The demographic assumptions used in the Medicare projections are the same as those used for the 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, 2025) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

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

There were two notable changes in demographic methodology.

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

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

From the period beginning on January 1, 2023, to the period beginning on January 1, 2024

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

For the current valuation (beginning on January 1, 2024), there was one change to the ultimate demographic assumptions.

- The ultimate total fertility rate was lowered from 2.0 children per woman to 1.9 children per woman, and at the same time, the year the ultimate total fertility rate is reached was changed from 2056 to 2040.

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

- Final birth rate data for calendar year 2022 and preliminary data for 2023 indicated slightly lower birth rates than were assumed in the prior valuation, leading to slightly lower assumed birth rates during the period of transition to the ultimate level.
- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.
- Mortality data, historical population data, temporary or unlawfully present immigration data, and divorce data were updated since the prior valuation.

There was one notable change in demographic methodology. The method for projecting fertility rates during the transition period to the ultimate rate was modified to produce more reasonable paths to the ultimate assumed rates by age group than had been previously used.

These changes resulted in a decrease in the estimated future net cash flow. For Part A, the present value of estimated income is lower and the present value of estimated expenditures is higher. The present values of estimated expenditures and income for both Part B and Part D are higher. Overall, these changes decreased the present value of the estimated future net cash flow by $698 billion.

Changes in Economic and Health Care Assumptions

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

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

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

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

Additionally, there were several notable changes in economic methodology.

- The model to project the civilian non-institutional (CNI) population was updated to make the CNI projections more consistent with the projections of the Social Security area population.
- The method used for projecting average weeks worked during a calendar year, a key component of projections of OASDI covered employment, was updated. The updated approach uses historical data through 2021 and a more directly relevant data source.

- The process used to calculate and apply adjustments that smooth the age profile of labor force participation rates was improved, resulting in a decrease in projected labor force participation rates of workers age 75 and older relative to the prior valuation.

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

- Higher Part A projected spending growth because of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.
- Higher Part B projected spending growth due to higher projected spending for outpatient hospital and physician-administered drugs.
- Lower Part D projected spending growth because of lower Part D enrollment which is disproportionately lower for those eligible for low-income subsidies.

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

For the period beginning on January 1, 2023 to the period beginning on January 1, 2024

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

The ultimate economic assumptions for the current valuation (beginning on January 1, 2024) 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 most significant changes are identified below.

- An update to educational attainment data caused a change in labor force participation rates at ages 55 and older for men and 50 and older for women.
- Historical OASDI covered employment for 2021 was higher than assumed under the prior valuation. Specifically, covered employment for 2021 was significantly higher than previously estimated at the youngest and oldest working ages, and lower for men at early prime working ages.
- Economic growth through 2023 was higher than assumed under the prior valuation, which led to a higher assumed level of labor productivity over the projection period.

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

- Lower Part A projected spending growth due to (i) a policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in section IV.C of the 2024 Medicare Trustees Report, and (ii) lower projected spending for hospital and home health agency services.
- Lower Part D growth mainly beyond the short-range period.

The net impact of these changes was an increase in the estimated future net cash flow for total Medicare. For Part A, these changes increased the present value of estimated future income and decreased the present value of expenditures. For Part B, these changes resulted in an increase in the present value of estimated expenditures (and income) and for Part D they resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes increased the present value of the estimated future net cash flow by $2,106 billion.

Changes in Law

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

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

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

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through November 30, 2032. (In other words, the benefit payment reductions for the month of November 2032 are changed from 0 percent to 2 percent.)
- The funding amount of $2,197,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-35 in last year's report, is reduced to $0. (This fund is intended to be available for improvements to the original fee-for-service program under Parts A and B, and funding is provided from the HI and SMI trust funds in such proportions as deemed appropriate by the Secretary of Health and Human Services.)
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through December 31, 2024 (from September 30, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After December 31, 2024, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2024, is extended through December 31, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through December 31, 2024 (from March 8, 2024).
- In the formula used for determining payment rates under the physician fee schedule, the physician payment update is changed for services furnished March 9, 2024, through December 31, 2024. As a result, the update of −1.22 percent, which was to be in effect throughout 2024, is now to apply only through March 8, and an update of 0.42 percent (as compared with the 2023 payment level) is to apply for the remainder of the year.
- For physicians participating in advanced alternative payment models, incentive payment availability is extended 1 year, through performance year 2024. However, for payment year 2026 (which applies to performance year 2024), the incentive payments are to equal 1.88 percent of fee schedule payments (as compared with 5 percent for 2019–2024 and 3.5 percent for 2025). In addition, the current freeze on the participation thresholds that must be met to qualify for the incentive payments is extended for the same additional year. (The more stringent thresholds will now first apply in 2027.)

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

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

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

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

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

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

- Certain ground ambulance add-on payments that had been extended through March 31, 2025, under Public Law 118-158 are now extended through September 30, 2025. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.

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

For the period beginning on January 1, 2023 to the period beginning on January 1, 2024

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

***The Further Continuing Appropriations and Other Extensions Act, 2024* (Public Law 118-22, enacted on November 16, 2023) included provisions that affect the HI and SMI programs.**

- The funding amount of $180 million that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 117-328 in last year's report, is increased to $466,795,056. This fund is intended to be available for improvements to the original fee-for-service program under Parts A and B, and funding is provided from the HI and SMI trust funds in such proportions as deemed appropriate by the Secretary of Health and Human Services.
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through January 20, 2024 (from January 1, 2024).
- For clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests, changes are made to the market-based system used to update the Medicare clinical laboratory fee schedule. First, laboratories are exempted for another year from the requirement that they report private payer rates; the next data-reporting period is now the first quarter of 2025 (instead of the first quarter of 2024). Next, for the caps in place to limit reductions in fee schedule payments during the phase-in period, the timing is changed. Specifically, tests furnished during 2021–2024 (rather than 2021–2023) are to be paid at the same rates as under the 2020 fee schedule, and payments for tests provided during 2025–2027 (rather than 2024–2026) may not be reduced by more than 15 percent per year.

***The National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023) included provisions that affect the HI and SMI programs.**

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through October 31, 2032. (In other words, the benefit payment reductions for the month of October 2032 are changed from 0 percent to 2 percent.)
- The funding amount of $466,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-22, is increased to $2,250,795,056.

***The Further Continuing Appropriations and Other Extensions Act, 2024* (Public Law 118-35, enacted on January 19, 2024) included provisions that affect the HI and SMI programs.**

- The funding amount of $2,250,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-31, is reduced to $2,197,795,056.
- The 1.00 floor on the geographic index for physician work is extended through March 9, 2024 (from January 20, 2024).

For Part A and Part D there was no change in the present values of estimated income and expenditures. For Part B, these changes resulted in a slight decrease in the present value of estimated expenditures (and income). Overall, these changes had no impact on the present value of the estimated future net cash flow for total Medicare.

NOTE 15:

Budget and Accrual Reconciliation

(Dollars in Millions)

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

As of September 30, 2025	Intragovernmental	Other than Intragovernmental	Total
NET COST OF OPERATIONS (SNC)	**$2,345**	**$1,688,881**	**$1,691,226**
Components of Net Cost Not Part of the Budgetary Outlays:			
Property, Plant, and Equipment Depreciation Expense		(526)	(526)
Applied Overhead/Cost Capitalization Offset		62	62
		(464)	**(464)**
Increase/(Decrease) in Assets:			
Accounts Receivable, Net	27	10,859	10,886
Securities and Investments	403		403
Advances and Prepayments	(1)		(1)
Other Assets		(32)	(32)
	429	**10,827**	**11,256**
(Increase)/Decrease in Liabilities:			
Accounts Payable	227	(14)	213
Debt Associated with Loans	129		129
Entitlement Benefits Due and Payable		(22,355)	(22,355)
Accrued Grant Liabilities		5	5
Contingencies and Commitments		(2,916)	(2,916)
Other Liabilities	(1)	2,423	2,422
	355	**(22,857)**	**(22,502)**
Other Financing Sources:			
Imputed Cost	(1,310)		(1,310)
Total Components of Net Operating Cost Not Part of the Budgetary Outlays	**(526)**	**(12,494)**	**(13,020)**
Components of Budget Outlays that are Not Part of Net Operating Cost:			
Other Financing Sources:			
Transfers out (in) without Reimbursements	4,088		4,088
Total Components of Budget Outlays that are Not Part of Net Operating Cost	**4,088**		**4,088**
Miscellaneous Items:			
Custodial/Non-exchange Revenue	(13,407)	934	(12,473)
Non-entity Activity	2		2
Appropriated Receipts for Trust/Special Funds		11,699	11,699
Reconciling Items:			
Debt Associated with Loans	(129)		(129)
Custodial/Non-exchange Revenue	13,407	(934)	12,473
Investment Interest Receivable	(403)		(403)
Other Reconciling Items	(1,565)	576	(989)
Total Miscellaneous Items	**(2,095)**	**12,275**	**10,180**
Total Net Outlays	**$3,812**	**$1,688,662**	**$1,692,474**

Required Supplementary Information

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

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

RSI material is generally drawn from the *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

With two exceptions, the projections are based on the current-law provisions[1] of the Social Security Act. The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

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

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

Certain features of current law may result in some challenges for the Medicare program. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician Medicare provider categories are reduced by the growth in economy-wide private nonfarm business total factor productivity.[2] However, these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

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[1] Because it was enacted after the release of the 2025 Medicare Trustees Report, the projections do not reflect the impact of the Medicare provisions in the *One Big Beautiful Bill Act* of 2025 (OBBBA: Public Law 119-21). Three provisions affect the Medicare program directly, with a negligible estimated impact on spending. The combined net effect of the income tax provisions in the OBBBA results in less overall tax liability for Social Security beneficiaries, meaning the HI trust fund is projected to receive less revenue from income taxation of Social Security benefits for all years beginning in 2025, and the timing for reserve depletion is accelerated by roughly one year. The 2026 Trustees Report will reflect updated economic and demographic assumptions that incorporate the effects of the OBBBA as well as other factors and experience into the projections. As a result, the status of the HI trust fund that will be reported in the 2026 Medicare Trustees Report is uncertain at this time.

