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Present Trends and the Evolution of Mandatory Spending

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Summary

Federal spending is divided into three broad categories: discretionary spending, mandatory spending, and net interest. Mandatory spending is composed of budget outlays controlled by laws other than appropriation acts, including federal spending on entitlement programs. Entitlement programs such as Social Security, Medicare, and Medicaid make up the bulk of mandatory spending. Other mandatory spending funds various income support programs, including Supplemental Security Income (SSI), unemployment insurance, and the Supplemental Nutrition Assistance Program (SNAP), as well as federal employee and military retirement and some veterans' benefits. In contrast to mandatory spending, discretionary spending is provided and controlled through appropriations acts. Net interest spending is the government's interest payments on debt held by the public, offset by interest income that the government receives.

In FY2016, mandatory spending accounted for an estimated 63% of total federal spending and over 13% of gross domestic product (GDP). Social Security alone accounted for about 24% of federal spending. Medicare and the federal share of Medicaid together accounted for an estimated 27% of federal spending. Therefore, spending on Social Security, Medicare, and Medicaid now make up about half of total federal spending. In previous decades, mandatory spending accounted for a smaller share of federal outlays. In 1962, before the creation of Medicare and Medicaid, mandatory spending was less than 30% of all federal spending. At that time, Social Security accounted for about 13% of total federal spending or about half of all mandatory spending.

Mandatory spending is projected to continue rising over the next decades. Over the next decade, mandatory spending is projected to reach 15% of GDP in FY2026, while discretionary spending is projected to fall to 5% of GDP, its lowest level ever. Much of the projected increase in mandatory spending stems from the demographic effects of an aging population and rising health care costs. Baby Boomers will continue to retire over the coming decade, and the proportion of retirees over age 85 has been rising steadily, thus increasing the expected flow of federal benefits. While health care costs per beneficiary have increased in recent years more slowly than previously expected, concerns remain that health care cost growth could again accelerate.

Other countries with advanced economies also face challenges related to rising costs of social insurance programs, although per capita health care costs are generally lower in those countries than in the United States. Some of those countries have more extensive social safety nets. Some in the United States have called for expanding certain social insurance benefits, or for programs that would do more to address challenges faced by non-elderly families, such as expanded options for repayment of student loans or support for child care.

Over the long term, projections suggest that if current policies remain unchanged, the United States could face major fiscal imbalances. According to CBO's extended baseline projections, Social Security would grow from 4.9% of GDP in FY2016 to 5.9% of GDP by FY2026 and 6.4% by FY2036. Federal mandatory spending on health care is projected to expand from about 5.5% of GDP in FY2016 to 6.5% in FY2026 and to 7.9% by FY2036. The share of mandatory spending in total federal spending is also projected to rise.

Because costs of mandatory programs account for nearly two-thirds of total federal outlays, some budget experts contend that putting federal finances on a sustainable path would require significant reductions in federal spending, including cuts in entitlement spending. Other budget and social policy experts contend that curtailing entitlement program eligibility or benefits would compromise the goals of improving the economic security of the elderly and the poor, as well as mitigating the financial consequences of adverse events such as unemployment or disability.

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Overview

Mandatory spending is composed of budget outlays controlled by laws other than appropriation acts, including federal spending on entitlement programs.[1] Entitlement programs such as Social Security and Medicare make up the bulk of mandatory spending. Mandatory spending also finances income support programs such as Supplemental Security Income (SSI),[2] unemployment insurance,[3] the Supplemental Nutrition Assistance Program (SNAP),[4] and the earned income and child tax credits.[5] In addition, mandatory spending encompasses certain veterans' benefits, federal employee retirement, as well as many smaller budgetary items, such as salaries of Members of Congress, certain federal judges, and the President. Congress sets eligibility requirements and benefits for entitlement programs. Once a beneficiary is determined to meet eligibility requirements of a specific mandatory program, benefits are generally then paid automatically.

This report describes the structure of the mandatory portion of the federal budget and past trends and projections for future mandatory outlays. Federal social insurance programs and many other federal programs funded through mandatory spending, by and large, were established to respond to events and conditions that heightened the economic vulnerability of many households. The report outlines how historical challenges shaped the evolution of those programs and changed the role of the federal government. That discussion focuses on mandatory spending programs that have had the most direct effect on federal finances.

