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THE LONG-TERM FISCAL OUTLOOK IS BLEAK

Restoring Fiscal Sustainability Will Require Major Changes to Programs, Revenues, and the Nation's Health Care System

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Summary

In 2006, the federal government ran a deficit of \$248 billion, or about 2 percent of the economy. Deficits are projected to average about 2 percent of GDP over the next ten years, assuming the 2001 and 2003 tax cuts are extended. After that, the fiscal situation is expected to deteriorate markedly.

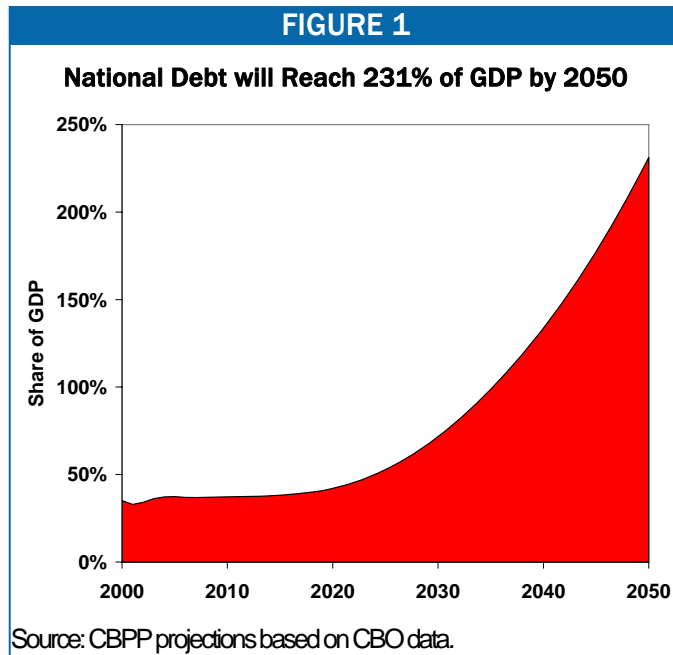
In this analysis, we present new projections for the federal budget through 2050. These projections, based on data and estimates from the Congressional Budget Office, are deeply disquieting. They show that the nation's budget policies are unsustainable, with deficits and debt growing to unprecedented and dangerous levels if policy changes are not made.

The new projections also shed light on the sources of these problems and on the types of changes that would be needed to address them responsibly. Our principal findings are the following:

- The main sources of rising expenditures are rising health care costs (throughout the U.S. health care system) and demographic changes, which together will drive up spending for the “big three” domestic programs — Medicare, Medicaid, and Social Security.
- A solution to the long-term fiscal problem will require not only difficult choices to reduce programs and increase revenues, but also fundamental changes to the *entire U.S. health care system*.
- Tax policy decisions Congress will face in coming years will have a substantial impact on the magnitude of the long-term problem. If Congress lets recent tax cuts expire by 2010 as scheduled or extends them (in whole or in part) but offsets the costs, the size of the problem through 2050 will shrink by 60 percent. This is because the resulting deficit reduction, begun in the next few years, would have an increasing impact on federal interest payments with each passing year and would thereby reduce long-term deficits even more over time. Even so, the budget would remain on an unsustainable fiscal path.
- Federal programs other than Medicare, Medicaid, and Social Security — including entitlement programs other than the “big three” — are *not* expected to grow rapidly; in fact, these programs will shrink as a share of the economy and thus will consume a smaller share of the nation's resources in 2050 than they do today.

Current Budget Policies are Unsustainable

The nation's budget policies are unsustainable. Our projections show that if current budget policies are continued (e.g., if current laws governing Medicare, Social Security, and other programs remain unchanged, the 2001 and 2003 tax cuts are made permanent, and relief from the Alternative Minimum Tax is continued), deficits will reach about 20 percent of the Gross Domestic Product by 2050, and the national debt will climb to 231 percent of GDP by that year, or more than twice the size of the U.S. economy. Debt-to-GDP ratios in this range are unprecedented in the United States, even during major wars.



Debt at this level would seriously damage the economy. It also would place severe strains on the federal budget. For example, by 2050, simply paying interest on the national debt would consume more than half of annual projected federal revenues.

Another way of measuring the size of the problem is to examine the magnitude of the long-term *fiscal gap*. The fiscal gap represents the amount of program reductions or revenue increases needed over the next four decades to ensure that the debt, measured as a share of the economy, is no larger in 2050 than it is today. Under our projections, the fiscal gap equals 3.2 percent of projected GDP through 2050. Hence, stabilizing the nation's finances through 2050 would require annual tax increases or budget cuts equal to 3.2 percent of GDP, starting with tax increases and budget cuts totaling \$461 billion in 2008 alone. (\$461 billion equals 3.2 percent of projected GDP for 2008.)

As these figures suggest, eliminating a fiscal gap equal to 3.2 percent of GDP would be very difficult. Even so, some readers may wonder how it is that the nation could reduce the debt in 2050 from 231 percent of GDP to its current level of 37 percent of GDP simply by making annual changes equal to 3.2 percent of GDP. This is possible if the changes *start immediately*. If we began to institute these revenue increases or program reductions this year, we would begin running surpluses rather than deficits, which would decrease rather than increase the national debt. The reductions in the debt, in turn, would reduce interest costs in every year through 2050, bringing the "miracle of compound interest" to bear on the budget problem. Compound interest also can work against us, however: if little or no deficit reduction is enacted in the near future, substantially larger deficit reduction will be required later.

Health Care Costs and Demographic Changes — Not Entitlements Generally — Account for Rising Expenditures

The main sources of rising expenditures are rising costs *throughout* the U.S. health care system and demographic changes, with health care costs playing the larger role. Together, these two forces will cause the “big three” domestic programs — Medicare, Social Security, and Medicaid — to grow considerably faster than the economy. Collectively, these three programs are projected to grow by slightly more than 13 percent of GDP between now and 2050.

All other programs, including all domestic programs other than the “big three,” are projected to grow *more slowly* than the economy in coming decades and consequently do not contribute to the projected rise in deficits and debt. Of particular note, *entitlement programs* outside of the “big three” are projected to grow more slowly than the economy. Common pronouncements that the nation’s fiscal problems result from a general “entitlement crisis” are thus mistaken.

Tax Policy Choices Will Have a Major Impact on the Long-Term Problem

Tax policy decisions Congress will make over the next few years have significant implications for the size of the long-term problem. As explained above, our projections show a fiscal gap of 3.2 percent of GDP. This means that enacting annual revenue increases or program reductions equal to 3.2 percent of GDP would ensure that debt in 2050 was no higher than it is today as a share of the economy. Since allowing recent tax cuts to expire as scheduled would increase revenues by about 2 percent of GDP each year, it would reduce the fiscal gap by three-fifths, shrinking it from 3.2 percent of GDP through 2050 to 1.3 percent. Stated differently, making the recent tax cuts permanent without paying for them would more than double the fiscal gap through 2050, relative to what it would otherwise be.

These tax policy decisions will have such a profound effect on the long-term fiscal outlook because they will be made soon. Declining to extend the tax cuts, or offsetting the cost of doing so, would quickly begin to reduce deficits and debt, and these changes would compound over time.

Still, allowing the tax cuts to expire falls far short of what is needed to place the nation on a sustainable fiscal path. Even if the tax cuts expired or were fully offset, debt in 2050 would stand at more than 100 percent of GDP. Moreover, after 2050, debt would continue to rise. Measured over a period that extended beyond 2050, allowing the tax cuts to expire would reduce the size of the problem by a smaller, but still substantial, percentage.