Similarly, the projections do not reflect the impact of the Medicare provisions in the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37), which was enacted on November 12, 2025. The provisions included were temporary extensions of prior policies, a reduction in the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through February of 2033. The estimated impact is negligible over the next few years and there is no impact beyond 2033.

Lastly, the projections do not reflect the impact of the skin substitute policies finalized in the Calendar Year 2026 Physician Fee Schedule final rule, which was published on November 5, 2025. These policies significantly reduce spending for skin substitute services provided under Part B. Based on the projections reflected in the 2025 Medicare Trustees Report, the estimated impact on total Part B expenditures is a reduction of roughly 3.4 percent, including the reduction in fee-for-service spending and the associated impact on payments to Medicare Advantage plans, beginning in 2026.

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

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

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

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

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

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most health care provider categories, 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 expenditure projections reflect the cost-reduction provisions required under current law.

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

- There would be a transition from current-law[3] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; and
- The average physician payment updates would transition from current law[4] to payment updates that reflect the Medicare Economic Index.

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[3] 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).

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

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

Additional information on the current-law and illustrative alternative projections is provided in Note 13 in these consolidated financial statements, in section V.C of this year's Trustees Report, and in a memorandum prepared by the CMS Office of the Actuary.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from the CMS website.[5]

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.[6] 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.[7]

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

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

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

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

Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.6 percent in 2049, or GDP plus 0.0 percent, declining gradually to 3.4 percent in 2099, or GDP minus 0.3 percent.

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

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

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

(ii) Physician services.

Payment rate updates are 0.75 percent per year for qualified physicians assumed to be participating in advanced alternative payment models and 0.25 percent for those assumed to be participating in the merit-based incentive payment system. The year-by-year cost growth rates for physician payments are assumed to decline from 3.1 percent in 2049, or GDP minus 0.5 percent, to 2.8 percent in 2099, or GDP minus 0.9 percent.

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

Such services include durable medical equipment that is not subject to competitive bidding,[8] care at ambulatory surgical centers, ambulance services, and medical supplies.

The year-by-year cost growth rates for these services are assumed to decline from 2.8 percent in 2049, or GDP minus 0.8 percent, to 2.6 percent in 2099, or GDP minus 1.1 percent.

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

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

The long-range cost growth rates for these services are assumed to equal the growth rates as determined from the "factors contributing to growth" model. The corresponding year-by-year cost growth rates decline from 4.3 percent in 2049, or GDP plus 0.7 percent, to 4.1 percent by 2099, or GDP plus 0.4 percent.

(v) Prescription drugs provided through Part D.

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

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

The corresponding year-by-year cost growth rates decline from 4.1 percent in 2049, or GDP plus 0.5 percent, to 3.9 percent by 2099, or GDP plus 0.2 percent.

These long-range cost growth rates must be modified to account for demographic impacts. Beginning with the 2020 Trustees Report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death adjustment. This adjustment reflects the fact that the closer an individual is to death, the higher his or her health care spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on health care is offset somewhat.[9] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing facility, and home health agency services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, the incorporation of the time-to-death adjustment has a smaller effect.

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[8] The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see section IV.B of the 2025 Trustees Report.

[9] More information on the time-to-death adjustment is available on the **CMS website**.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent in 2049,[10] or GDP plus 0.3 percent, declining to 3.8 percent by 2099, or GDP plus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2049, declining to 3.7 percent, or GDP plus 0.0 percent by 2099.

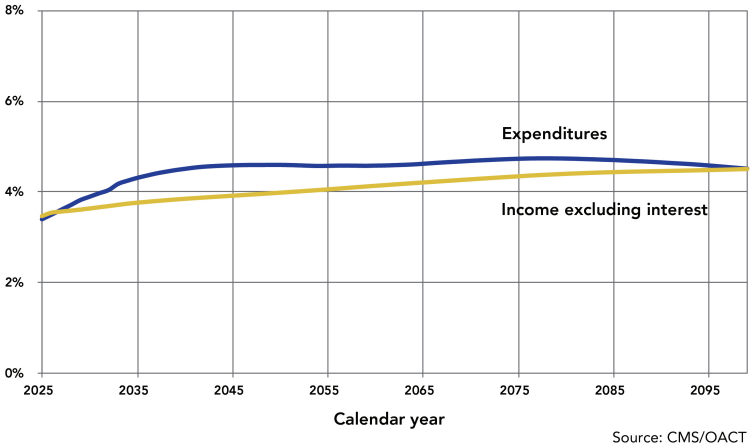
HI Cash Flow as a Percentage of Taxable Payroll

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates are higher than those from last year for all years because of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. High-income workers also pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns).

Chart 1
HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll
2025 – 2099



Source: CMS/OACT

Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation; this outcome will occur because the income thresholds determining taxable benefits are not indexed for price inflation and the income tax brackets are indexed to the chained CPI, which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the chained CPI as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as taxable payroll.[11] Thus, as chart 1 shows, the income rate is expected to gradually increase over current levels.

After remaining steady in 2023 and 2024, as indicated in chart 1, the cost rate is projected to rise in 2025 and beyond primarily as a result of an acceleration of health services cost growth. This cost rate increase is moderated by the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2034 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.0 percent in 2050 and 6.9 percent in 2099.

[10] In 2049, the shares of Part B spending are 28 percent for services updated by input price indexes, 16 percent for physician services, 6 percent for services updated by the CPI, and 51 percent for the remaining Part B services.

[11] For more detailed information on the projection of income from taxation of Social Security benefits, see section V.C7 of the *2025 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.*

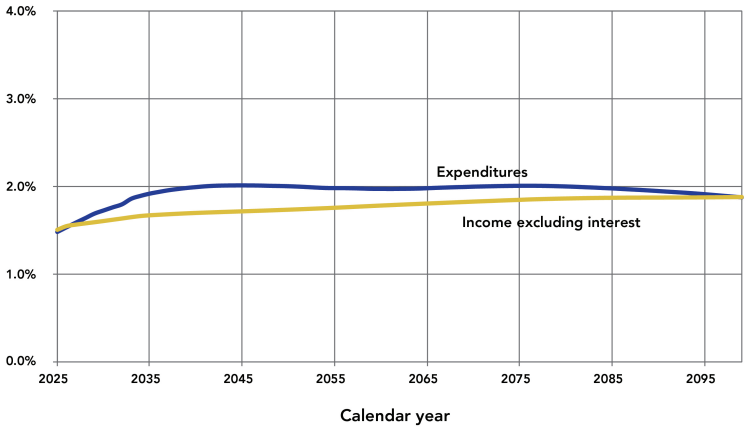
HI and SMI Cash Flow as a Percentage of GDP

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

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2024, the expenditures were $422.5 billion, which was 1.4 percent of GDP. As chart 2 illustrates, this percentage is projected to increase steadily until about 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 2.9 percent in 2099.

Chart 2
HI Expenditures and Income Excluding Interest as a Percentage of GDP
2025 – 2099



Source: CMS/OACT

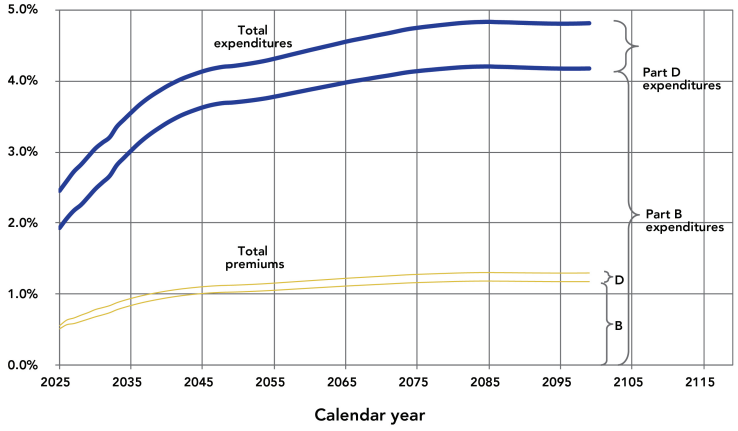
SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and government contributions, which are transfers from the general fund of the Treasury.

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

In 2024, SMI expenditures were $699.6 billion, or about 2.4 percent of GDP. Under current law, they would grow to about 4.2 percent of GDP within 25 years and to 4.8 percent by the end of the projection period, as demonstrated in chart 3. Under the illustrative alternative, total SMI expenditures in 2099 would be 5.9 percent of GDP.

Chart 3
SMI Expenditures and Premiums as a Percentage of GDP
2025 – 2099



Source: CMS/OACT

To match the faster growth rates for SMI expenditures, government contributions and beneficiary premiums would increase more rapidly than GDP over time but at a slower rate compared with the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2024 by about 4.3 percent annually. The associated beneficiary premiums—and general fund financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. State payments have increased faster than GDP for most years since 2015 and are projected to do so for most of the long-range period; for most of the short-range period, however, they are projected to increase more slowly than GDP.

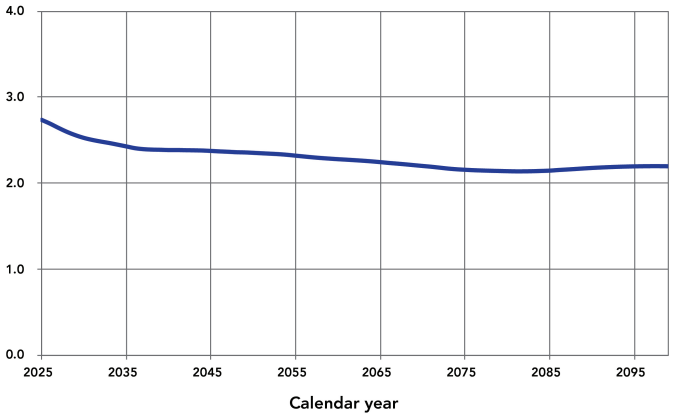
Worker-to-Beneficiary Ratio

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 2024, every beneficiary had about 2.8 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in chart 4. The projected ratio continues to decline until there are only 2.2 workers per beneficiary by 2099.