The report also discusses some implications of the growth of mandatory spending on budget policy and on the long-term fiscal stance of the federal government. Trends that have influenced mandatory spending over time, such as the growth of health care costs in excess of general inflation and the retirement and aging of the Baby Boom generation, present policy makers with choices whether to increase federal revenues, change the structure of mandatory programs, reduce spending on other programs, or some combination of those strategies. In recent years, net interest outlays and growth in health care costs have been lower than expected, keeping mandatory spending below previously projected levels, although whether those favorable trends will continue is uncertain. While mandatory spending and other fiscal policy decisions have created challenges for the federal budget over recent decades, economic conditions have also shifted in ways that have undermined the financial resiliency of many households.

[1] Mandatory spending is also referred to as direct spending in budgetary legislation.

[2] See CRS Report 94-486, *Supplemental Security Income (SSI)*, by William R. Morton.

[3] See CRS In Focus IF10336, *The Fundamentals of Unemployment Compensation*, by Julie M. Whittaker and Katelin P. Isaacs.

[4] The Food Stamps program has been renamed as the Supplemental Nutrition Assistance Program (SNAP). See CRS Report R42505, *Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefits*, by Randy Alison Aussenberg.

[5] The refundable portion of those tax credits is classified as mandatory spending. The portion used to offset tax liabilities is considered a tax expenditure. See CRS Report R43805, *The Earned Income Tax Credit (EITC): An Overview*, by Gene Falk and Margot L. Crandall-Hollick.

Mandatory Spending and Net Interest Account for Two-Thirds of Outlays

In FY2016, mandatory spending—totaling an estimated 13% of gross domestic product (GDP)—exceeded discretionary spending's 6.5% share of GDP.[6] In addition, federal net interest payments accounted for 1.4% of GDP. Together, total federal spending represented an estimated 21% of GDP. Presenting spending or revenue data as a percentage of GDP compares them with the size of the overall economy and avoids the need for inflation adjustments. A constant share of GDP over time implies that spending or revenue growth has proceeded at the same rate as economic growth.

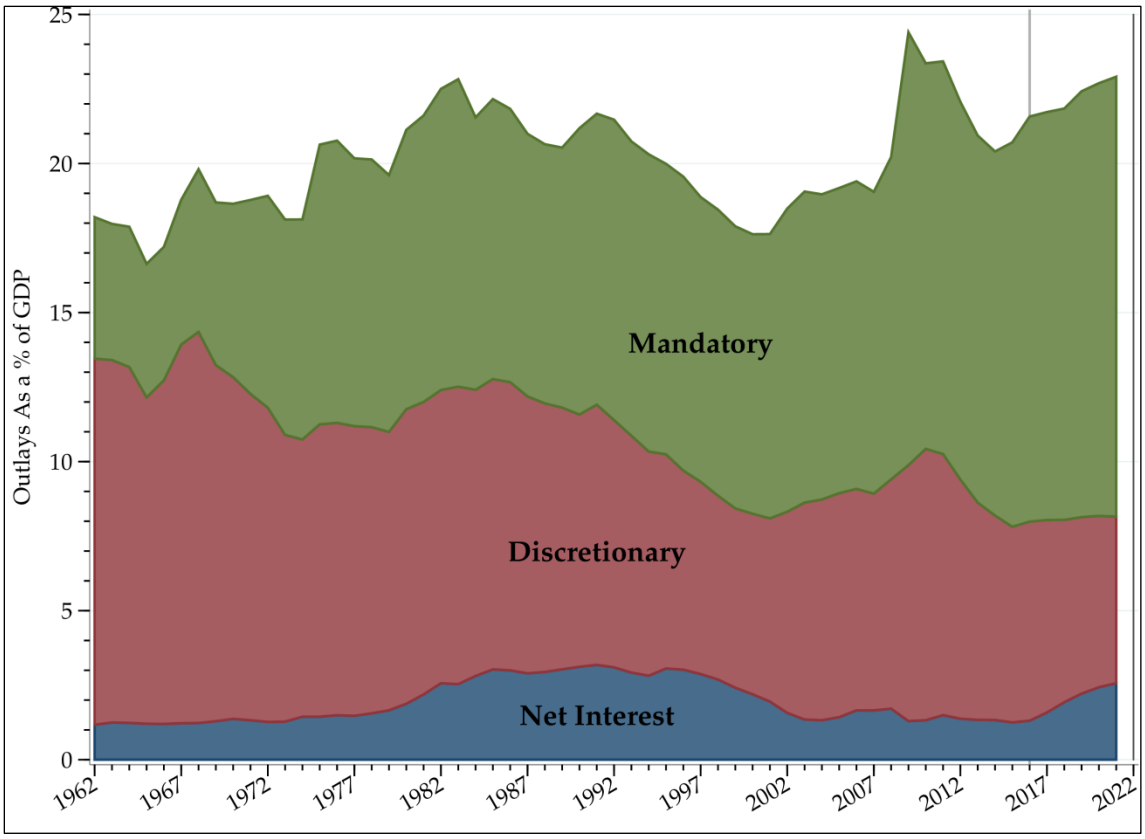
Mandatory spending composed about 63% of all federal spending in FY2016. Social Security, Medicare, and the federal share of Medicaid alone composed about half of all federal spending. Mandatory spending, when combined with net interest's share of spending (6.5% in FY2016), accounts for over two-thirds of federal outlays in FY2016, and that proportion is expected to grow over time.

