# GAO's Simulations – Key Budget Assumptions

| Model inputs | Baseline Extended simulation | Alternative simulation |
|---|---|---|
| **Revenue** | Congressional Budget Office's (CBO) June 2017 baseline through 2027. It assumes tax provisions expire as scheduled under current law and growth of real income causes a greater proportion of taxpayers' income to be taxed in higher brackets through 2027. After 2027 remains constant at 18.4 percent of gross domestic product (GDP) (the share projected in 2027). | CBO's estimates assume expiring tax provisions are extended through 2027; thereafter revenue remains constant at 18.3 percent of GDP (the share projected in 2027). |
| **Discretionary spending** | CBO's June 2017 baseline through 2027. The baseline reflects the caps and automatic enforcement procedures established in the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), as amended.[a] After 2027 remains constant at 5.4 percent of GDP (CBO's projection in 2027). | Follows the caps established by BBEDCA through 2023, but not the lower caps triggered by the automatic enforcement procedures; thereafter it gradually phases up to 7.2 percent of GDP (the 20-year historical average). |
| **Other mandatory spending** | CBO's June 2017 baseline through 2027, which incorporates the reductions in spending, scheduled to occur under the automatic enforcement procedures established by BBEDCA; thereafter remains constant at 2.5 percent of GDP (the share projected in 2027). | CBO's June 2017 baseline and exclude the effects of the automatic enforcement procedures established by BBEDCA and revised by subsequent legislation through 2027; thereafter remains constant as a share of GDP at 2.5 percent (the share projected in 2027). |

| Model inputs | Baseline Extended simulation | Alternative simulation |
|---|---|---|
| **Social Security spending** | CBO's June 2017 baseline through 2027; thereafter phases into the 2017 Social Security Trustees' intermediate projections. | Same as Baseline Extended. |
| **Medicare spending** | CBO's June 2017 baseline through 2027. The baseline incorporates the effects of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which, among other things, revised the methodology for determining physician payment rates. It assumes the automatic enforcement procedures established by BBEDCA reduce spending.[b] After 2027, phases into the 2017 Medicare Trustees' current law projections in which cost containment mechanisms, including those enacted in the Patient Protection and Affordable Care Act, reduce excess cost growth to 0.0 percentage points on average over the long term.[c] | Based on CMS Actuary's alternative scenario that assumes physician payment rates under MACRA are not sustainable in the long term and that the beneficiary growth rate transitions to a long-term rate similar to the per capita increase in overall health spending; spending reductions scheduled under current law do not occur[b] and policies that would restrain Medicare cost growth are applied fully through 2019 but begin to phase out thereafter; excess cost growth averages 0.6 percentage points over the long term.[c] |

| Model inputs | Baseline Extended simulation | Alternative simulation |
|---|---|---|
| **Medicaid, the Children's Health Insurance Program (CHIP), and exchange subsidies spending** | CBO's June 2017 baseline through 2027; thereafter growth in spending for these programs is consistent with CBO's March 2017 long-term assumptions for the number and age composition of enrollees and the 2017 Trustees' current law assumptions for excess cost growth; excess cost growth averages 0.6 percentage points over the long term.[c] | Same as Baseline Extended. |

Source: GAO.

Notes: CBO's projections are from *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 29, 2017) and *The 2017 Long-Term Budget Outlook* (March 30, 2017). These reports were prepared prior to the enactment of the Tax Cuts and Jobs Act and the Bipartisan Budget Act of 2018. Trustees' projections are from *The 2017 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* and the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which were both issued on July 13, 2017. Projections from the CMS Actuary are based on data underlying the "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers" (July 13, 2017). GAO assumes that Social Security and Medicare benefits are paid in full regardless of the amounts available in the trust funds.

[a]The Budget Control Act of 2011 (BCA) amended BBEDCA, establishing discretionary spending limits for 2012 through 2021. The BCA also established the Joint Select Committee on Deficit Reduction (Joint Committee), which was tasked with proposing legislation to reduce the deficit by at least $1.2 trillion by fiscal year 2021. The Joint Committee did not report a proposal and Congress and the President did not enact legislation, which triggered the sequestration process in section 251A of BBEDCA. Section 251A required (1) a sequestration for fiscal year 2013 and (2) downward adjustments to discretionary spending limits and sequestration of nonexempt mandatory spending programs from fiscal years 2014 through 2021. These are collectively referred to here as the automatic enforcement procedures. Subsequent legislation extended reductions of nonexempt mandatory spending programs through fiscal year 2025. CBO's data were prepared prior to the enactment of the Bipartisan Budget Act of 2018, which extended the reductions of nonexempt mandatory spending programs through fiscal year 2027.

[b]In addition to limits on discretionary budget authority, BBEDCA, as amended by the BCA, initially required reductions in nonexempt mandatory spending, including Medicare, through 2021. Subsequent legislation extended these reductions through 2025. CBO's data were prepared prior to the enactment of the Bipartisan Budget Act of 2018, which extended the reductions of nonexempt mandatory spending programs through fiscal year 2027.

[c]Excess cost growth refers to the annual growth rate of health care spending per enrollee in excess of the annual growth rate of potential GDP per capita, adjusted for demographic characteristics.

## GAO's Simulations – Key Economic Assumptions

| Model inputs | All simulations |
|---|---|
| **Real GDP growth** | CBO's June 2017 baseline through 2027; thereafter averages 2.1 percent based on the intermediate assumptions of the 2017 Social Security and Medicare Trustees reports. |
| **Inflation (percentage change in GDP price index)** | CBO's June 2017 baseline through 2027; 2.1 percent thereafter (CBO's projection in 2027). |
| **Interest rate (on debt held by the public)** | Rate implied by CBO's June 2017 baseline net interest payment projections through 2027; phasing to 3.9 percent by 2053 and then constant thereafter (CBO's March 2017 long-term projection). |

Source: GAO.

Notes: GDP in GAO's simulations does not incorporate the negative effect of long-term deficits on the economy.

CBO's projections are from *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 29, 2017) and *The 2017 Long-Term Budget Outlook* (March 30, 2017). These reports were prepared prior to the enactment of the Tax Cuts and Jobs Act and the Bipartisan Budget Act of 2018. Trustees' projections are from *The 2017 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* and the *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which were both issued on July 13, 2017.