Chart 4
Number of Covered Workers per HI Beneficiary
2025 – 2099



Source: CMS/OACT

Sensitivity Analysis

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

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[12] The assumptions varied are the health care cost factors, real-wage growth, CPI, real-interest rate, fertility rate, and net immigration.[13]

For this analysis, the intermediate economic and demographic assumptions in the *2025 Trustees Report* were used as the reference point. Each selected assumption was varied individually to produce three scenarios. All present values were calculated as of January 1, 2025, and are based on estimates of income and expenditures during the 75-year projection period.

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

[13] 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.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 15 to 20 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

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

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

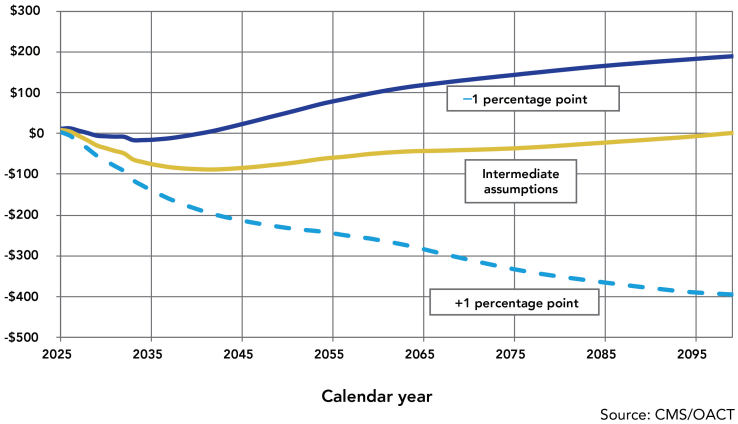
Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$6,916	−$3,301	−$19,623

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $10,217 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 $16,322 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.

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

Chart 5
Present Value of HI Net Cash Flow with Various Healthcare Cost Factors
2025 – 2099
(in billions)



Source: CMS/OACT

Real-Wage Growth

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage growth assumptions: 0.53, 1.13, and 1.73 percentage points.[14] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent.

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

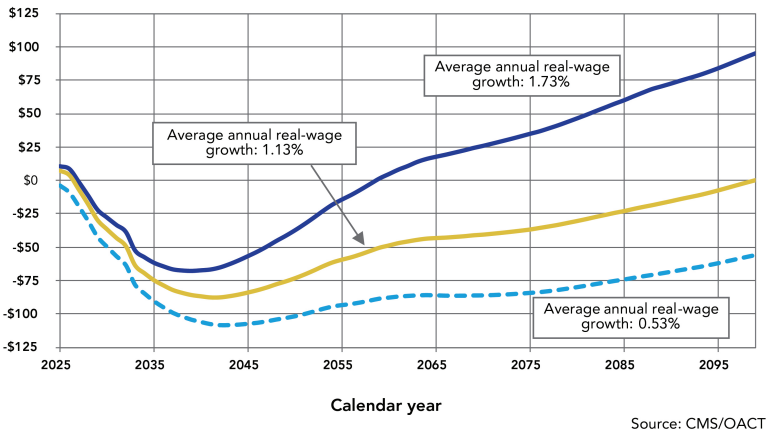
Ultimate percentage increase in real-wage growth	0.53	1.13	1.73
Income minus expenditures (in billions)	−$6,021	−$3,301	$622

As indicated in table 2, for each 0.6-percentage-point increase in the ultimate real-wage growth assumption, the deficit—expressed in present-value dollars—decreases, on average, by about $3,321 billion.

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

When expressed in present-value dollars, faster real-wage growth results in smaller HI cash flow deficits, as demonstrated in chart 6. Higher real-wage growth immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers.

Chart 6
Present Value of HI Net Cash Flow with Various Real-Wage Growth Assumptions
2025 – 2099
(in billions)



Source: CMS/OACT

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

Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the ultimate real-wage growth assumption is 1.13 percent.

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

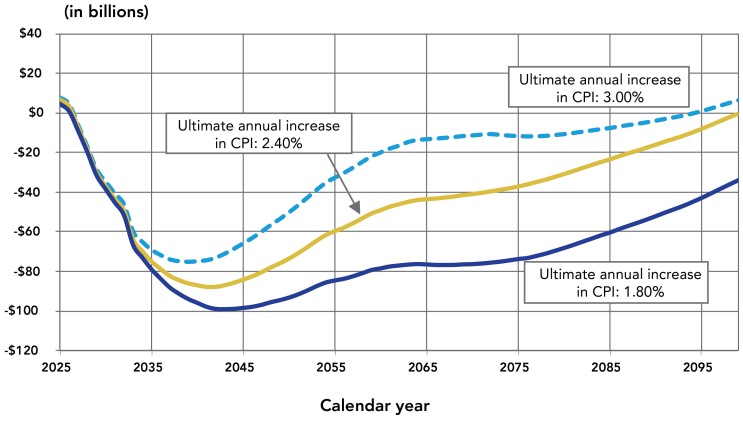
Ultimate percentage increase in CPI	3.00	2.40	1.80
Income minus expenditures (in billions)	–$2,001	–$3,301	–$5,144

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,300 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by approximately $1,842 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 is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Chart 7
Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions
2025 – 2099



Source: CMS/OACT

Real-Interest Rate

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

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

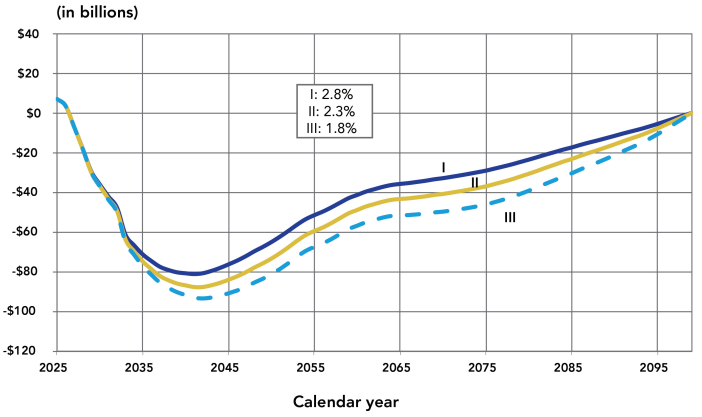
Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	−$3,744	−$3,301	−$2,887

As demonstrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $85 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 2033. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Chart 8
Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions 2025 – 2099



Source: CMS/OACT

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: 1.6, 1.9, and 2.1 children per woman.

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

Ultimate fertility rate[1]	1.6	1.9	2.1
Income minus expenditures (in billions)	−$4,471	−$3,301	−$2,494

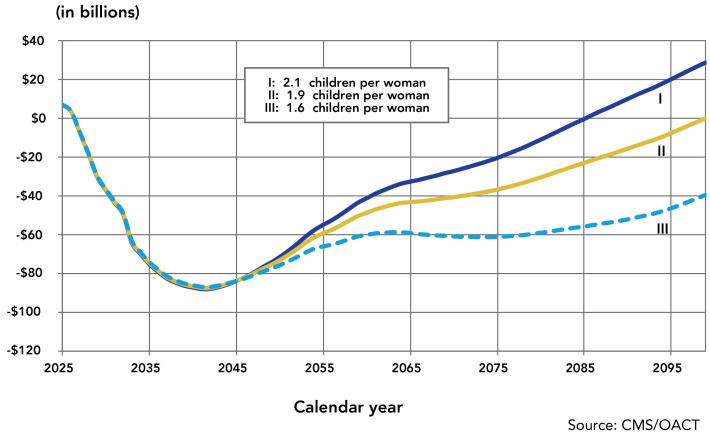
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As table 5 demonstrates, for every increase of 0.1 percentage point in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $395 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.

Chart 9
Present Value of HI Net Cash Flow with Various Ultimate Fertility Rate Assumptions
2025 – 2099



Source: CMS/OACT

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: 836,000 persons, 1,273,000 persons, and 1,733,000 persons per year.

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

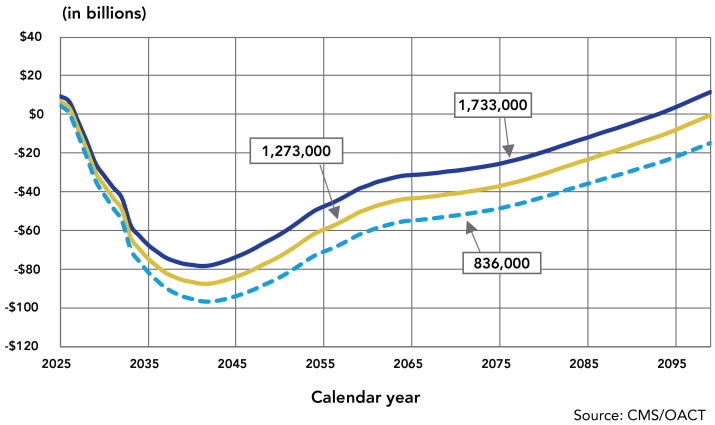
Average annual net immigration	836,000	1,273,000	1,733,000
Income minus expenditures (in billions)	−$4,093	−$3,301	−$2,533

As indicated in table 6, if the average annual net immigration assumption is 836,000 persons, the deficit—expressed in present-value dollars—increases by $792 billion. Conversely, if the assumption is 1,733,000 persons, the deficit decreases by approximately $769 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 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.