Tough Changes, Including Health Care Reform, Will be Required

In light of this budget outlook, very tough choices will have to be made. As explained above, eliminating the fiscal gap through 2050 would require tax increases or program cuts totaling 3.2 percent of GDP annually through 2050, if the process started immediately. It would be politically implausible (as well as inadvisable on policy grounds) to try to eliminate the fiscal gap solely by raising taxes or solely by cutting programs. Doing so would require the equivalent of an immediate and permanent 18 percent increase in tax revenues or an immediate and permanent 15 percent reduction in all programs, including Social Security, Medicare, defense and anti-terrorism activities, education, veterans’ benefits, law enforcement, border security, environmental protection, and

assistance to the poor. Thus, it is crucial that *both* sides of the budget — revenues and expenditures — be on the table when serious conversations about deficit reduction begin.

An important finding of our projections, however, is that responsibly addressing the nation's budget problems will require more than making changes to both sides of the budget. Addressing the nation's fiscal problem also will require fundamental reforms to the U.S. health care system as a whole. As discussed below, health care costs are the single largest contributor to the long-run budget problem, and cost growth in Medicare and Medicaid tends to mirror — and is driven to a very large extent by — cost growth in the health care system as a whole, including private-sector health care. Indeed, for the past 30 years, the average annual rate of increase in Medicare costs per beneficiary has been very close to the average rate of increase in health care costs per beneficiary system-wide.

Consequently, trying to slow public-sector health care cost growth appreciably without addressing private-sector health care cost growth would require draconian cuts in Medicare and Medicaid that would have severe effects on the poor, the elderly, and those with serious disabilities. Moreover, such cuts would, to some extent, simply shift public-sector health care costs onto the private sector, for instance by forcing health care providers to give greater amounts of uncompensated care, the costs of which would be passed on to private-sector employers and patients. For these reasons, any reforms aimed at reducing the rate of growth of Medicare and Medicaid must be part of a package of reforms designed to slow cost growth throughout the health care system, a point that Comptroller General David Walker has repeatedly made.

It also should be understood that even with major reforms, it is likely to prove virtually impossible to hold health care expenditures in either the public or the private sector to their current levels as a share of the economy. While the U.S. health care system contains significant inefficiencies that raise its costs, the *rate of growth* in health care costs is driven largely by medical advances that tend to improve health and lengthen lifespans but that also increase costs. It is inconceivable that Americans will not want to avail themselves of the medical breakthroughs that will occur in the years and decades ahead, even if they entail significant costs. Furthermore, ongoing economic growth will raise incomes in coming decades, and it would not be unreasonable for Americans to elect to invest a substantial share of that increase in securing better health and longer lives. The challenge therefore is to pursue major reforms that eliminate inefficiencies in the health care system and restrain costs in the system to the greatest extent possible without unduly constraining medical progress. Of course, if, as seems likely, Americans conclude that better health and longer lives merit a somewhat larger share of their income in the future, it will be necessary to pay for these added costs, rather than simply pile up ever-mounting levels of debt.

In sum, solving the nation's long-term budget problems will require that political leaders enact *both* program reductions and revenue increases and, perhaps most difficult of all, substantial, system-wide health-care reforms.

The Basis for Our Projections

The projections presented here of expenditures and revenues through 2050 rest on estimates by the Congressional Budget Office. In brief, we rely on CBO's January 2007 baseline projections

through 2017 (the final year that those projections cover). Thereafter, we draw on CBO’s December 2005 report on the long-term budget outlook and CBO’s June 2006 Social Security projections. These are the most recent long-term projections that CBO has issued.

Expenditure projections after 2017. We project Social Security costs in accordance with CBO’s Social Security projections. Because CBO’s long-term projections present multiple scenarios for Medicare and Medicaid, we must choose among them in constructing our projections. We use the CBO scenario in which health costs are assumed to continue rising at the same average rate (relative to GDP) at which they have risen since 1960. (We also consider an alternative CBO scenario, based on the assumptions adopted by the Medicare trustees, under which the rate of health care cost growth is assumed to slow markedly; see the box on page 13.)

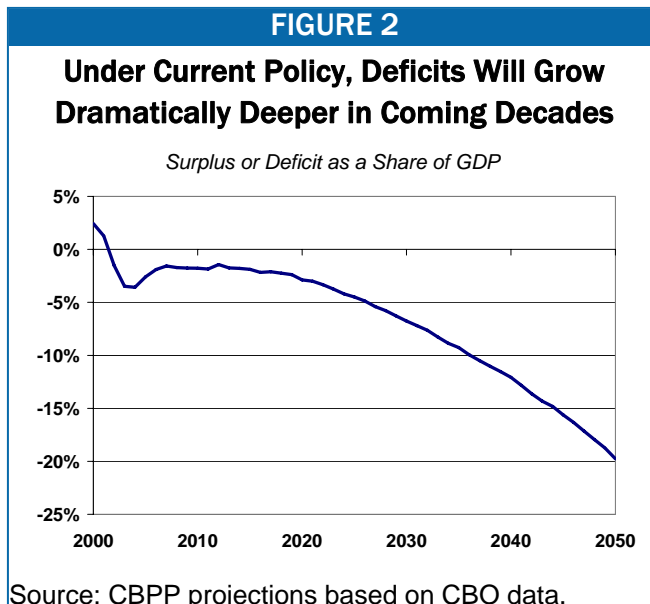
In the case of defense and of domestic programs *other than* Social Security, Medicare, and Medicaid, we assume that overall costs will increase at the rate of inflation plus population growth. This approach essentially assumes that these programs will continue providing the same level of per-person services in the future as they do under CBO’s baseline projections for 2017. This approach is consistent with the last 30 years of historical experience, during which programs other than the “big three” have, taken together, risen at a rate remarkably close to the rate of inflation plus population growth.

Revenue projections after 2017. We base our long-term revenue projections on CBO’s long-term projections, and we assume that the recent tax cuts and relief from the Alternative Minimum Tax are permanently extended. Our revenue projections therefore reflect the consequences of continuing current policies, rather than current law.

Appendix 1 at the end of this analysis provides a more detailed description of how we developed our projections. Appendix 2 explores how these projections would change under alternative assumptions. As that appendix demonstrates, under virtually any plausible set of assumptions, the nation’s long-term fiscal outlook remains grim.

Deficits and Debt Will Reach Unsustainable Levels

Like others who have examined the long-run fiscal situation, we find current policies to be unsustainable.¹ The federal government is projected to run sizable budget deficits over the next ten



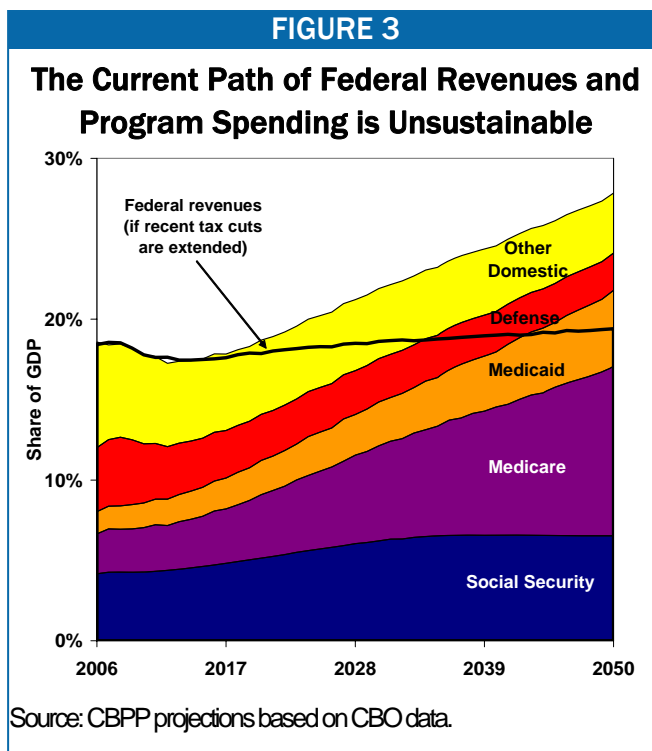
¹ See “The Long-Term Budget Outlook,” Congressional Budget Office, December 2005; Alan J. Auerbach, William G. Gale, and Peter R. Orszag, “New Estimates of the Budget Outlook: Plus Ça Change, Plus C’est la Même Chose,”

years if the tax cuts are made permanent and program policies remain unchanged. After that, if no changes are made, deficits will swell dramatically, from 2 percent of GDP today to almost 20 percent of GDP in 2050. (See Figure 2.)