Aggregate Trends in Mandatory Spending Since FY1962

Figure 1 shows how mandatory, discretionary, and net interest outlays have evolved since FY1962 as a share of the economy. Over that time period, mandatory spending has become the dominant component of the federal budget. In 1962, before the creation of Medicare and Medicaid, mandatory spending was less than 30% of all federal spending. At that time, Social Security accounted for about 13% of total federal spending or about half of all mandatory spending. **Figure 2** shows how components of mandatory spending grew in the same period.

[6] Unless otherwise noted, all data are from Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2016 to 2026*, August 23, 2016, https://www.cbo.gov/publication/51908.

Figure 1. Federal Outlays by Category Since FY1962 As a % of GDP



Source: CRS calculations based on OMB data from the FY2017 budget submission.

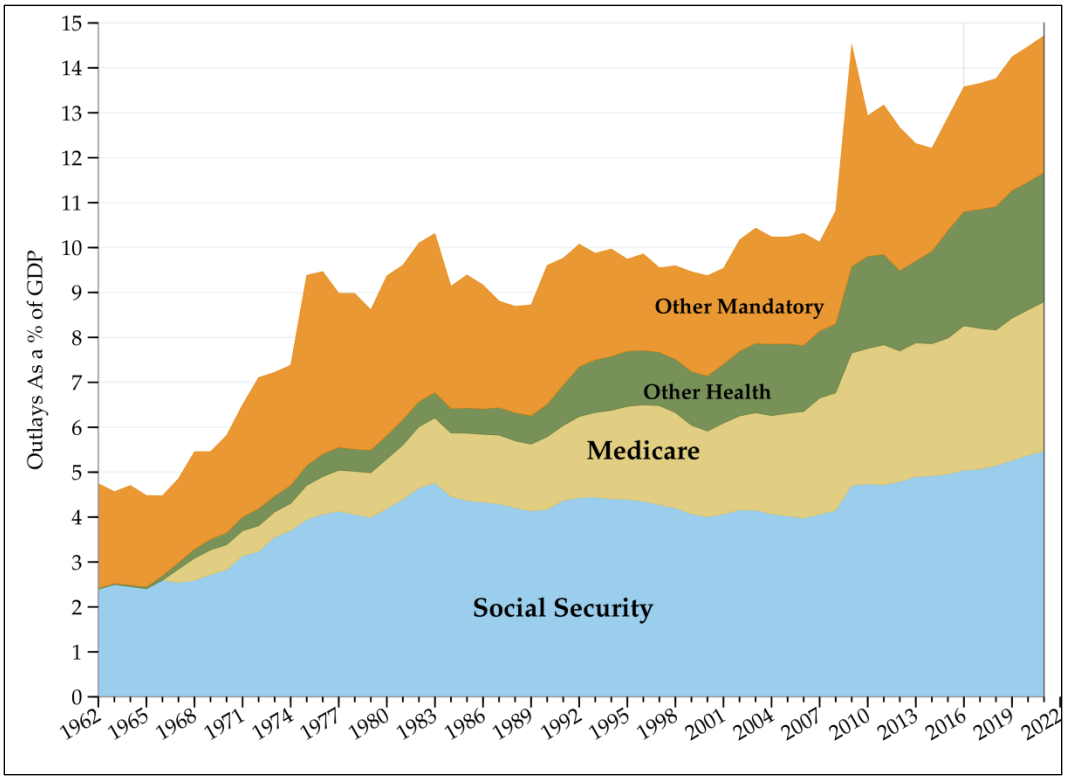
Notes: Levels for FY2017-FY2021 reflect Obama Administration proposals.