Chart 10
Present Value of HI Net Cash Flow with Various Net Immigration Assumptions
2025 – 2099



Source: CMS/OACT

Trust Fund Finances and Sustainability

HI

This year's short-range financial outlook for the HI trust fund is less favorable than last year's Medicare Trustees Report projections. The estimated depletion date for the HI trust fund is 2033, 3 years earlier than projected in last year's Trustees Report. HI income is projected to be initially higher and then lower throughout the projection period because average wages are initially higher and then lower. HI expenditures are projected to be higher through the short-range period mainly as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

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

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

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

SMI

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

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program expenditures and dedicated financing sources[15] will exceed 45 percent of total Medicare expenditures within the next 7 fiscal years (2025–2031). For the 2025 Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2025. The Trustees are therefore issuing a determination.[16]

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

- The President to submit to Congress proposed legislation to respond to the warning within 15 days after the Fiscal Year 2027 Budget submission; and
- Congress to consider the legislation on an expedited basis.

Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 through 2024 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the HI trust fund's projected depletion, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2025 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together to quickly address these challenges."

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

[16] Section V.B of the 2025 Trustees Report contains additional details on these tests.

Combining Statement of Budgetary Resources

For the Year Ended September 30, 2025

(in millions)

	Medicare			Payments to Trust Funds	Medicaid	CHIP	Other	Program Management	Combined Total
	HI	SMI	Part D						
Budgetary Resources:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	**$1,870**	**$1,394**	**$1,477**	**$219,774**	**$50,232**	**$46,107**	**$18,681**	**$1,337**	**$340,872**
Appropriations (discretionary and mandatory)	444,127	579,608	158,129	630,204	665,739	27,337	15,113	3	2,520,260
Spending authority from offsetting collections (discretionary and mandatory)			17,471		1,861		2,881	5,708	27,921
Total Budgetary Resources	**$445,997**	**$581,002**	**$177,077**	**$849,978**	**$717,832**	**$73,444**	**$36,675**	**$7,048**	**$2,889,053**
Status of Budgetary Resources:									
New Obligations and upward adjustments	$445,997	$581,002	$176,115	$629,955	$717,809	$21,599	$17,655	$5,243	$2,595,375
Unobligated balance, end of year									
Apportioned, unexpired accounts				244	5	31,117	12,945	945	45,256
Exempt from Apportionment, unexpired accounts			962						962
Unapportioned, unexpired accounts				5	18	8,173	5,504	62	13,762
Unexpired unobligated balance, end of year			962	249	23	39,290	18,449	1,007	59,980
Expired unobligated balance, end of year				219,774		12,555	571	798	233,698
Unobligated balance, end of year (total)			962	220,023	23	51,845	19,020	1,805	293,678
Total Budgetary Resources	**$445,997**	**$581,002**	**$177,077**	**$849,978**	**$717,832**	**$73,444**	**$36,675**	**$7,048**	**$2,889,053**
Outlays, net:									
Outlays, net (discretionary and mandatory)	$444,833	$578,553	$163,025	$592,024	$661,745	$23,121	$15,424	$(284)	$2,478,441
Distributed offsetting receipts	(57,178)	(727,170)				(887)	(732)		(785,967)
Agency Outlays, Net (discretionary and mandatory)	**$387,655**	**$(148,617)**	**$163,025**	**$592,024**	**$661,745**	**$22,234**	**$14,692**	**$(284)**	**$1,692,474**
Disbursements, Net							**$(134)**		**$(134)**

Audit Reports

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

January 12, 2026

TO: Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: John D. Hagg
JOHN HAGG Digitally signed by JOHN HAGG Date: 2026.01.12 08:17:40 -05'00'
Acting Deputy Inspector General for Audit Services

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2025*, OAS-25-17-070

This memo transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2025 financial statements and on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*. The 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 CMS financial statements in support of the Department of Health and Human Services' audit.

We contracted with the independent certified public accounting firm of Ernst & Young LLP (EY) to audit the CMS: (1) consolidated balance sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position; (2) the combined statement of budgetary resources for the year then ended; and (3) the statement of social insurance as of January 1, 2025, 2024, 2023, 2022, and 2021, and 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 24-02, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Based on its audit, EY found that the FY 2025 CMS consolidated balance sheet and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. EY was unable to obtain sufficient appropriate audit evidence for the amounts presented in the statements of social insurance as of January 1, 2025, 2024, 2023, 2022, and 2021, and the related statements of changes in social insurance amounts for the periods ended January 1, 2025, and 2024. As a result, EY was not able to, and did not,

express an opinion on the financial condition of the CMS social insurance program and related changes in the social insurance program for the specified periods.

EY noted one matter involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, EY identified a significant deficiency in CMS's financial reporting processes, related to limitations in the claim-level data impacting Medicaid Entitlement Benefits Due and Payable estimates and analyses and internal controls surrounding the statement of social insurance not functioning at the level of precision as designed. EY also identified that during FY 2025, CMS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (P.L. No. 116-117).

EY disclosed no other instances of noncompliance that must be reported under *Government Auditing Standards* and OMB Bulletin 24-02.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS 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 CMS officials
- Monitoring the progress of the audit
- Examining audit documentation, including that related to the review of internal controls over financial reporting
- Reviewing the auditors' reports
- Reviewing the CMS *FY 2025 Agency Financial Report*

EY is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208), or compliance with other laws and regulations. However, our review, as limited to the procedures listed above, disclosed no instances in which EY did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 834-5992 or Carla.Lewis@oig.hhs.gov. Please refer to report number OAS-25-17-070.

Attachment

cc:
Gustav Chiarello
Assistant Secretary for
Financial Resources

Teresa Miranda
Deputy Assistant Secretary, Office of Finance
and HHS Deputy Chief Financial Officer

Kimberly Brandt
Deputy Administrator
and Chief Operating Officer
Centers for Medicare & Medicaid Services

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Report of Independent Auditors

The Administrator and Chief Financial Officer of the Centers for
Medicare & Medicaid Services and the Inspector General of the U.S.
Department of Health and Human Services

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of the Centers for Medicare & Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources for the year then ended, and the related notes (collectively referred to as the "financial statements").

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

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

We were also engaged to audit the sustainability financial statements of CMS, which comprise the statement of social insurance as of January 1, 2025, 2024, 2023, 2022 and 2021, and the related statement of changes in social insurance amounts for the periods ended January 1, 2025 and 2024, and the related notes (collectively referred to as the "sustainability financial statements").

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

Basis for Opinion

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

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Standards), and in accordance with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 24-02 are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of CMS and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources for the year then ended.

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

As discussed in Note 12 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from, or on behalf of, the participants and estimated future expenditures to be paid to, or on behalf of, participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statement of social insurance and the related statement of changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA).

With respect to the estimates for the social insurance program presented as of January 1, 2025, 2024, 2023, 2022 and 2021, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections, using certain alternative payment provisions, intended to quantify the potential understatement of projected Medicare costs in future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 13, certain features of current law may result in some challenges for the Medicare program. As a

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result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. As a result of these matters, we were unable to obtain sufficient appropriate audit evidence for the amounts presented in the statement of social insurance as of January 1, 2025, 2024, 2023, 2022 and 2021, and the related statement of changes in social insurance amounts for the years ended January 1, 2025 and 2024, and the related notes.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CMS's internal control. Accordingly, no such opinion is expressed.

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

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

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

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis and Required Supplementary Information, as identified on CMS's Agency Financial Report Table of Contents, be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Federal Accounting Standards Advisory Board who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We were unable to apply certain limited procedures to the Required Supplementary Information related to the sustainability financial statements in accordance with GAAS because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our report. We do not express an opinion or provide any assurance on the Required Supplementary Information related to the sustainability financial statements. We have applied certain limited procedures to the Management's Discussion and Analysis and other required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Management is responsible for the other information included in the annual report. The other information comprises the introduction information on pages i through vi, A Message from the Chief Financial Officer, Other Information, Glossary and CMS Key Management Officials, as identified on CMS's Agency Financial Report Table of Contents but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

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

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated January 12, 2026 on our consideration of CMS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of CMS's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS's internal control over financial reporting and compliance.

Ernst & Young LLP

January 12, 2026

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

The Administrator and Chief Financial Officer of the Centers for
Medicare & Medicaid Services and the Inspector General of the U.S.
Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the Centers for Medicare & Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year then ended, and the related notes (collectively referred to as the "financial statements"), and our report dated January 12, 2026 expressed an unmodified opinion thereon. We also were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2025, and the related statement of changes in social insurance amounts for the period ended January 1, 2025, and the related notes (collectively referred to as the "sustainability financial statements"), and our report dated January 12, 2026 disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors as we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of CMS's internal control. Accordingly, we do not express an opinion on the effectiveness of CMS's internal control. We did not consider all internal controls relevant to operating objectives as broadly defined by the *Federal Managers' Financial Integrity Act of 1982* (FMFIA), such as those controls relevant to preparing performance information and ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's

financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We identified certain deficiencies in internal control described below that we consider to be significant deficiencies.

Significant Deficiencies

Financial Reporting Processes

Financial management in the Federal government requires accountability of financial and program managers for the reporting of financial results related to the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems and internal controls must be in place to process and record financial events effectively and efficiently and to provide complete, timely, reliable and consistent information for decision-makers and the public. CMS is a very large organization that is responsible for the management of complex programs that are continuing to increase in complexity and size. Financial reporting of the cost of health programs and the oversight role is important as the country continues to make decisions about this critical mission.