Over the next four decades, total program expenditures are projected to grow sharply. By 2050, total non-interest expenditures are projected to equal 27.8 percent of GDP, compared with 18.4 percent of GDP today. Between now and 2050, expenditures for Social Security, Medicare, and Medicaid are expected to grow by 13.4 percent of GDP. All other non-interest expenditures are projected to shrink by 4.0 percent of GDP.

As shown in Figure 3, however, the budget situation becomes critical long before 2050. Indeed, by 2034, expenditures in just four program areas — Social Security, Medicare, Medicaid, and defense — are projected to consume *all federal government revenues*. In 2007, the programs *not* included in these four areas (such as education, transportation, housing, nutrition, veterans’ programs, law enforcement, international affairs, border security, environmental protection, and many others) are projected to constitute about a third of federal program spending, or \$803 billion. Those programs clearly are not about to disappear *en masse*. Moreover, Figure 3 does not show the cost of paying interest on the debt.

As a result of these trends, revenues, which are already inadequate to finance government programs and pay interest on the debt, will prove even more inadequate in coming years. The federal government is projected to run deficits every year from now through 2050. These deficits will add to the debt, causing interest payments to balloon. The higher interest payments will further add to deficits, which will add still more to the debt. This “calamity of compound interest” will cause the federal debt to explode, rising from 37 percent of GDP at the end of 2007 to a projected 231 percent of GDP in 2050. (See Figure 1 on page 2.)² Such a level of debt would far exceed the all-time high level of debt for this country — about 110 percent of GDP — reached at the end of World War II. Moreover, the interest costs



February 15, 2006; Government Accountability Office, “The Nation’s Long-Term Fiscal Outlook,” September 2006; Jagadeesh Gokhale and Kent Smetters, “Fiscal and Generational Imbalance: An Update,” August 2005.

² As Appendix 1 explains, we base our GDP growth and interest rate assumptions on CBO’s, which do not reflect the economic impact of fiscal policies over the long term. If the explosion in debt and deficits outlined above actually occurred, interest rates would almost certainly rise significantly, and growth would slow. As a result, deficits and debt would rise even more rapidly as a share of the economy than we show in this analysis.

However, the main goal of analyses like ours (and those produced by CBO and others) is to determine the magnitude of the policy changes that would be necessary to solve the nation’s fiscal problems, not to determine what would happen if

accompanying such a high level of debt would be huge: they would consume 11 percent of GDP, or more than half of projected federal revenues, in 2050.

Deficits and debt of the magnitude that we project for future decades are widely recognized to be damaging to the economy. Growing deficits and debt would push interest rates up and crowd out productive investment, reducing economic growth and, thereby, people's incomes. This process could occur gradually over a long period of time, although ultimately the high levels of debt we project would increasingly lead lenders to decline to lend the government additional money.

But a number of experts, including former Treasury Secretary Robert Rubin, newly-appointed CBO Director Peter Orszag, and Wall Street economist Allen Sinai, have warned that the large, sustained deficits projected under current policies could have negative consequences that are more sudden than conventional economic analyses suggest. Rubin, Orszag, and Sinai have written that "ongoing deficits may severely and adversely affect expectations and confidence, which in turn can generate a self-reinforcing negative cycle among the underlying fiscal deficit, financial markets, and the real economy."³ They warn that failure to address the long-term budget problem could contribute to a serious economic crisis long before debt reaches the levels that we project would occur several decades from now.

Quantifying the Magnitude of the Long-term Fiscal Problem

One useful measure for thinking about the nation's long-term fiscal problems — one that helps to quantify the changes that will be needed to address them — is known as the "fiscal gap." The fiscal gap is equal to the total amount of deficit reduction that would be needed through 2050 so that the debt in 2050 would stand at the same level, as a share of the U.S. economy, as it stands at today.⁴ The fiscal gap through 2050 is equal to 3.2 percent of GDP over this period. (If current policies are continued, rising health costs will cause the nation's fiscal position to continue to worsen after 2050. Hence, the fiscal gap over a period that extended beyond 2050 would be somewhat larger.)

The fiscal gap through 2050 also equals 18 percent of projected revenues over this period or 15 percent of projected program costs.⁵ This means that closing the fiscal gap through 2050 could be

the nation's fiscal problems were never solved. By definition, if policy changes are made that solve the long-term problem, then the fiscal calamity described would not come to pass and the negative economic effects of fiscal collapse would not materialize. Hence, when considering possible policy solutions and quantifying their effects, one should do so under economic assumptions like ours, not under economic assumptions that presume fiscal collapse.

³ For more detailed discussion of how a sudden crisis could develop, see Robert E. Rubin, Peter R. Orszag, and Allen Sinai, "Sustained Budget Deficits: Longer-Run U.S. Economic Performance and the Risk of Financial and Fiscal Disarray," January 4, 2004.

⁴ In technical terms, the fiscal gap through 2050 is the present discounted value of the change in revenues and non-interest spending that would be required to ensure that the debt comprises the same share of GDP in 2050 as it does today. For the original presentation of the fiscal gap concept, see Alan J. Auerbach. "The U.S. Fiscal Problem: Where We Are, How We Got Here And Where We're Going," National Bureau of Economic Research Working Paper 4709, April 1994.

⁵ The fiscal gap can also be stated in dollars (our calculations show a fiscal gap through 2050 of \$18 trillion in present value), but such numbers are often misunderstood and can be presented in a misleading way. The magnitude of the long-term fiscal problem can better be understood by relating the fiscal gap to other figures, for instance by displaying it as a share of the present value of projected GDP, projected revenues, or projected program expenditures.

achieved by increasing revenues by 18 percent (relative to the revenue levels projected for each year) starting right away, reducing program costs by 15 percent each year starting right away, or undertaking a combination of revenue increases and program reductions totaling 3.2 percent of GDP each year.

In 2008, achieving deficit reduction equal to 3.2 percent of GDP would require increasing revenues or cutting programs by \$461 billion (\$461 billion is 3.2 percent of projected GDP for 2008). If

Congress enacts smaller amounts of deficit reduction in the near future (or does not act at all), it will need to enact still larger savings in later years, because future interest costs will be higher and will have to be offset.

As a point of comparison, the budget reconciliation bill enacted in February 2006, which contained significant reductions in Medicaid and some other programs that directly affect low-income families and which passed both the House and the Senate by very slim margins, reduced program expenditures by \$39 billion over *five* years. This is far less than the amount of deficit reduction that will be needed to close the fiscal gap.

No Broad “Entitlement Crisis”

Contrary to a popular misimpression, programs outside of the “big three” — including entitlement programs other than Social Security, Medicare, and Medicaid — are projected to grow *more slowly* than the economy. CBO projects that over the next ten years, overall spending for domestic discretionary programs and entitlement programs outside of the “big three” will fall, both as a share of the economy and in real per-capita terms. (See Table 1.) After 2017, our projections assume that these programs, as well as defense expenditures, will grow at the rate of inflation plus population growth, which is modestly faster than they are currently growing. Their costs will, however, continue to decline as a share of the economy. That decline will occur not because the programs are being cut, but simply because the economy is projected to grow at a somewhat faster rate than inflation plus population growth, as it has throughout U.S. history.

Considered together, the costs of programs outside the “big three” are projected to shrink by 4.0 percent of GDP from 2007 through 2050. This means that in areas of the budget not greatly affected by health care cost increases and demographic pressures, the government would be able to maintain the same level of per-person services even while devoting a smaller share of national resources to these programs.⁶ It also means that these parts of the budget are *not* contributing to the

Program Category	Real Per-Capita Growth (percent change)	Growth as Share of GDP (percentage point change)
All other entitlements	+ 1.3 %	- 0.3 %
Domestic discretionary	- 11.3 %	- 0.8 %
<i>Domestic discretionary and “other entitlements” combined</i>	- 6.2 %	- 1.0 %
The “Big Three”	+ 39.2 %	+1.8 %

Source: CBPP calculations based on CBO and Census data.