The growth of mandatory outlays in that timespan reflects several distinct influences. In 1962, Social Security was not yet an actuarially mature program. As the number of retirees grew, so did outlays for Social Security. Congress also acted many times to expand eligibility or enhance benefits for Social Security and other mandatory programs. In 1965, the federal government made a major commitment to support the health needs of the elderly through Medicare and the poor through Medicaid. As prices for medical and hospital care grew, spurred by the demands of newly insured beneficiaries and largely unconstrained by cost controls, so did federal outlays for health programs. In the 1980s and 1990s, those cost pressures prompted efforts to curtail some benefits and limit the trajectory of health care prices. Nonetheless, some initiatives sought to expand coverage of federal health programs to particular vulnerable populations or to limit the financial consequences of serious medical episodes to existing beneficiaries.

Mandatory spending trends also reflect the business cycle. Economic downturns reduce household incomes, and thus expand the pool of those eligible for income support programs such as unemployment insurance. The effects of the recession following the first oil shock of 1973-1974 and the second oil shock and tightening Federal Reserve monetary policies in 1979 are evident in **Figure 1**. The effects of the Great Recession of 2007-2009 on mandatory spending were even more prominent.

Mandatory spending, by offsetting the fall in private demand during recessions, acts to some extent as an automatic stabilization force and helps promote macroeconomic stability. The responsiveness of mandatory spending to economic conditions is discussed in a later section.

Figure 2. Components of Mandatory Outlays Since FY1962 As a % of GDP



Source: CRS calculations based on OMB data from the FY2017 budget submission.

Notes: Other Health includes Medicaid and other public health programs. Most Veterans' health programs are funded via discretionary spending. FY2016 amounts are estimated and FY2017-FY2021 levels reflect Obama administration proposals.

Mandatory Spending Projected to Continue Rising

In recent years, mandatory spending has been around 12% to 13% of GDP. The Congressional Budget Office (CBO) projects mandatory spending will rise gradually from its current levels reaching 14.9% of GDP in FY2026. CBO current-law baseline projections, which extend 10 years forward, do not reflect the full force of the pressures the aging population and increasing health care costs are expected to exert on the federal budget over the longer term.[7]

Financial Imbalances Pose Challenges to Some Mandatory Programs

The financing of some mandatory programs has raised concerns that funding streams will at some future point be insufficient to cover promised benefits. Both Social Security and Medicare face serious challenges to their long-term financial stability.[8]

Social Security payroll tax collections usually exceeded benefit payments during the peak earning years of the Baby Boom generation, and remaining funds were used to build up the two Social Security trust funds. In coming years, however, benefit payments are expected to exceed collections, thus requiring a draw-down of trust fund balances. The Social Security Disability

[7] Long-term fiscal issues are discussed in a later section.

[8] Social Security Administration, *A Summary of the 2016 Annual Reports*, website, updated July 12, 2016, https://www.ssa.gov/OACT/TRSUM/index.html.

Insurance (DI) program faces more immediate challenges. According to actuarial projections of the Social Security trustees, the DI trust fund will be exhausted by 2023 under current policies, although tax collections in that year would be able to cover about 90% of promised benefit payments. The larger Old Age and Survivors Insurance (OASI) trust fund, according to those projections and assumptions, would be exhausted by 2035, although tax collections could cover about three-fourths of promised benefits.[9]

Medicare, according to the 2016 report of its trustees, faces "a substantial financial shortfall that will need to be addressed with further legislation."[10] Under the trustees' current-law projections, the Health Insurance (HI) trust fund, which supports Medicare Part A benefits, would be exhausted in 2028. After that date, incoming payroll taxes could cover about 87% of that program's costs. The Supplemental Medical Insurance (SMI) trust fund, which supports Medicare Part B benefits, is not vulnerable to exhaustion because of how that program is financed. Part B premiums are generally set to cover about a quarter of program costs, while general revenues cover about three-quarters of program costs. Part B costs, which account for about 1.7% of GDP in FY2016, are expected to rise to about 2.7% of GDP by 2090 according to trustees' projections.[11] As a point of comparison, defense and non-defense discretionary spending under CBO current-law projections are each expected to equal 2.7% of GDP in FY2024.[12]

What Is Mandatory Spending?

The distinction between mandatory and discretionary spending stems from how Congress provides funding for each of those categories. Mandatory spending in budgetary laws is referred to as "direct spending."[13] Mandatory spending is controlled by laws other than appropriations acts, most commonly in the form of authorizing legislation.[14] Authorizing legislation establishes or continues the operation of a federal program or agency, either indefinitely or for a specified period. Mandatory spending typically is provided in permanent or multi-year appropriations contained in the authorizing law. Funding therefore becomes available automatically each year, without further legislative action by Congress. In most cases, the authorizing law requires payment, based on a benefit formula, to an individual or entity (e.g., a state) if eligibility criteria are met.