The following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

Medicaid Entitlement Benefits Due and Payable (EBDP)

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

In prior years, CMS completed the implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. As of the end of fiscal year 2025, while data maintained within T-MSIS is utilized for operational purposes, management continues to evaluate the reliability and completeness of the claims-level information maintained within T-MSIS, prior to determining how this could be utilized in the financial accounting and reporting for Medicaid, and specifically Medicaid EBDP. CMS should continue to evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate

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abnormalities in state-related Medicaid expenditures that may require consideration in determining the Medicaid EBDP liability as of year-end, as required by Statement of Federal Financial Accounting Standards No. 5*, Accounting for Liabilities of the Federal Government,* even if this data ultimately never becomes the basis for the EBDP estimate. Given the claims-level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability calculated during prior periods which could serve to validate the continued use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2025 financial statements and is subject to volatility. The lack of detailed claims data limits the ability to detect the impact of such a change, or other changes such as those related to the claims processing timing, on a timely basis or consider the potential impact of these items on the EBDP estimate, presenting a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Statement 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 models, and, as a result, the reviews of the underlying data is robust, in line with CMS's policies and procedures. As part of this review, the input into the spreadsheet models are checked against the original data sources to ensure that no input errors have been made. In addition, output data, including that which is generated from updating and running any macro in the spreadsheet, is checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet models or Excel macro programs to ensure that the projection output from the programs are as expected and reasonable. The Government Accountability Office (GAO)'s *Standards for Internal Control in the Federal Government* indicate that management should design control activities to achieve objectives and respond to risks. However, during our audit procedures of the SOSI, we identified that documentation evidencing the review of inputs/outputs were not sufficiently precise. Additionally, formula errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the related internal control was not functioning at the level of precision as designed. Inadequate review procedures may result in errors within the SOSI models and could lead to misstatements within the SOSI financial statements and related footnotes.

Recommendations

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

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

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record this liability.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision to ensure the completeness and accuracy of the models and the related financial statements. When changes are made to the SOSI models, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

Report on Compliance and Other Matters

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

Payment Integrity Information Act of 2019

The *Payment Integrity Information Act of 2019* (Public Law 116-117) (PIIA) requires federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. CMS's programs deemed susceptible to significant improper payments are: Medicare Fee-for-Service (Medicare FFS), Medicare Advantage (Part C), Medicare Prescription Drugs (Part D), Medicaid, CHIP and Advance Premium Tax Credits (APTC).

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates.

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However, CMS is not in full compliance with PIIA. While CMS has calculated and reported an improper payment estimate for the Federally-facilitated Exchange of the APTC program, it has not calculated and reported an improper payment estimate for the State-based Exchanges, which has been deemed susceptible to significant improper payments. CMS was also not in full compliance with PIIA as recovery activities of the identified improper payments for the Part C program are delayed.

CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. While management continues to implement corrective actions to reduce the improper payment rates for all programs, the rates for the Medicare Part C, Medicare Part D, Medicaid, and CHIP programs increased from the prior year.

CMS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on CMS's response to the findings identified in our audit and described in the accompanying letter dated January 12, 2026. CMS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and accordingly, we express no opinion on the response.

Purpose of This Report

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

Ernst & Young LLP

January 12, 2026

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-24
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

January 12, 2026

Ernst & Young, LLP
1101 New York Avenue, N.W.
Washington, DC 20005

Dear Sir/Madame:

On behalf of the Centers for Medicare & Medicaid Services, thank you for another successful year in completing this year's Chief Financial Officer's Act audit. We have reviewed the Report of Independent Auditors concerning our fiscal year 2025 financial statements. We are pleased to receive our 27th consecutive unmodified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, and the Combined Statement of Budgetary Resources.

We understand that you are still not able to express an opinion on the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts due to the uncertainty of the long-range assumptions used in the model. CMS has properly disclosed and documented the nature and uncertainty surrounding these projections and remains assured that our SOSI model projections are fairly presented. We remain fully committed to continuing our partnership with you to find a solution to reporting the SOSI projections that will allow auditors to opine on these statements in the future.

While your audit found no material weaknesses in our internal controls, you continue to report one significant deficiency in our financial reporting processes. We are pleased that you removed a longstanding deficiency in our information systems controls. We remain committed to addressing any audit deficiencies by establishing corrective action plans to strengthen our internal controls and remediate deficiencies.

We understand the complexity of our programs and the effort required to audit our financial statements. We greatly appreciate the professional conduct and manner exhibited by your audit team.

Sincerely,

Megan Worstell

Megan Worstell

3

Other Information

- Other Financial Information
- Summary of Financial Statement Audit and Management Assurances
- Improper Payments

Other Financial Information

Consolidating Balance Sheet

As of September 30, 2025

(in millions)

	Medicare		Health				Combined Totals	Intra-CMS Eliminations	Consolidated Totals
	HI	SMI	Medicaid	CHIP	Other	Program Management			
ASSETS									
Intragovernmental:									
Fund Balance with Treasury	$4,560	$257,933	$78,512	$74,795	$25,573	$943	**$442,316**		**$442,316**
Investments	255,149	154,589					**409,738**		**409,738**
Accounts Receivable, Net	36,736	72,967	2,837		1,942	4,888	**119,370**	$(118,689)	**681**
Other Assets	1				2	3	**6**		**6**
Total Intragovernmental	**296,446**	**485,489**	**81,349**	**74,795**	**27,517**	**5,834**	**971,430**	**(118,689)**	**852,741**
Other than intragovernmental:									
Accounts Receivable, Net	1,866	29,890	7,070	204	9,302	1	**48,333**		**48,333**
General Property, Plant & Equipment, Net	196				409	718	**1,323**		**1,323**
Advances and Prepayments	1						**1**		**1**
Other Assets			31		377		**408**		**408**
Total Other than Intragovernmental	**2,063**	**29,890**	**7,101**	**204**	**10,088**	**719**	**50,065**		**50,065**
TOTAL ASSETS	**$298,509**	**$515,379**	**$88,450**	**$74,999**	**$37,605**	**$6,553**	**$1,021,495**	**$(118,689)**	**$902,806**
LIABILITIES									
Intragovernmental:									
Accounts Payable	$41,304	$78,762			$2	$46	**$120,114**	$(118,664)	**$1,450**
Debt		94			358		**452**		**452**
Other Liabilities	1				112	8	**121**	(25)	**96**
Total Intragovernmental	**41,305**	**78,856**			**472**	**54**	**120,687**	**(118,689)**	**1,998**
Other than intragovernmental:									
Accounts Payable	74	69			146	172	**461**		**461**
Entitlement Benefits Due and Payable	34,938	69,757	$57,979	$1,278			**163,952**		**163,952**
Other Liabilities									
Contingencies and Commitments	2,250		5,994				**8,244**		**8,244**
Other	206	2,404	2		14,271	86	**16,969**		**16,969**
Total Other than Intragovernmental	**37,468**	**72,230**	**63,975**	**1,278**	**14,417**	**258**	**189,626**		**189,626**
TOTAL LIABILITIES	**$78,773**	**$151,086**	**$63,975**	**$1,278**	**$14,889**	**$312**	**$310,313**	**$(118,689)**	**$191,624**
NET POSITION									
Unexpended Appropriations-Funds from Dedicated Collections	$2,594	$230,923			$3,329	$57	**$236,903**		**$236,903**
Unexpended Appropriations-Funds from Other than Dedicated Collections			$23,368	$70,325	9,935		**103,628**		**103,628**
Total Unexpended Appropriations	**2,594**	**230,923**	**23,368**	**70,325**	**13,264**	**57**	**340,531**		**340,531**
Cumulative Results of Operations-Funds from Dedicated Collections	217,142	133,370			9,506	6,184	**366,202**		**366,202**
Cumulative Results of Operations-Funds from Other than Dedicated Collections			1,107	3,396	(54)		**4,449**		**4,449**
Total Cumulative Results of Operations	**217,142**	**133,370**	**1,107**	**3,396**	**9,452**	**6,184**	**370,651**		**370,651**
TOTAL NET POSITION	**$219,736**	**$364,293**	**$24,475**	**$73,721**	**$22,716**	**$6,241**	**$711,182**		**$711,182**
TOTAL LIABILITIES AND NET POSITION	**$298,509**	**$515,379**	**$88,450**	**$74,999**	**$37,605**	**$6,553**	**$1,021,495**	**$(118,689)**	**$902,806**

Consolidating Statement of Net Cost

For the Year Ended September 30, 2025

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	$431,321			**$431,321**
Operating Expenses	1,946	$1,446	$21	**3,413**
Total Cost	433,267	1,446	21	**434,734**
Less: Earned Revenues	(6,143)	(3)		**(6,146)**
Net Cost Medicare HI	**$427,124**	**$1,443**	**$21**	**$428,588**
Medicare SMI				
Benefit/Program Expenses (Part B)	$568,070			**$568,070**
Benefit Expenses (Part D)	150,136			**150,136**
Operating Expenses	(18)	$3,917	$32	**3,931**
Total Cost	718,188	3,917	32	**722,137**
Less: Earned Revenues	(154,799)	(15)		**(154,814)**
Net Cost Medicare SMI	**$563,389**	**$3,902**	**$32**	**$567,323**
Medicaid				
Benefit/Program Expenses	$670,475			**$670,475**
Operating Expenses	3	$238		**241**
Total Cost	670,478	238		**670,716**
Less: Earned Revenues		(1)		**(1)**
Net Cost Medicaid	**$670,478**	**$237**		**$670,715**
CHIP				
Benefit/Program Expenses	$23,098			**$23,098**
Operating Expenses	21	$23		**44**
Total Cost	23,119	23		**23,142**
Less: Earned Revenues				
Net Cost CHIP	**$23,119**	**$23**		**$23,142**
Other				
Program Expenses	$16,354			**$16,354**
Operating Expenses	426	$629		**1,055**
Total Cost	16,780	629		**17,409**
Less: Earned Revenues	(15,895)	(3)	$(53)	**(15,951)**
Net Cost Other	**$885**	**$626**	**$(53)**	**$1,458**
NET COST OF OPERATIONS	**$1,684,995**	**$6,231**		**$1,691,226**