⁶ As discussed in Appendix 1, the assumption that these programs will grow at the rate of inflation plus population growth is consistent both with the nature of these programs and with historical experience. It means that our

rapid expenditure growth described above. The only programs that contribute to this rapid expenditure growth are Medicare, Medicaid, and Social Security.

Because entitlements other than the “big three” are shrinking as a share of the economy, it is misleading to speak of a general “entitlement problem.” Such a phrase can leave policymakers with mistaken impressions about the nature and causes of our long-term fiscal difficulties and may lead them to advocate inappropriate policies.

Rapid Increases in Health Care Costs Are the Largest Driver of Expenditure Growth

As noted above, the three programs that will cause expenditures to grow faster than the economy over coming decades are Medicare, Social Security, and Medicaid. Growth in these “big three” programs is driven by two powerful factors: the demographic shifts that will occur as the baby boomers retire and the fact that per-person health care costs are growing much faster than per-person GDP.

Figure 4 uses CBO data to separate the effects of these two factors. The darker shading shows the amount of growth that would occur in each of these three programs as a result of demographic changes if health care costs per person grew no more rapidly than the economy. The lighter shading shows the amount of additional growth that results when demographic changes are coupled with the much higher health care cost growth that we project.

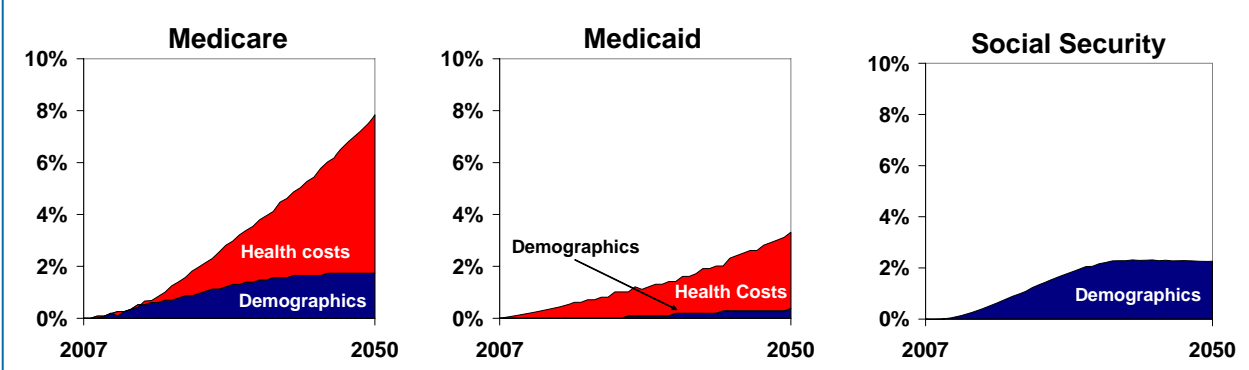
Figure 4 leads to two important conclusions. First, Medicare is by far the largest contributor to the overall growth in expenditures through 2050 because it bears the full brunt of *both* demographic changes and health care cost growth (and because it is a bigger part of the federal budget than Medicaid). Social Security contributes less to the growth in expenditures because it is not a health program — its per person costs do *not* grow faster than the economy. Medicaid contributes less to the overall growth of expenditures mostly because it is a smaller federal program than either Medicare or Social Security, but also because it faces milder demographic challenges.⁷

projections for these areas of the budget, considered together, fall between CBO’s high and low spending scenarios. (In the case of defense, which does not provide services on a per-person basis, our assumption simply means that the resources devoted to this area are projected to rise in real terms and the military is projected to have a larger budget, adjusted for inflation, even though its budget will decline as a share of the economy.)

⁷ Medicaid will, however, be affected by the aging of the population, in large part because it covers long-term care expenses for the low-income elderly.

FIGURE 4

Sources of Cost Growth in the “Big Three” as a Share of GDP



Source: CBPP calculations based on CBO data.

Note: “Demographics” denotes the program growth that would occur solely due to demographic changes if per-beneficiary health costs merely rose with per-person GDP. “Health costs” denotes the additional growth due to the fact that per-beneficiary health costs are growing faster than per-person GDP.

Second, Figure 4 demonstrates that the program growth attributable strictly to demographic factors is modest in size relative to the growth induced by piling rising health care costs on top of these demographic changes. In any case, the demographic effects begin to plateau by the end of the projection period. In contrast, rapid health cost growth continues to cause steep program cost growth indefinitely.

Together, these conclusions indicate that through 2050 and, certainly, over the longer term, addressing the rate of growth in per-beneficiary Medicare and Medicaid spending is essential to restoring fiscal stability.

Doing so, however, will require solutions that extend beyond the public health sector. Health-care costs per beneficiary are growing rapidly in Medicare and Medicaid largely because they are growing rapidly throughout the entire U.S. health-care system, including the private sector. Historically, as shown in Table 2, private-sector costs per beneficiary and costs per beneficiary in Medicaid and Medicare have grown at about the same rates. Research also has found that Medicaid generally costs significantly less than private-sector health insurance does for people with similar health status, as shown in Figure 5.⁸

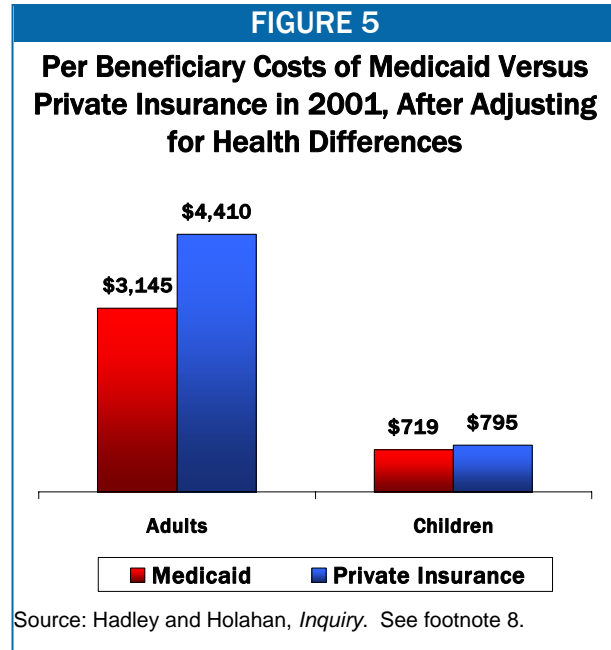
TABLE 2	
Health Cost Growth in Public Programs and the Entire Economy 1975-2004	
Growth in Per-Beneficiary Health Costs Compared to Growth in Per-Person GDP (percentage points)	
Entire economy	+ 2.4
Medicare	+ 2.8
Medicaid	+ 2.4

Sources: Medicaid data from CBO. Medicare and entire economy from CBPP calculations based on Center for Medicare and Medicaid Services and Medicare Trustees data.

⁸ See Jack Hadley and John Holahan, “Is Health Care Spending Higher under Medicaid or Private Insurance?” Inquiry, 40 (2003/2004): 323-42. Similar comparisons are impossible for Medicare since private insurers do not provide Medicare-like coverage to a population comparable to Medicare beneficiaries.

This means that rapid growth in health care costs is a health-system-wide issue, not just a government expenditure issue. This is hardly surprising, given that cost growth is driven in large part by rapidly improving but increasingly expensive health-care technology, which affects the public and private sectors alike. As Comptroller General David Walker, the head of the GAO, has stated:⁹

[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole. For example, Medicare and Medicaid cannot grow over the long term at a slower rate than cost in the rest of the health care system without resulting in a two-tier health care system. This, for example, could squeeze providers who then in turn might seek to recoup costs from other payers elsewhere in the health care system. Rather, in order to address the long-term fiscal challenge, it will be necessary to find approaches that deal with health care cost growth in the overall health care system.