Discretionary spending was defined as budgetary resources provided in and controlled by appropriations acts.[15] Net interest payments, the final category of federal spending, are automatically authorized and are the government's interest payments on debt held by the public

[9] CBO projects that the DI trust fund would be exhausted in 2022, the OASI trust fund would be exhausted in 2030, and a combined OASDI trust fund would be exhausted in 1929. See CBO, *CBO's 2016 Long-Term Projections for Social Security: Additional Information*, December 21, 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52298-socialsecuritychartbook.pdf.

[10] Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 22, 2016, p. 4, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2016.pdf.

[11] Ibid., pp. 8-9. Also see CRS Report R43122, *Medicare Financial Status: In Brief*, by Patricia A. Davis.

[12] CBO, *The Budget and Economic Outlook: 2017 to 2027*, January 24, 2017, https://www.cbo.gov/publication/52370.

[13] Hence, CBO cost estimates refer to net increases or decreases in direct spending.

[14] The 1985 Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177; § 250(c)(6)) defined direct spending as "budget authority provided by law other than appropriation Acts; entitlement authority; and the Supplemental Nutrition Assistance Program [SNAP]."

[15] For more information on discretionary spending trends, see CRS Report RL34424, *The Budget Control Act and Trends in Discretionary Spending*, by D. Andrew Austin.

offset by interest income that the government receives. Although net interest costs are typically reported separately in budgetary estimates and projections, as a formal matter they could be considered part of mandatory spending as they are paid on the basis of a permanent authorization. The budget categories of discretionary, mandatory/direct, and net interest are often referred to as BEA categories.[16]

What Do Mandatory and Discretionary Spending Fund?

The BEA categories of discretionary and mandatory spending are primarily procedural classifications, in that they are used to allow evaluations of whether legislation complies with budget enforcement measures. Nonetheless, some broad, if imperfect, generalizations can be made.

Most mandatory spending, as noted above, supports social insurance or income security programs, such as Social Security and Medicare. Most discretionary spending supports operations of federal agencies. In some cases, activities funded by mandatory and discretionary spending may be similar. For instance, the responsibilities of Article III federal judges, whose pay is protected by the Constitution and is thus classified as mandatory spending, resemble in many ways the responsibilities of other federal judges, whose pay is funded via discretionary spending.

Entitlements and Appropriated Entitlements

Some entitlement spending, such as for the Supplemental Nutrition Assistance Program (SNAP), Medicaid and certain veterans' programs, is funded in annual appropriations acts. Such entitlement spending is referred to as appropriated entitlements. The level of spending for appropriated entitlements, like other entitlements, is based on the benefit and eligibility criteria established in law. The amount of budget authority provided in appropriations acts for these specific programs is based on meeting projected spending levels. Since the authorizing legislation effectively determines the amount of budget authority required, the Budget Enforcement Act of 1990 (BEA; P.L. 101-508) classified appropriated entitlement spending as mandatory.[17]

The terms "entitlement" or "entitlement authority" are often used in conjunction with mandatory spending. The definition of an entitlement, however, is tied to a judgement of whether the federal government is legally obliged to pay a person or government.[18] Some federal programs, such as Social Security, may be clear examples of entitlement programs, but determining whether other programs could be so considered may involve complex legal issues. For those reasons, budget analysts generally employ the procedural terms "mandatory" or "direct."[19]

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[16] Budget Enforcement Act of 1990 (BEA; P.L. 101-508).

[17] For a discussion of procedural issues, see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

[18] The Congressional Budget Act (P.L. 93-344, as amended; § 3(9) defines entitlement authority as "the authority to make payments (including loans and grants), the budget authority for which is not provided for in advanced by appropriation Acts, to any person or government if, under the provisions of the law containing that authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by that law."

[19] The BEA (P.L. 101-508 § 13101) endeavored to address those potential uncertainties by requiring that "all references to entitlement authority shall include the list of mandatory appropriations included in the joint explanatory statement of managers accompanying the conference report on the Omnibus Budget Reconciliation Act of 1990."