Consolidating Statement of Changes in Net Position

For the Year Ended September 30, 2025

(in millions)

	Dedicated Collections					Funds from Other than Dedicated Collections				Consolidated Total
	Medicare		Health		Total Funds From Dedicated Collections	Health (Other Funds)			Total Funds from Other than Dedicated Collections	
	HI	SMI	Other	Program Management		Medicaid	CHIP	Other		
UNEXPENDED APPROPRIATIONS										
Beginning Balances	**$2,174**	**$258,391**	**$3,264**	**$87**	**$263,916**	**$24,775**	**$70,030**	**$10,856**	**$105,661**	**$369,577**
Appropriations Received	42,841	614,842	248	3	**657,934**	732,671	27,801	639	761,111	**1,419,045**
Appropriations Transferred-in/out						(5,943)			(5,943)	**(5,943)**
Other Adjustments	(46)	(75,189)	(3)	(1)	**(75,239)**	(60,360)	(4,411)	(32)	(64,803)	**(140,042)**
Appropriations Used	(42,375)	(567,121)	(180)	(32)	**(609,708)**	(667,775)	(23,095)	(1,528)	(692,398)	**(1,302,106)**
Change in Unexpended Appropriations	**420**	**(27,468)**	**65**	**(30)**	**(27,013)**	**(1,407)**	**295**	**(921)**	**(2,033)**	**(29,046)**
Total Unexpended Appropriations: Ending Balance	**$2,594**	**$230,923**	**$3,329**	**$57**	**$236,903**	**$23,368**	**$70,325**	**$9,935**	**$103,628**	**$340,531**
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	**$196,554**	**$130,095**	**$8,696**	**$5,456**	**$340,801**	**$1,949**	**$2,534**	**$37**	**$4,520**	**$345,321**
Appropriations Used	42,375	567,121	180	32	**609,708**	667,775	23,095	1,528	692,398	**1,302,106**
Nonexchange Revenue:										
FICA and SECA Taxes	400,622				**400,622**					**400,622**
Interest on Investments	8,718	3,803			**12,521**		886		886	**13,407**
Other	503	2,721			**3,224**					**3,224**
Transfers-in/out without Reimbursement	(4,516)	(6,981)	36	5,657	**(5,804)**	1,861		(145)	1,716	**(4,088)**
Imputed Financing	10		16	1,270	**1,296**			14	14	**1,310**
Other								(25)	(25)	**(25)**
Net Cost of Operations	**427,124**	**563,389**	**(578)**	**6,231**	**996,166**	**670,478**	**23,119**	**1,463**	**695,060**	**1,691,226**
Net Change in Cumulative Results of Operations	**20,588**	**3,275**	**810**	**728**	**25,401**	**(842)**	**862**	**(91)**	**(71)**	**25,330**
Cumulative Results of Operations: Ending Balance	**$217,142**	**$133,370**	**$9,506**	**$6,184**	**$366,202**	**$1,107**	**$3,396**	**$(54)**	**$4,449**	**$370,651**
NET POSITION	**$219,736**	**$364,293**	**$12,835**	**$6,241**	**$603,105**	**$24,475**	**$73,721**	**$9,881**	**$108,077**	**$711,182**

Summary of Financial Statement Audit and Management Assurances

Table 1: Summary of Financial Statement Audit

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

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Reporting (FMFIA Section 2)

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

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

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

* In FY 2025, CMS resolved material noncompliance with PIIA by demonstrating improvements in the Medicare FFS program.

** The CMS identified material noncompliance with PIIA due to not reporting an improper payment estimate for the State-based Exchange component of the APTC program.

Improper Payments

PIIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. PIIA defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Improper payments also include payments to ineligible recipients, payments for ineligible services, duplicate payments, and payments for services not received, as well as payments that are missing sufficient documentation to determine if proper.

CMS has instituted comprehensive processes that measure improper payments for the Medicare FFS, Medicare Advantage (Part C), Medicare Prescription Drug (Medicare Part D), Medicaid, CHIP, and APTC programs.

Medicare FFS

CMS measures the Medicare FFS improper payment estimate annually through the Comprehensive Error Rate Testing (CERT) program.

The Medicare FFS improper payment estimate for FY 2025 is 6.55 percent or $28.83 billion. The primary root causes were insufficient documentation, particularly in skilled nursing facility (SNF) and hospital outpatient claims, and medically unnecessary services in hospice and inpatient rehabilitation facility claims. CMS reduced the sample size from 50,000 to 37,500 claims to maintain statistically valid and precise improper payment estimates while lowering program costs. Medicare FFS improper payment program-specific data is available on the **CERT website.**

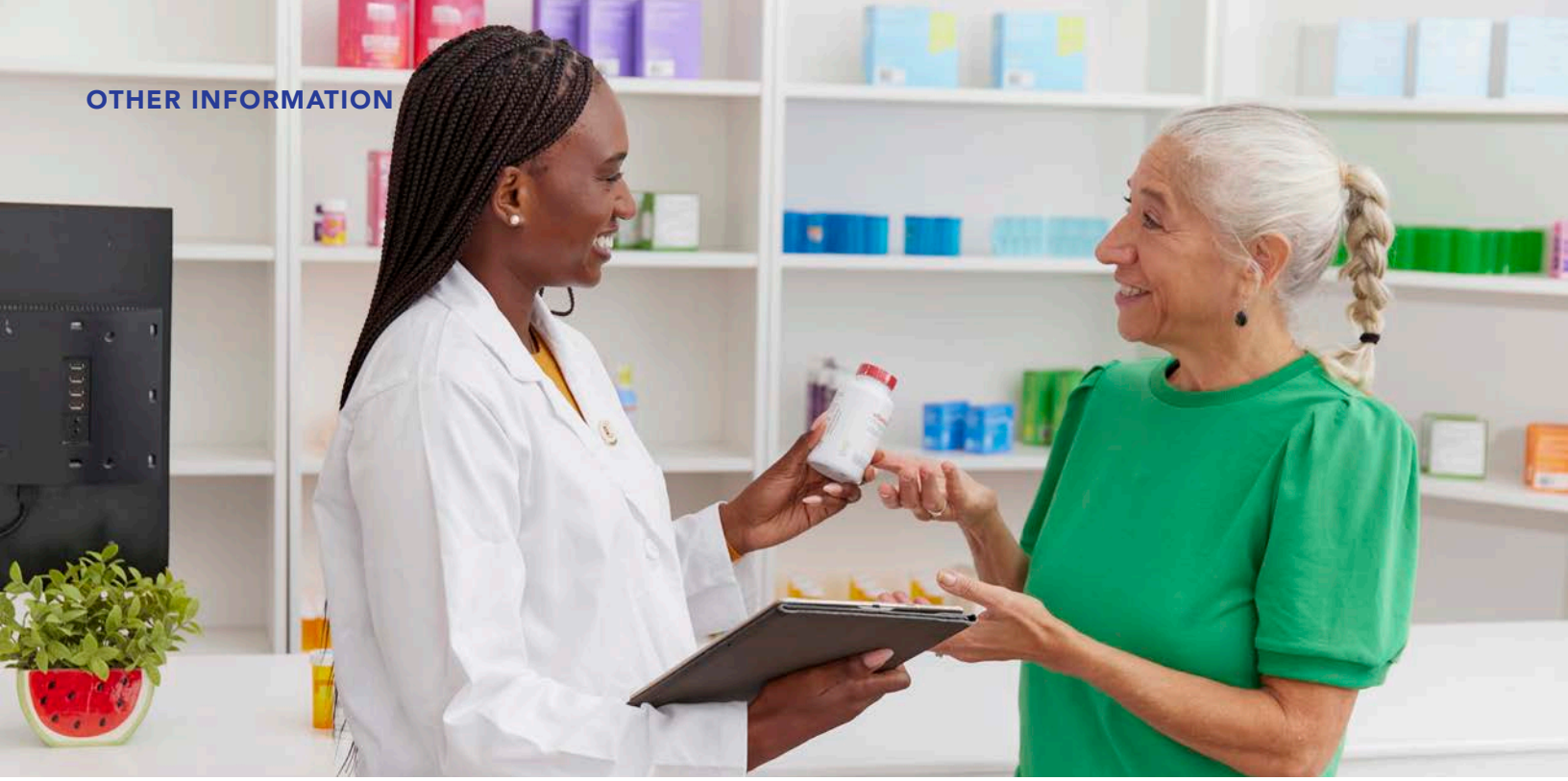
CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS including but not limited to, provider education, automated system edits, enhanced prior authorization, targeted medical reviews, and predictive data analytics to reduce and prevent improper payments. CMS is also continuing prior authorization initiatives, as appropriate, which help to ensure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. CMS has developed several preventative measures for specific service areas with high improper payments. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Medicare Advantage and Prescription Drugs

CMS measures the Medicare Part C improper payments made to MA contracts through the Part C Improper Payment Measurement (IPM) program. CMS estimated 6.09 percent improper payments in Medicare Part C, totaling $23.67 billion. The primary root cause was medical record discrepancies. In these cases, diagnoses submitted by Medicare Advantage Organizations for payment calculations were not substantiated by supporting documentation. Medicare Part C improper payment data is available on the **Medicare Part C IPM website**.

CMS measures the Medicare Part D improper payments related to prescription drug event data through the Part D IPM program. CMS estimated 4.00 percent improper payments in Medicare Part D, totaling $4.23 billion. The primary root cause was missing or insufficient documentation submitted by plan sponsors to support prescription drug event data which determines payment. Medicare Part D improper payment data is available on the **Medicare Part D IPM website**.

CMS uses data from the improper payment measurement processes to address improper payments in Medicare Parts C and D through various corrective actions. To address Medicare Part C improper payments, CMS is implementing targeted corrective actions, including but not limited to, plan training and education, an accelerated and expanded contract-specific Risk Adjustment Data Validation (RADV) audit program, and investigations to identify fraud and recover overpayments. To address Medicare Part D improper payments, CMS is implementing targeted corrective actions, including but not limited to, plan training and education, targeted audits of high-risk drugs, and investigations to identify potential fraud and recover overpayments.