As Walker warns, seeking to slow the growth of Medicare and Medicaid markedly without changing the dynamics in the broader health care system would create a “two-tier health care system,” one in which individuals in the private health system receive one level of health-care coverage and those enrolled in Medicare and Medicaid receive a substantially lower level. The longer the difference in growth rates between the public programs and the private system persisted, the larger this difference would grow. Over time, the quality of care available to those covered by public programs would erode substantially.

Alternatively, Medicare and Medicaid costs could be cut by removing beneficiaries from the programs. Such an approach would swell the ranks of the uninsured and leave many low-income, elderly, and disabled people without access to needed health care. Also, it would likely shift significant costs to private-sector hospitals, which are required to cover acute care for the uninsured, and so would have only a limited impact on overall health care spending.

If policymakers were to attempt to significantly reduce the growth rate of public-sector health costs without system-wide reform, they would necessarily fall into one or all of these traps: reducing the quality of health care for a significant part of the population, abdicating responsibility for much of the low-income, elderly or disabled population, or shifting health care costs from the federal government onto state and local governments and the private sector. To address the very sizable

⁹ “Long-Term Fiscal Issues: The Need for Social Security Reform,” Statement of David M. Walker, Comptroller General of the United States, before the Committee on the Budget, U.S. House of Representatives, February 9, 2005, page 18.

health-care component of the long-term budget problem, therefore, a more comprehensive approach will be essential.

Adding to this challenge is the large role that advances in medical technology play *both* in improving health *and* in increasing health-care expenditures. The U.S. health-care system contains significant inefficiencies that substantially raise its underlying level of cost. But the *rate of growth* in health-care costs is driven less by inefficiency than by medical advances that can improve health and lengthen life.¹⁰ (Noted Harvard health economist David Cutler has calculated that the health improvements that have resulted just from advances in neonatal care and the treatment of heart disease have been sufficient to justify all of the increase in health care spending that occurred in the United States between 1950 and 1990.¹¹) It is hard to believe that Americans will not seek to avail themselves of the medical breakthroughs that will occur in the years and decades ahead. As a result, it is likely to prove virtually impossible, and probably undesirable, to hold health care expenditures in either the public or private sectors to their current levels as a share of the economy.

Fortunately, it is not essential to hold health care costs to their current level as a share of the economy, if the increases in health care costs are offset by reductions (as a share of the economy) in consumption in other areas. It is possible for the economy to absorb some level of increase in the share of GDP devoted to health care. As Table 3 indicates, the share of the economy devoted to health care has increased by more than 10 percentage points since 1960, with that increase being accompanied by a corresponding reduction in the share of GDP devoted to all other activities. (Since the U.S. economy has grown substantially since 1960, per-person expenditures for items other than health care actually increased by more than 200 percent in real terms even though those expenditures declined as a share of GDP.)

Economic growth will cause incomes to increase further in coming decades. As incomes rise, it is likely Americans will choose to devote a sizable portion of their additional resources to health care, especially if it holds the promise of better health and increased longevity.¹²

TABLE 3		
Changes in Health and Non-Health Output, 1960-2005		
Sector	Real Per-Person Growth	Change as Share of GDP
Health care	821%	+ 10.7%
All other	239%	- 10.7 %
<i>Entire Economy</i>	269%	N/A

Source: CBPP calculations based on Bureau of Economic Analysis and Center for Medicare and Medicaid Services data.

¹⁰ Medical advances can increase overall health care expenditures even when the advances result in new treatments or procedures that are *less* expensive than the treatments or procedures they replace. This can occur when the new treatments or procedures are more effective, leading more doctors to prescribe them and more patients to want to use them. The resulting increase in health care utilization raises overall health care spending.

¹¹ David M. Cutler, *Your Money or Your Life*, (New York: Oxford, 2004).

¹² For a discussion of the effect of rising incomes on health spending, see “More Life vs. More Goods: Explaining Rising Health Expenditures,” Federal Reserve Bank of San Francisco Economic Letter, May 27, 2005.

Assuming Lower Health Cost Growth Would Not Alter Our Conclusions

Our projections use CBO projections of Medicare and Medicaid costs that assume that the difference between the rate of economic growth and the rate of growth in health spending per person will be similar to the difference seen over the last several decades. CBO also presents an alternative expenditure path, based on the 2005 Medicare trustees report, that assumes that future growth in health care costs will be substantially lower than historical patterns suggest (while remaining above the rate of economic growth).*

The Medicare Trustees assume lower future health cost growth for two reasons. First, they argue that some of the historical growth in health costs was due to non-recurring factors, like the spread of health insurance, that are unlikely to contribute to growth in health costs in the future. Second, GDP growth is projected to slow in future decades, and the Trustees implicitly assume that the rate of health care cost growth will slow commensurately. For a variety of technical reasons, however, the Medicare trustees likely overstate the extent to which the rate of growth in health costs will decline relative to the past, unless policy changes are instituted.**

Consequently, we assume here that future health cost growth, in the absence of policy changes, will be more similar to the rates projected in the CBO scenario that assumes a continuation of historical trends than to the rates projected in the CBO scenario that is based on the trustees' assumptions, and we use the higher growth scenario as our base case. Nonetheless, given the substantial uncertainty involved in projecting health care costs, it is worth considering what the nation's fiscal future would look like if costs grew at the lower rate projected by the Medicare Trustees.

Using the lower health cost growth assumptions would substantially reduce the projected growth in Medicare and Medicaid and the overall fiscal gap. Even so, the national debt would still increase dramatically over the coming decades, reaching 166 percent of GDP in 2050 (instead of the 231 percent of GDP it reaches in our base projections). Likewise, the nation would still face a large fiscal gap through 2050 of 2.1 percent of GDP (compared with 3.2 percent of GDP under our base case projections). Achieving deficit reduction of 2.1 percent of GDP in 2008 would require enacting tax increases and program reductions totaling \$306 billion.

Assuming lower health care cost growth thus would not fundamentally alter our central finding: that current policies are unsustainable and that restoring fiscal stability requires painful choices. Nor would it alter the conclusion that spending outside of the "big three" is growing more slowly than the economy and, hence, is not contributing to the rapid growth in expenditures. Moreover, even under this scenario, the level of health cost growth is unsustainable, and reforms in the nation's health care system would be essential. (Also of note, under this scenario, either allowing recent tax cuts to expire or offsetting the costs of extending them would address an even larger fraction of the nation's long-run fiscal problem.)

* The 2005 Medicare Trustees report projects that annual per-beneficiary health cost growth will gradually decline to 1 percentage point faster than per-person GDP growth by 2030 and then remain at that level in subsequent years.

** For a detailed discussion of these issues, see Richard Kogan and Matt Fiedler, "The Methodology Underlying CBPP's Long-Term Projections," Center on Budget and Policy Priorities, January 29, 2007.

Yet it must be emphasized that the rapid rate of increase in health care costs that has prevailed in recent decades cannot be allowed to continue much longer. If it does, the adverse consequences for the budget and the economy will be profound, as this analysis shows. In fact, if health care spending system-wide continues to grow at its historical rate, the amount of household income available for purposes other than health care (after adjusting for inflation) will begin to *decline* by the mid-2020s.