Mandatory Programs Funded in Several Ways

How mandatory programs are funded varies.[20] Social Security and Medicare Part A (Hospital Insurance) are supported by payroll taxes paid by employers and employees, which are earmarked for trust funds from which benefits are paid. A combination of beneficiary premiums, which cover about a quarter of those program's costs, and general federal revenues, which cover the remainder, funds Medicare Part B (Supplemental Medical Insurance) and Part D (Prescription Drug Plan).[21] Medicaid is a joint federal-state program. The federal Medicaid cost share, which is determined by a statutory formula, is funded by general revenues.[22] Retirement programs for those in federal service are supported by payroll deductions and contributions, as well as general revenues.[23] Some other mandatory programs, such as veterans' income security benefits and agricultural subsidies, are typically funded from general revenues.

In general, the administration of federal benefits programs is supported by discretionary funding, even if the benefits are paid out of mandatory funds.

Offsetting Receipts

Mandatory spending is partially offset by certain fees and payments, known as offsetting receipts, which are generally counted as negative budget authority. Market-like charges, such as Medicare premiums, are considered offsetting receipts. Medicare premiums and the federal government's tax and pension contributions in its role as an employer comprise the largest components of offsetting receipts.

Federal Credit Programs and Mandatory Spending

Most mandatory spending is accounted for in the budget based on the dollar amount spent in each fiscal year. However, some mandatory programs are recorded differently. For example, federal student loan programs, like other federal loan and loan guarantee programs, are scored under terms of the Federal Credit Reform Act of 1990 (FCRA; P.L. 101-508). Rather than being accounted for on a cash basis, FCRA programs are accounted for on a net subsidy basis. FCRA required that the reported budgetary cost of a credit or loan program equal the estimated subsidy costs at the time the credit is provided. In other words, the subsidy cost is the estimated long-term cost to the government of a direct loan or a loan guarantee, calculated on a net present value basis, excluding administrative costs. This budgetary treatment was intended to place the cost of federal credit programs on a budgetary basis equivalent to other federal outlays.[24]

Other Inflows Counted as Negative Mandatory Spending

Certain other inflows are counted as negative mandatory spending. In some recent years, federal student loans were estimated to generate a negative subsidy under FCRA rules, although most

[20] See CRS Report R44582, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*, by Jessica Tollestrup.

[21] See CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

[22] CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell.

[23] See CRS Report RL30023, *Federal Employees' Retirement System: Budget and Trust Fund Issues*, by Katelin P. Isaacs.

[24] For details, see CRS Report R44193, *Federal Credit Programs: Comparing Fair Value and the Federal Credit Reform Act (FCRA)*, by Raj Gnanarajah.

recent estimates show a small positive subsidy.[25] Transfers of net surpluses from the mortgage guarantors Fannie Mae and Freddie Mac, which were put into federal receivership in 2008, are counted as negative mandatory spending, as is the difference between Federal Deposit Insurance Corporation (FDIC) premiums and payouts.

How Congress Came to Define Mandatory Spending

During the 1970s, Congress made important changes to how it exercised its power of the purse and in particular, how it controlled what is now known as mandatory spending. In 1974, Congress enacted the Congressional Budget and Impoundment Control Act (CBA; P.L. 93-344), which established new budgetary concepts, processes and rules as a means to reassert its fiscal prerogatives.[26] The CBA enabled Congress to exercise greater control on how federal funds were spent. The CBA also provided instruments to conform budgetary legislation to what Congress considered appropriate levels of aggregate spending, revenue, deficits (or surpluses), and debt.[27]

Some pre-CBA budgetary practices, such as the use contract authority or borrowing authority, had eroded the ability of Congress to constrain certain types of spending.[28] Reestablishing more effective fiscal control over those spending types required an evolution in how Congress considered funding not controlled in the annual appropriations process. Budget discussions in the mid-1970s included overlapping concepts such as entitlement spending, uncontrollable spending, programs funded via trust funds, and permanent authorizations.[29] Distinctions between categories of spending took on special importance in 1985 when Congress established sequestration procedures, which could require across-the-board cuts for some accounts but exempted others.[30] In 1990, enactment of the Budget Enforcement Act was accompanied by an account-by-account definition of direct—more generally known as mandatory—spending accounts.

OMB has retroactively applied 1990 BEA definitions to calculate historical data budget series for mandatory outlays back to FY1962 to allow a more consistent analysis of fiscal trends.[31]

National Challenges and Key Developments in the Evolution of Mandatory Programs

The evolution of social insurance and other mandatory programs reflects the influence of a complex array of social forces and events acting over the course of many decades, although many of the key policy responses were decided in the middle third of the 20th century. Some specific

[25] CBO, *Updated Budget Projections: 2016 to 2026*, Table 4, March 2016; http://www.cbo.gov/publication/51384.