Medicaid and CHIP

CMS measures Medicaid and CHIP improper payments through the Payment Error Rate Measurement (PERM) program, measuring three components: FFS claims, managed care payments, and eligibility determinations. PERM uses a 17 states-per-year, 3-year rotation to produce and report national program improper payment rates. CMS observed an increase in improper payments for Medicaid and CHIP resulting in the estimated 6.12 percent improper payments in Medicaid, totaling $37.39 billion, and 7.05 percent improper payments in CHIP, totaling $1.37 billion.

The national improper payment estimate for each Medicaid component is:

- Medicaid FFS: 4.60 percent
- Medicaid managed care: 0.00 percent
- Medicaid eligibility: 4.42 percent

The national improper payment estimate for each CHIP component is:

- CHIP FFS: 4.65 percent
- CHIP managed care: 0.94 percent
- CHIP eligibility: 5.23 percent

The primary root causes of the Medicaid and CHIP improper payment estimates were:

- Missing or insufficient documentation accounts for the most significant portion of improper payments and occurred when states did not provide required eligibility verifications, such as income or resource checks, or when medical records lacked information needed to support medical necessity.
    - CMS continued to work with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included CMS independently accessing databases and reviewing submitted eligibility determination information that had been produced after the original claim payment or determination date to evaluate if a provider or beneficiary would have been eligible. When CMS verified information related to the missing or insufficient documentation; and confirmed that the payment was proper, the payment was classified as a technically improper payment (344 cases deemed technically improper of the 1,017 cases eligible for independent verification over the past three cycles for Medicaid and 454 cases deemed technically improper out of the 855 cases eligible for independent verification over the past three cycles for CHIP).

- State non-compliance included inadequate screening of newly enrolled providers, payments to providers not enrolled, claims paid without the required national provider identifier, and claims paid when creditable third-party insurance was present.
- Improper eligibility determinations occurred when states incorrectly claimed beneficiaries under Title XXI (CHIP) instead of Title XIX (Medicaid) due to errors in income calculations, household composition, third-party insurance status, or tax filer status.

Additionally, Reporting Year 2025 (July 1, 2023–June 30, 2024) included visibility into eligibility redeterminations and provider screenings, as states began unwinding from the COVID-19 public health emergency and phasing out flexibilities, which contributed to the increase in the FY 2025 national Medicaid and CHIP improper payment estimates. For more information on the measurement of Medicaid and CHIP, see the **PERM Website**.

To address Medicaid and CHIP improper payments, CMS is implementing targeted corrective actions, including but not limited to, state-specific Corrective Action Plans, enhanced training through the Medicaid Integrity Institute (MII), technical assistance on improved screening and enrollment processes, access to the Social Security Administration's Death Master File for eligibility checks, and audits of eligibility determinations to strengthen compliance and reduce improper payments.

APTC

Through the Exchange Improper Payment Measurement program, CMS measures APTC improper payments. A statistically valid random sample of health insurance applications is reviewed to determine if the Federally-facilitated Exchange properly paid APTC benefits under the statutory and regulatory requirements relating to eligibility and payment determinations.

The Federally-facilitated Exchange improper payment estimate for RY 2025, for measurement of Calendar Year 2023, is 0.89 percent, totaling $657.46 million. The primary root cause of improper payments were overpayments due to manual errors (47.08 percent of improper payments, or $309.54 million) where the Federally-facilitated Exchange accepted consumer submitted documentation with unacceptable name and date of birth variances to resolve an eligibility verification issue and improperly inputting information in the income verification tool. The second root cause was technically improper payments (42.96 percent of improper payments, or $282.44 million), which are situations where payments are made to eligible recipients for correct amounts but failed to satisfy all legally applicable requirements relevant to payment. In these cases, the system failed to conduct a periodic data match required to check Medicare eligibility or enrollment but the Exchange later confirmed that the applicant was not eligible or enrolled in Medicare and therefore eligible for APTC.

The improper payment rate and amounts estimated herein do not reflect APTC payments made by State-based Exchanges or repayment of excess APTC payments. CMS intends to begin the State-based Exchange sampling and estimation measurement no earlier than January 1, 2027. In Calendar Year 2023, State-based Exchanges made payments totaling approximately $18.37 billion, or 19.93 percent of total APTC payments. CMS will continue to provide updates on the status of the State-based Exchange improper payment program implementation. APTC improper payment data is available on the **Exchange Improper Payment Measurement website**.

To target APTC improper payments, CMS is implementing targeted corrective actions, including but not limited to, automation improvements, enhanced eligibility personnel training, internal and external audits, and risk-based monitoring of agents and brokers to detect and prevent improper payments and harm to consumers.

Combined Improper Payment Data

The second payment stream relates to additional Premium Tax Credit amounts claimed by taxpayers at the time of their tax filings, referred to as "Net Premium Tax Credits" (Net PTC).[1] That is, total Premium Tax Credit outlays/claims are equal to APTC payments plus Net PTC claims. The Internal Revenue Service (IRS) measures improper payments associated with Net PTC claims, and for Calendar Year 2023 reported Net PTC claims of 1.49 billion, improper payments of $470.00 million, and an improper payment rate of 31.61 percent. The combined APTC and Net PTC improper payment estimate is $1,127.46 million out of $75.30 billion total Premium Tax Credit outlays/claims, or 1.50 percent. Similar to the APTC improper payment information provided above, this combined APTC and Net PTC improper payment information does not reflect payments made by State-based Exchanges.

Additional information on the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, CHIP, and APTC improper payments can be found in the HHS Agency Financial Reports and CMS Improper Payments Measurement Programs websites.

[1] The Treasury Annual Financial Report can be found at U.S. Department of the Treasury: Agency Financial Report.

Glossary

A

Accountable Care Organization (ACO)
A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) who work together to coordinate care for the patients they serve.

Accrual Accounting
A system of accounting in which revenues are recorded when earned (when goods are delivered or services are performed) and expenses are recorded when incurred (when goods or services are received), even though the actual receipt of revenues and payment for goods or services may occur, in whole or in part, at a different time.

Administrative Costs
General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are composed of the Medicare-related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the federal share of the states' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries, expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

Advance Payments of the Premium Tax Credit (APTC)
Payment amounts calculated by the Exchange and paid to an eligible consumer's insurance company on the consumer's behalf to lower the consumer's out-of-pocket cost for health insurance premiums. The amount the consumer is eligible for is based on the cost of the second lowest silver plan available through the applicable Exchange and the consumer's estimated annual household income compared to the federal poverty line. Consumers that receive the benefit of APTC payments must file a tax return to reconcile the amount of APTC payments received with the amount of the actual premium tax credit for which they are eligible.

Alternative Payment Model (APM)
A program or model (except for a health care innovation award model) implemented by the Center for Medicare and Medicaid Innovation at CMS; a demonstration under the Health Care Quality Demonstration Program; an ACO model participating in the Medicare shared savings program; or a Medicare demonstration required by law.

B

Balanced Budget Act of 1997 (BBA)
Major provisions of the BBA provided for the Children's Health Insurance Program, Medicare + Choice (currently known as the Medicare Advantage program), and expansion of preventive benefits.

Beneficiary
An individual who receives health care related services under a health care system.

Benefit Payments
Benefits consumed or funds outlaid for services delivered to beneficiaries.

Board of Trustees
A Board established by the Social Security Act to oversee the financial operations of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The Board comprises six members, four of whom serve automatically by virtue of their positions in the federal Government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of HHS; and the Commissioner of Social Security. Two other members are public representatives whom the President appoints, and the Senate confirms. These positions are currently vacant. The Administrator of CMS serves as Secretary of the Board of Trustees.

C

Chief Financial Officers Act of 1990 (CFO Act)

The CFO Act was enacted to improve the financial management and accountability of the federal government. It provides for production of complete, reliable, timely, and consistent financial information for use by the executive branch of the government and the Congress in the financing, management, and evaluation of federal programs. It also designated a Chief Financial Officer in each executive department and each major executive agency in the federal government.

Children's Health Insurance Program (CHIP) (also known as Title XXI)

CHIP (previously known as the State Children's Health Insurance Program, or SCHIP) was originally created in 1997 as Title XXI of the Social Security Act. CHIP is a state and federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for Medicaid, but often too low to afford private coverage.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

CHIPRA extended and expanded CHIP, which was enacted as part of the BBA. CHIPRA increased CHIP funding, strengthened and expanded health care for children, reduced the number of uninsured, and promoted outreach, education, and preventative health care.

Clinical Laboratory Improvement Amendments of 1988 (CLIA)

Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and to have an applicable certificate in effect.

Covered Services

Services for which HI or SMI pays, as defined and limited by statute. Covered HI services are provided by hospitals (inpatient care), skilled nursing facilities, home health agencies, and hospices. Covered SMI Part B services include most physician services, care in outpatient departments of hospitals, diagnostic tests, durable medical equipment, ambulance services, and other health services that are not covered by HI.

D

Deficit Reduction Act of 2005

The Deficit Reduction Act restrains federal spending for entitlement programs (i.e., Medicare and Medicaid) while ensuring that Americans who rely on these programs continue to get needed care. Some provisions of the Act require wealthier seniors to pay higher premiums for Medicare coverage. The Act also establishes a restraint on Medicaid spending by reducing federal overpayment for prescription drugs so that taxpayers do not pay inflated markups. In addition, the Act includes provisions that increase benefits to students and to those with the greatest need.