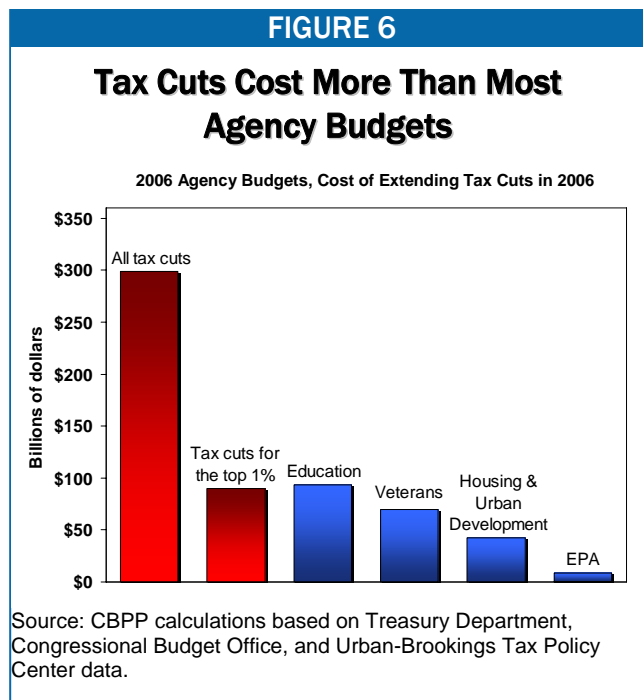
Consequently, one of the principal challenges that policymakers — and the country — face is the need to institute major reforms that sharply reduce inefficiencies in the health care system and also restrain the rate of growth in health care costs to the extent that is possible without unduly constraining medical progress. This almost certainly will mean some continued rise in public and private health care expenditures as a share of the economy — but at significantly less than the historical rate. And it will be necessary to pay for the added costs that do occur by reduced consumption elsewhere. In terms of the federal budget, this means that the increases in federal health care costs as a share of GDP that occur even after health-care reform will need to be financed by increased revenues, reductions in projected expenditures for other purposes, or most likely, a combination of the two.

The Importance of Coming Tax-Policy Decisions

Our revenue projections assume that the tax cuts enacted since 2001 will be extended, as the President has urged.¹³ CBO projects that, with the tax cuts in place, revenues edge up modestly over time as a share of the economy. (In a progressive tax system, tax revenues edge up as a share of the economy as the population grows richer, due to “real bracket creep.”) But revenues will be a little more than 2 percent of GDP lower each year than they would be if the recent tax cuts were allowed to expire as scheduled at the end of 2010, or if the cost of extending those tax cuts was offset with other revenue-raising measures.

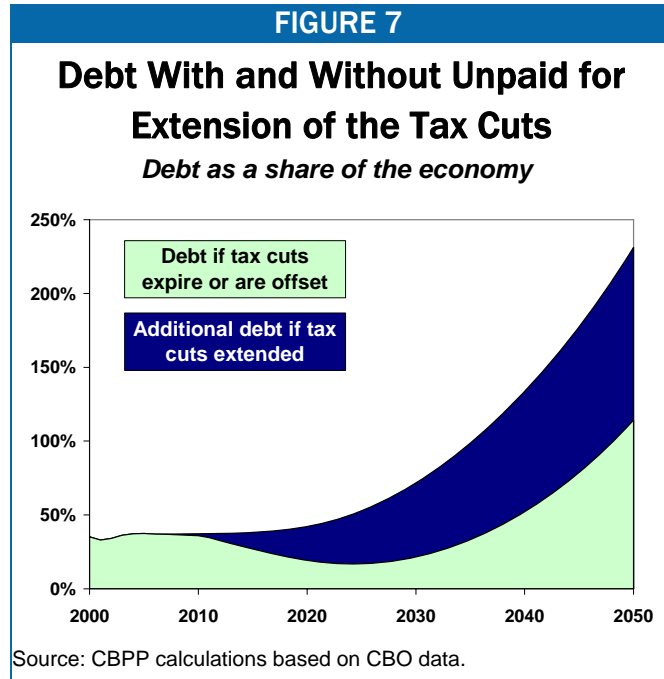
Recall that the fiscal gap through 2050 is equal to 3.2 percent of GDP under our projections, which means that annual revenue increases or program reductions equal to 3.2 percent of GDP are required to eliminate the fiscal gap through 2050. Since the cost of the tax cuts is about 2 percent of GDP each year (once the tax cuts are fully in effect), allowing them to expire as scheduled — or fully offsetting the cost of extending them — would reduce the fiscal imbalance to 1.3 percent of GDP, shrinking it by three-fifths. Looked at another way, were policymakers to choose to extend all expiring tax provisions without paying for them, the nation’s fiscal problem, measured through 2050, would be more than twice as large as it otherwise would be.

(As noted earlier, the fiscal gap over a period that extended beyond 2050 would be somewhat larger. Correspondingly, looked at over a longer window, allowing the tax cuts to expire would eliminate a smaller, but still very substantial, share of the long-term problem.)



¹³ Our projections also assume that the so-called “extenders,” such as the research and development tax credit and the state and local sales tax deduction, are made permanent as well.

That the tax cuts are a major contributor to the nation’s long-run fiscal problems should come as no surprise. In today’s terms, the annual cost of extending recent tax cuts, when the tax cuts are fully in effect, will exceed the entire budgets of the Departments of Education, Homeland Security, Veterans’ Affairs, Housing and Urban Development, State, and the Environmental Protection Agency *combined*. (See Figure 6.) In fact, the annual cost of the tax cuts just for the top one percent of Americans — those with annual household incomes in excess of \$400,000 — will be about as large as the entire budget of the Department of Education or the Department of Veterans Affairs (i.e., as large as the budget for all education programs or all veterans programs).



Still, eliminating or offsetting the costs of the tax cuts is no panacea. Even if the tax cuts are not extended or the cost of extending them is offset, the fiscal gap through 2050 will be 1.3 percent of GDP and, as Figure 7 indicates, the nation will still face a debt explosion. Declining to extend the tax cuts without paying for them would be far from sufficient; additional difficult choices would still be needed. Nonetheless, the decisions that policymakers make about taxes over the next several years will have very important implications for the nation’s fiscal future.

Appendix 1: An Explanation of the Projections

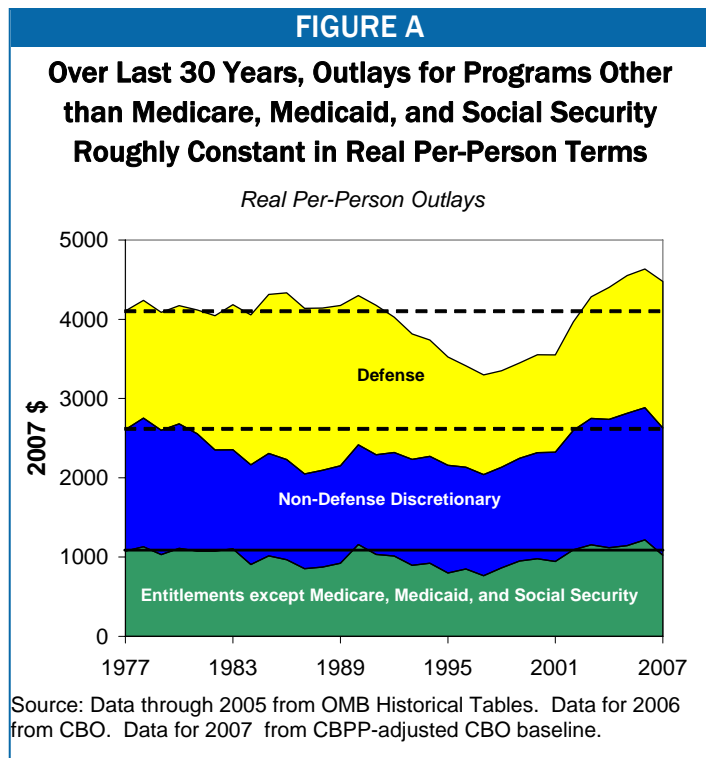
Our projections are estimates of the effects of continuing current government policies through 2050. They draw on three main data sources: CBO’s January 2007 baseline projections for 2008-2017, CBO’s December 2005 long-term projections, and CBO’s June 2006 Social Security projections.

Through 2017, our expenditure projections are identical to CBO’s January 2007 estimates, except that we assume that expenditures for operations in Iraq and Afghanistan will phase down, following a path specified in CBO’s January report, and we assume that funding for the remaining defense activities will grow as requested in the President’s 2007 budget.