[26] U.S. Congress, Senate Committee on the Budget, *Committee on the Budget: 1974-2006*, 109th Cong., 2nd sess., 2006, S.Doc. 109-24, pp. 28-39.

[27] The full potential of reconciliation procedures created by the CBA to control spending, however, was not realized until the Reagan Administration.

[28] John F. Cogan, "The Dispersion of Spending Authority and Federal Budget Deficits," in *The Budget Puzzle: Understanding Federal Spending*, John F. Cogan, Timothy J. Muris, and Allen Schick, eds., (Stanford, 1994).

[29] U.S. Congress, House Committee on the Budget, *Congressional Control of Expenditures*, prepared by Allen Schick, 105th Cong., 1st sess., January 1977, C.Prnt. 95-1, pp. 61-66.

[30] The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) is commonly referred to as GRH, reflecting the names of the measure's sponsors, Senator Phil Gramm, Senator Warren Rudman, and Senator Fritz Hollings.

[31] FY2017 Budget, *Historical Tables*, Table 8.1; https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/hist08z1.xls.

historical events, such as wars and severe economic depressions, can be linked to changes in some federal programs. More gradual social trends, such as urbanization, industrialization, higher rates of migration, rising incomes, labor conditions, the broadening of market ties across the national and world, expansions and contractions of electoral franchise, and improved longevity also played important roles in changing American society, as well as influencing the structure and role of the federal government.

From the early 19th century to the early 20th century, the United States was transformed from a largely agricultural and rural nation to a mostly urban and industrial one. Moreover, in the post-Civil War decades, the federal government gained wider legal and regulatory authorities, although those activities accounted for a small fraction of federal outlays and employment.[32] Not until after World War I, however, did social expenditures, apart from veterans' pensions and other benefits, make up an appreciable portion of the federal budget. The Great Depression that commenced in late 1929 prompted deeper changes in how the federal government addressed social challenges.

This section outlines public demands for federal responses to national challenges and social forces that may have contributed to the establishment of federal mandatory programs.[33] A fuller description of those forces is beyond the scope of this report, although more extensive descriptions of those events, social movements, and policy responses are cited in the notes.[34]

Early Federal Health and Retirement Programs Were Limited

From the first years of the federal government, funds were used to support pensions and compensation for veterans of the Revolutionary War. Those amounts, however, comprised a small fraction of federal outlays.[35] In 1798, the Act for the Relief of Sick and Disabled Seamen (1 Stat. 605) created a network of hospitals that cared for merchant sailors arriving in U.S. ports, which was later extended to cover the U.S. Navy.[36] Costs of that care were funded by compulsory deductions from seamen's wages.[37] Few federal funds, however, were allocated for the relief of the poor and elderly, or for education in the 18th and 19th centuries, in part because those responsibilities—to the extent they were fulfilled—were considered those of households or state and local governments.[38] In 1850, spending in the United States on relief for the poor, according

[32] For one explanation that emphasizes the roles of specialization of production combined with scientific and technical advances in the growth of government, see Douglass C. North, "The Growth of Government in the United States: An Economic Historian's Perspective," *Journal of Public Economics*, vol. 28, December 1985, pp. 383-399.

[33] The *Green Book* issued by the House Committee on Ways and Means provides authoritative analyses of mandatory programs within the purview of the committee. The latest version was issued in December 2016: http://greenbook.waysandmeans.house.gov/2016-green-book.

[34] For a summary of the history of federal health insurance policy, see CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford.

[35] *Historical Statistics of the United States: Millennial Edition* (Cambridge Univ. Press, January 2006), Table Ea636-643, "Federal government expenditure, by major function: 1789-1970."

[36] U.S. Department of Health and Human Services, Commissioned Corps of the U.S. Public Health Service, *History*, website, http://www.usphs.gov/aboutus/history.aspx.

[37] Abe Bortz, "Lecture on the History of Social Security," *Social Security Administration Special Study* 1, n.d., https://www.ssa.gov/history/bortz.html.