Demonstrations

Projects that allow CMS to test various or specific attributes, such as payment methodologies, preventive care, and social care, and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Disproportionate Share Hospital (DSH)

A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME)
Purchased or rented items, such as ventilators, hospital beds, and wheelchairs used in the patient's home, as well as blood glucose monitors for individuals with diabetes. DME is equipment which: (1) can withstand repeated use; (2) has an expected life of at least three years if classified as DME after January 1, 2012; (3) is primarily and customarily used to serve a medical purpose; (4) generally is not useful to a person in the absence of an illness or injury; and (5) is appropriate for use in the home.

E

Earned Revenues
Earned or exchange revenues arise when an entity provides goods or services to the public or another Government entity for a price.

End-Stage Renal Disease (ESRD)
Permanent kidney failure requiring dialysis or a transplant.

Evidence-based Policymaking Act of 2018
The Evidence Act, as it is simply known, was established to advance evidence building in the federal government by improving access to data and expanding evaluation capacity.

Expenditure
Budgeted funds that are actually spent. When used in the discussion of the Medicaid program, expenditure refers to funds actually spent as reported by the states.

Expense
An outlay or an accrued liability for services incurred in the current period.

F

Federal Financial Management Improvement Act of 1996 (FFMIA)
FFMIA requires agencies to have financial management systems that substantially comply with federal management systems requirements, standards promulgated by the Federal Accounting Standards Advisory Board (FASAB), and standards of the U.S. Standard General Ledger (USSGL) at the transaction level. The primary purpose of FFMIA is to enhance the accuracy, reliability, and usefulness of federal financial information.

Federal General Revenues
Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

Federal Hospital Insurance (HI) Trust Fund (Part A)
The Medicare trust fund that covers specified inpatient hospital services, post-hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A. A portion of CMS payments to Medicare Advantage (MA) plans are also charged to this trust fund.

Federal Insurance Contribution Act (FICA) Payroll Tax
Medicare's share of payroll taxes used to fund the Hospital Insurance (HI) trust fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

Federal Managers' Financial Integrity Act of 1982 (FMFIA)
Requires agencies to establish internal control and financial systems that provide reasonable assurance of achieving control objectives, including the effectiveness and efficiency of operations; compliance with laws and regulations; and reliability of financial reporting. FMFIA requires agency heads to conduct an annual evaluation and report on the adequacy of internal control systems.

Federal Supplementary Medical Insurance (SMI) Trust Fund (Part B)
The Medicare trust fund comprising the Part B account and the Part D account. The Part B account pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals. The Part D account pays for private plans to provide prescription drug coverage, beginning in 2006. A portion of CMS payments to Medicare Advantage (MA) plans are also charged to this trust fund.

Fee-for-Service (FFS)
A system of health care payment in which a provider is paid separately for each particular service rendered.

Fee Schedule
A schedule that reflects the relative level of resources required for each service. The fee schedule amount is equal to the product of the procedure's relative value, a conversion factor, and a geographic adjustment factor.

G

General Fund of the Treasury
Funds held by the U.S. Treasury, other than revenue collected for a specific trust fund (such as HI or SMI) and maintained in a separate account for that purpose. The majority of this fund is derived from individual and business income taxes.

Government Management Reform Act of 1994 (GMRA)
Aims to improve the management, operation, and accountability of federal agencies. It requires the auditing of executive agencies' annual financial statements prior to submission to OMB.

Government Performance and Results Act Modernization Act of 2010 (GPRA Modernization Act)
Aims to improve the performance management, accountability, and transparency of federal agencies. It amends the Government Performance and Results Act of 1993 to require each executive agency to make its strategic plan available on its public website and to Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences, and to notify the President and Congress that the strategic plan is available.

H

Health Care Fraud Prevention Partnership (HCFPP)
Voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and health care anti-fraud associations.

Health Insurance Exchanges
A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and Cost Sharing Reductions (CSRs). States can establish their own Exchange or the Federal government can operate an Exchange on their behalf.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
A federal law that sets national standards to protect the privacy and security of protected health information of individuals.

Home-Community Based Services (HCBS)
Programs that provide opportunities for Medicaid-eligible older adults and people with disabilities to receive long term services and support in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

I

Inflation Reduction Act of 2022
Aims to lower prescription drugs costs by allowing Medicare to negotiate prices with drug companies through the imposition of an inflation cap on drug prices; also extends provisions geared toward improving health insurance affordability and access through 2025.

Internal Control
A process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of the entity will be achieved. Management's tools, such as the organization's policies and procedures, that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include program, operational, and administrative areas, as well as accounting and financial management.

M

Material Weakness
A deficiency, or a combination of deficiencies, in internal control over financial reporting, 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.

Medicaid
A joint federal and state program that helps with health care costs for people with limited income and resources.

Medical Loss Ratio (MLR)
Requires health insurance companies to spend 80 to 85 percent of premium dollars on medical care and health care quality improvement, rather than on administrative costs. When they do not, health insurance companies are required to provide a rebate to their customers.

Medicare
The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with ESRD.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
Legislation passed to strengthen Medicare, extend CHIP, and make numerous other improvements to the health care system.

Medicare Administrative Contractor (MAC)
A private entity that CMS contracts with under section 1874A of the Social Security Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Part A and Part B MACs handle Medicare fee-for-service claims processing and related services under the MMA, and DME MACs handle Medicare claims for DME.

Medicare Advantage (MA) Program (Part C)
This program reforms and expands the availability of private health options previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organization plans, as well as a new process for determining beneficiary premiums and benefits. Title II of MMA modified and renamed the existing Medicare + Choice program established under Title XVIII of the Social Security Act to the MA program. The MA program payments are drawn from the HI and SMI trust funds.

Medicare Integrity Program (MIP)
A program established by HIPAA to promote the integrity of the Medicare program, as specified in Section 1893 of the Social Security Act.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
Legislation that established a new Medicare program (Medicare Part D) to provide a prescription drug benefit. Additionally, MMA set forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

Medicare Prescription Drug Program (Part D)
An optional prescription drug benefit created by the MMA for individuals with Medicare who are entitled to benefits under Part A or enrolled in Part B. Eligible individuals can enroll in either a stand- alone prescription drug plan to supplement their traditional Medicare coverage, or in an MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full-benefit dual-eligible and other qualified low- income individuals.

Medicare Secondary Payer (MSP)
A part of the Social Security Act that stipulates that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

Medicare Trust Funds
Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for Medicare.

Merit-Based Incentive Payment System (MIPS)
A system for adjusting payments under the Medicare physician fee schedule to nonadvanced alternative payment model (APM) providers based on metrics assessing provider quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities.

N

2019 Novel Coronavirus Disease (COVID-19)
A respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019 in Wuhan, China.

O

Obligation
Legal requirement to pay funds.

OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control (OMB Circular A-123)
Provides guidance to federal managers on improving the accountability and effectiveness of federal programs and operations by establishing, assessing, correcting, and reporting on management's controls. The Circular is issued under the authority of the FMFIA.

Outlay
Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the states for Medicaid benefits.

P

Part A
The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as the Federal Medicare Hospital Insurance or HI trust fund.

Part B
The account within the Federal Medicare Supplementary Medical Insurance or SMI trust fund that pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals.

Patient Protection and Affordable Care Act (PPACA)
A federal statute enacted in 2010 to drive health insurance reforms. The law requires insurers to accept all legal applicants, to cover a specific list of benefits, and to charge the same rates regardless of pre-existing conditions.

Payment Integrity Information Act of 2019 (PIIA)
A law that requires government agencies to identify, report, and reduce improper payments in the government's programs and activities. The implementation guidance in Appendix C of OMB Circular A-123 requires executive branch agency heads to review their programs and activities annually and identify those that may be susceptible to significant improper payments.

Program Integrity (PI)
Encompasses the operations and oversight necessary to ensure that accurate payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries of the Medicare, Medicaid, CHIP, and PPACA programs. PI activities target the range of causes of improper payments, errors, fraud, waste, and abuse.

Program Management
The CMS operational account that supplies CMS with the resources to administer Medicare, the federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are program operations, survey and certification, research, and federal administrative costs.

Prospective payment system (PPS)
A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, Diagnosis-Related Groups (DRGs) for inpatient hospital services).

Provider
A health care professional or organization that provides medical services.

Public Health Emergency (PHE)
An emergency need for health care [medical] services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack, or other significant or catastrophic event.

Q

Quality Improvement Organizations (QIOs)
Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

R

Recipient
An individual covered by the Medicaid program. Also referred to as a beneficiary.

Retiree Drug Subsidy (RDS) Program
The RDS is one of several options available under Medicare that is designed to encourage employers and unions to continue to provide high-quality prescription drug coverage to their retirees.

Revenue
An inflow of resources that the government earns, demands, or receives by donation. Resources arise when the government entity provides goods and services, or from the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties).

Risk Adjustment (private health insurance market)
The risk adjustment program is designed to protect issuers that attract a high-risk population, such as those with chronic conditions. Under this program, money is transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees. This is a state-based program that applies to non-grandfathered plans in the individual and small group markets, inside and outside of Exchanges.

S

Self-Employment Contribution Act (SECA) Payroll Tax
A tax on self-employed individuals of 2.9% of taxable net income, with no limitation. Medicare's share of SECA is used to fund the HI Trust Fund.

Sequestration
The process of applying automatic reductions to certain Federal funding, which was required by the Budget Control Act of 2011.

Significant Deficiency
A deficiency, or a combination of deficiencies, in internal control over financial reporting, that is less severe than a material weakness yet important enough to merit attention by those charged with governance.

Statement on Standards for Attestation Engagements 18 (SSAE 18)
For the purposes of CMS, a report on the internal controls of a servicing organization (i.e., contracted entities that provide services on behalf of CMS) issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA). The AICPA SSAE 18 defines the professional standards to assess the internal controls at a service organization.

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CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Agbeko O Kumordzie by email at CMSFinancialReport@cms.hhs.gov.

Copies of this report are also available at CMS.gov/CFOReport.

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