After 2017, we follow CBO’s long-run projections of the growth in Social Security, Medicare, and Medicaid as a share of the economy and we assume that overall costs for other entitlements, domestic appropriations, and defense grow at the rate of inflation plus population growth, consistent with the nature of these programs and the past 30 years of historical experience. (See Figure A.) We base our revenue estimates on CBO’s estimate of revenues if the tax cuts are extended and the AMT is indexed for inflation. Below, we explain these projections in more detail. For a more in-depth explanation of the reasoning behind our methodological choices, see Richard Kogan and Matt Fiedler “The Technical Methodology Underlying CBPP’s Long-Term Projections.”

Entitlements: In its ten-year projections, CBO assumes that entitlement programs such as Social Security, Medicare, Medicaid, federal retiree pensions, Food Stamps, and so on will grow in whatever ways are required by law. We use CBO’s baseline. Beyond 2017, CBO projects Social Security, Medicare, and Medicaid growth based on long-term demographic, economic, and health care assumptions. We adopt CBO’s forecasts for how these programs will grow as a share of the economy. Specifically, for Social Security, we use the main path in CBO’s June 2006 report.

To project Medicare and Medicaid costs, we make the additional assumption that the broad structure of the nation’s health care system will remain stable. We further assume that health cost growth in Medicare and Medicaid will track economy-wide cost growth, consistent with historical experience. On this basis, we select CBO’s December 2005 high-



cost scenario for projecting health costs. The CBO scenario assumes that health costs grow at the same average rate (relative to GDP) that they have since 1960.¹⁴

To project all other entitlements after 2017, we assume that these programs will grow, in the aggregate, at the rate of inflation plus the growth rate of the U.S. population. This assumption is broadly consistent with the nature of these programs since most provide services on a per-person basis and the costs of providing those services rise with overall prices. As shown in Figure A, this assumption is also consistent with the historical growth rate of the programs in this category.

Non-Defense Discretionary Appropriations: CBO assumes that the level for these programs set by the enacted homeland security appropriations bill and the continuing resolution that will expire on February 15, 2007 will grow with inflation through 2017. We follow CBO's projections, except that we assume that a small emergency appropriation included in the homeland security appropriations bill is not repeated in future years. After 2017, we assume that non-defense discretionary programs will continue to provide the same level of services that they do in 2017. Due to the wide variety of programs included in this category, it would be difficult to determine the spending growth rate needed to maintain current service levels on a program-by-program basis. For many of these programs, a continuation of current policy implies constant real resources per person, as it does for most entitlement programs. Moreover, this is the historical experience of non-defense discretionary programs in the aggregate, as shown in Figure A. Therefore, we assume that expenditures for these programs will grow with inflation and population growth over the long term.

Defense: CBO's baseline assumes that \$70 billion enacted this fall for operations in Iraq and Afghanistan wars and the "international war on terror" are part of the 2007 defense base, and that the 2007 base as so defined will continue to grow with inflation in all future years. Instead of using CBO's mechanical projection of war costs, we assume that the cost of the wars in Iraq and Afghanistan will follow an alternative path specified in CBO's report. This path assumes that the number of troops deployed in Iraq and Afghanistan, will rise somewhat during 2007 and then decline to 30,000 in 2010, where it remains in years thereafter.¹⁵

We further assume that the level of defense funding (outside of funding for the wars) will grow as requested in the Bush budget for 2007, a rate somewhat faster than inflation. On balance, our assumptions lead us to project somewhat higher defense spending than CBO projects through 2011 and somewhat lower spending than CBO projects from 2012 through 2017.

Projecting defense spending after 2017 is more difficult since it is unclear what it means to continue providing the current level of defense services. We take as the best available guide the

¹⁴ Specifically, CBO's high-cost scenario assumes that the annual growth rate of per-beneficiary health costs is 2.5 percentage points faster than per-person GDP. Over the period 1960-2005, economy-wide per-person health spending also grew 2.5 percentage points faster than per-person GDP. The experience of Medicare and Medicaid over the last 30 years has been similar.

¹⁵ CBO's January report also presents in a path in which the number of troops deployed in Iraq and Afghanistan stabilizes at a higher level of 75,000 and does not decline to that level until 2013. We did not adopt this path because we project defense spending for years after 2017 on the basis of its level in 2017, and using the higher of CBO's two alternative paths for Iraq/Afghanistan spending would essentially lead us to project that the United States will keep 75,000 troops in Iraq and Afghanistan through 2050. This seems implausible. Regardless, using this alternative path would change our estimate of the fiscal gap only slightly. (See Table B in Appendix 2.)

Our Treatment of the Alternative Minimum Tax

In our revenue projections, we assume that the Alternative Minimum Tax relief that expired at the end of 2006 will be extended. Since 2001, Congress has regularly extended AMT relief, raising the AMT “exemption amount” more or less in line with inflation. If this relief were discontinued and the AMT were left unchanged for the next four decades, it would practically replace the regular income tax by 2050. CBO estimates that, in 2050, more than 60 percent of households would pay the AMT, and revenues would rise far more rapidly than under our projections.

When we discuss the fiscal impact of allowing recent tax cuts to expire as scheduled, we do *not* assume the expiration of AMT relief. We assume that Congress will continue AMT relief regardless of the fate of the 2001 and 2003 tax cuts. As a result, we measure the cost of those tax cuts relative to a tax code in which the AMT is indexed for inflation on an ongoing basis.* Without such indexing, taxpayers would find that their real tax liabilities would increase even when their real incomes did not.

Put another way, we include in the costs of the 2001 and 2003 tax cuts the cost of providing AMT relief only to those taxpayers who would *not* be subject to the AMT were it not for the tax cuts. We do *not* include any other costs related to continuing AMT relief. In addition, when we estimate the savings that would result from not extending the tax cuts, we do not include the impact of paying for future AMT relief that is simply equivalent to indexing the AMT exemption for inflation. We essentially consider an indexed AMT to be an underlying part of the tax code.

* Technically, we consider the costs of the tax cuts relative to an AMT exemption level set equal to the exemption level in 2000, as indexed for inflation.

historical growth rate of defense expenditures over the last 30 years, which was approximately equal to the rate of inflation plus the rate of population growth (see Figure 7). We assume that defense expenditures will grow at the rate of inflation plus the rate of population growth after 2017.

Revenues: For our revenue projections, we adopt CBO’s January estimates of revenue levels through 2017 if the expiring tax provisions (the 2001 and 2003 tax cuts and the provisions often referred to as “extenders,” such as the research and development tax credit), are made permanent and AMT relief is continued. We assume that total revenues will grow slowly as a share of the economy after 2017, as CBO’s long-run projections show will occur if the tax cuts and AMT relief are made permanent. We assume that the cost of the tax cuts will remain constant as a share of the economy after 2017.¹⁶

Economic Assumptions: We assume that interest rates follow the path specified in CBO’s June 2006 Social Security projections, the most recent long-term economic projections issued by CBO. For GDP and inflation, we adopt CBO’s January 2007 projections through 2017. Thereafter, we adopt the projections of GDP growth and inflation contained in CBO’s June 2006 Social Security projections. (Note that CBO’s long-term economic projections do not incorporate the negative economic effects that would result from a substantial increase in the debt-to-GDP ratio.) For the purposes of projecting spending after 2017 on programs other than the Social Security, Medicare, and Medicaid, we use population growth rates from the Census Bureau’s March 2004 Interim Projections.

¹⁶ Continued rapid growth in health costs could have important ramifications for revenues. For example, rapid health cost growth could cause employees to receive a greater share of their compensation in the form of health benefits. Since such benefits are excluded from taxation, this would tend to reduce the amount collected in payroll and income taxes. Conversely, rapidly rising health costs could induce employers to stop providing health benefits altogether, raising the share of employee compensation that is subject to taxation. In any case, the CBO data on which we base our projections do not attempt to account for these effects, and so our projections do not attempt to do so either.

Appendix 2: Sensitivity to Alternative Assumptions

Long-run projections are inevitably subject to considerable uncertainty since constructing them requires making assumptions about events that will unfold decades in the future. In addition, analysts sometimes disagree about how best to conceive of projecting “current policy” into the distant future.

Differences in assumptions and methodology can cause analysts to differ markedly in their assessment of the size of the long-term fiscal problem posed by current policies. As Table A indicates, our estimate of the size of long-term fiscal problem is in the middle of the range of estimates that other analysts and institutions have generated.¹⁷

TABLE A	
Fiscal Gaps 2008-2050 Under Different Methodologies	
Methodology	Fiscal Gap 2008-2050 (% GDP)
GAO Scenario #2	6.0
Auerbach, Gale, and Orszag	5.1
CBPP	3.2
GAO Scenario #1	2.7
Gokhale and Smetters	1.9
Office of Management and Budget	0.5

Note: None of groups listed above publishes a fiscal gap for the period 2008-2050. These figures reflect CBPP calculations of the fiscal gap through 2050 using the economic and programmatic assumptions underlying each group's long-term projections.

Government Accountability Office Scenario #1 differs from the other scenarios listed in the table because it assumes that temporary tax provisions, including the 2001 and 2003 tax cuts, expire as scheduled.

It should be noted that our estimate is based in significant part on CBO's January 2007 projections of the budget outlook for the next ten years. The other analyses cited here were based on earlier and generally somewhat more pessimistic assumptions about the medium-term budget path, especially with regard to Medicare and Medicaid costs. These differences modestly increase others' estimates of the fiscal gap relative to ours, although the bulk of the differences between our projections and others' reflect differences in methodology. For more detail on how our projections compare to others', see Appendices 1 and 2 of Richard Kogan and Matt Fiedler, “The Technical Methodology Underlying CBPP's Long-Term Projections.”

This appendix examines how our results would change under a variety of alternative approaches and assumptions. Table B summarizes the results of examining such alternatives. The overall message is clear: no change to the methodology would alter the conclusion that the nation faces a

¹⁷ For the published versions of others' projections, see “The Long-Term Budget Outlook,” Congressional Budget Office, December 2005; Alan J. Auerbach, William G. Gale, and Peter R. Orszag, “New Estimates of the Budget Outlook: Plus Ça Change, Plus C'est la Même Chose,” February 15, 2006; Government Accountability Office, “The Nation's Long-Term Fiscal Outlook,” September 2006; Jagadeesh Gokhale and Kent Smetters, “Fiscal and Generational Imbalance: An Update,” August 2005; Office of Management and Budget, *Analytical Perspectives: Fiscal Year 2007* (Washington: Government Printing Office, 2006), pp. 175-201.

Auerbach, Gale, and Orszag present four scenarios. The four scenarios differ in whether or not they assume extension of expiring tax provisions, how they project discretionary spending through the first 10 years, and in the data used to project Social Security and Medicare over the long term. Table A considers Scenario III, which assumes extension of expiring tax provisions, assumes that discretionary funding grows with inflation and population through 2017, and projects Medicare on the basis of a combination of CBO and Trustees' data.

The Government Accountability Office (GAO) presents two scenarios. The first is its “baseline extended” scenario that, roughly speaking, projects current law (and thus assumes that the recent tax cuts expire). Table A refers to this scenario as GAO Scenario #1. GAO also presents a scenario that assumes higher discretionary spending and assumes that expiring tax provisions, including the 2001 and 2003 tax cuts, are extended. We refer to this scenario as GAO Scenario #2.

TABLE B		
Effects on the Fiscal Gap of Alternative Projection Assumptions		
Alternative Assumption	Fiscal Gap Under Alternative Assumption (% GDP)	Change Relative to Base Scenario (% GDP)
Health cost growth as in 2005 Medicare Trustees report*	2.1%	-1.1%
Non-defense discretionary grows with GDP, starting immediately	3.9%	+ 0.7%
Revenues stay constant as a share of GDP after 2017	4.0%	+ 0.7%
“Other mandatory” spending grows with GDP after 2017	3.4%	+ 0.2%
Defense grows only with inflation after 2017	3.0%	- 0.2%
Defense grows with GDP after 2017	3.4%	+ 0.2%
Number of US troops in Iraq and Afghanistan declines to 75,000 by 2013 and remains at that level thereafter	3.4%	+ 0.2%

Source: CBPP calculations based on CBO data.

* Assumes that per-beneficiary health care cost growth declines to 1 percentage point more than per-person GDP growth by 2030 and remains there thereafter.

serious long-run fiscal problem. What follows is a more in-depth discussion of alternative assumptions.

Health Costs

By far the most important and most uncertain assumption in our analysis is the growth rate for health care costs. While adopting alternative growth rate assumptions within plausible ranges would have substantial effects on some of our numerical findings, it would not fundamentally alter any of our central conclusions, at least through 2050.

For example, assuming a health cost growth rate that is even higher than we do would increase the projected fiscal gap, reinforcing the conclusion that current budget policies are unsustainable and that reforming the U.S. health care system is crucial to solving the nation’s long-term fiscal problem.

Assuming lower health cost growth would markedly reduce the size of the fiscal problem through 2050, but the fiscal path would still be unsustainable. (See the box on page 13.)

Revenues

In our projections, we assume that revenues will rise gradually over time as a share of the economy since, in a progressive tax system, tax revenues rise as a share of the economy as people’s incomes rise. Some analysts instead project revenues by following the CBO baseline (adjusted for the extension of recent tax cuts) through the first ten years and then freezing revenues in subsequent years at the level, as a share of GDP, at which revenues stand at the end of the ten-year window. This approach leads to somewhat lower projected revenues through 2050 and implies a fiscal gap through 2050 that is 0.7 percent of GDP larger than our basic projection.

Non-Defense Discretionary

Through 2017, our projections of non-defense discretionary spending follow the CBO baseline, which assumes that underlying discretionary funding rises with inflation. After 2017, we grow non-defense discretionary spending with inflation and population, for the reasons outlined in Appendix 1. Alternatively, one could assume that discretionary spending will rise at the rate of GDP growth, which is somewhat faster. If we assumed that discretionary funding would grow with GDP starting immediately, our estimated fiscal gap through 2050 would increase to 3.9 percent of GDP (0.7 percent of GDP larger than in our basic projection).

Defense

Defense spending is particularly difficult to project because it is unclear what it means to maintain “current defense services.” As noted in Appendix 1, our projection follows an adjusted CBO baseline through 2017 and grows defense spending with inflation and population growth thereafter. Some other analysts have suggested growing defense spending with inflation only — which would result in a slightly smaller fiscal gap — while others have suggested assuming that defense spending grows with GDP over the long term, which would produce a slightly larger fiscal gap. As shown in Table A, neither of these alternative approaches would appreciably change the size of the fiscal gap through 2050.

As discussed in Appendix 1, we assume that expenditures for operations in Iraq and Afghanistan follow the path specified in CBO’s January 2007 report that assumes that the number of U.S. troops deployed in Iraq and Afghanistan will decline to 30,000 by 2010 and remain at that level thereafter. CBO also presents a path in which the number of U.S. troops in Iraq and Afghanistan declines more slowly, reaching 75,000 in 2013 and remaining at that level thereafter. Using that path instead of the path we adopted would slightly increase the fiscal gap through 2050, from 3.2 percent of GDP to 3.4 percent of GDP.

“Other Mandatory”

Through 2017, our projection of mandatory spending outside of the “big three” follows the CBO baseline, which assumes that program spending grows in accordance with the program rules set forth in current law. Thereafter, we grow these programs with inflation and population. As explained in Appendix 1, we believe this to be the best available approximation of continued growth under existing rules for these mandatory programs. Some other analysts have chosen to grow these programs with GDP rather than with inflation and population growth after the first ten years. Growing these programs with GDP would not appreciably change our results, as it would increase the fiscal gap through 2050 by only 0.2 percent of GDP.