[38] Some federal lands were used or sold for the support of local schools in the Northwest Territories. Northwest Ordinance of 1785, *Journals of the Continental Congress*, v. 28, p. 378; http://memory.loc.gov/cgi-bin/ampage?collId=lljc&fileName=028/lljc028.db&recNum=389. Some questioned the efficacy of that support. See Samuel Eliot Morison and Henry Steele Commager, *The Growth of the American Republic* (Oxford, 1942), vol. 1, p. 512.

to one estimate, was 0.13% of GDP, while public elementary and secondary education accounted for 0.33% of GDP.[39]

Civil War Pensions as a Social Safety Net

After the Civil War (1861-1865), military pensions became a growing component of federal finances.[40] Pensions were initially limited to Union veterans disabled in combat or while in military service,[41] but eligibility was eventually extended to nearly all Union veterans and their family members as well.[42] Between 1889 and 1898, the number of pensioners doubled from about a half million to a million, an expansion enabled by rising tariff revenues and falling debt service costs. War pensions accounted for about a quarter of federal spending between 1880 and 1910.[43] Veterans' pensions at the time were an appropriated entitlement. Pension acts entitled veterans or family members to specific benefits and annual appropriations acts funded the costs.[44]

Permanent appropriations, including payment of interest on federal debt, accounted for approximately another quarter of the budget at the end of the 19th century.[45] Other items included settlement of Civil War and Reconstruction claims, various customs administrative and claims costs, bond service on transcontinental railroad bonds, mariners' hospitals, education for the blind, payments to state derived from a percentage of land sales proceeds, among others.[46]

The Social Insurance Concept

Some contend that Civil War pension system led that way for social insurance proposals in the early 20th century.[47] For example, in 1920, 40 states offered Mothers' Pensions to aid widowed mothers with young children.[48] Others point to other historical trends, such as social insurance programs introduced in a newly unified Germany in 1883.[49] All wage earners above a low minimum annual income level, which encompassed most manual and white-collar workers, were required to contribute to a national health insurance fund. Coverage for other hazards was later

[39] Peter H. Lindert, *Growing Public*, (Cambridge Univ. Press, 2006), vol. 1, part 1, p. 8.

[40] See William Henry Glasson, *History of Military Pension Legislation in the United States*, dissertation, Columbia University, 1900, https://books.google.com/books?id=sRLuay__L10C.

[41] The initial Civil War pension measure was "An Act to grant Pensions," enacted on July 14, 1862; http://www.loc.gov/law/help/statutes-at-large/37th-congress/session-2/c37s2ch166.pdf.

[42] Theda Skocpol, *Protecting Soldiers and Mothers* (Cambridge, Massachusetts: Harvard, 1992). For a criticism of that work see G. William Domhoff, "Class, Power, and Parties in the New Deal: A Critique of Skocpol's State Autonomy Theory," *Berkeley Journal of Sociology*, v. 36 (1991), pp. 1-49, http://www.jstor.org/stable/41035438.

[43] Daniels (1899), pp. 41-43. The number of pensioners in 1889 was 489,725 and 993,714 in 1898.

[44] For instance, see "An Act Making appropriations for the payment of invalid and other pensions of the United States for the fiscal year ending June 30th, 1905," https://www.loc.gov/law/help/statutes-at-large/58th-congress/session-2/c58s2ch1617.pdf. A Navy pension fund was originally financed by proceeds of prizes (i.e., seized ships).

[45] Daniels (1899), p. 357. Also see Revised Statutes (1878), § 3689; 18 Stat. 724, https://memory.loc.gov/cgi-bin/ampage?collId=llsl&fileName=018/llsl018.db&recNum=796.

[46] 18 Stat. 724 et seq.; available at https://memory.loc.gov/cgi-bin/ampage?collId=llsl&fileName=018/llsl018.db&recNum=796.

[47] See Skocpol (1992).

[48] Ibid.

[49] The Law concerning Health Insurance for Workers (Gesetz betreffend die Krankenversicherung der Arbeiter) was enacted on June 15, 1883. Germany enacted the Accident Insurance Act (Unfallsversicherungsgesetz) in 1884 and the Law on Invalidity and Old Age Insurance for Workers, Journeymen and Apprentices (Gesetz über Invaliditäts- und Alterssicherung für Arbeiter, Gehilfen und Lehrlinge) in 1889.

expanded, and several other European countries adopted their own national insurance systems in following decades.[50]

Insurance spreads individual risks over larger groups, so that the costs of unforeseen events can be averaged and made more manageable. Proponents of social insurance contended that when voluntary or private insurance arrangements were not forthcoming to cover certain risks, such as unemployment or industrial accidents, then governments could advance public interests by establishing mandatory social insurance programs among certain employment or population categories.[51] Mandatory coverage can mitigate the traditional insurer's concern of adverse selection, which occurs when voluntary plans attract disproportionate numbers of high-risk or high-cost persons. Social insurance, however, can be vulnerable to moral hazard, a second traditional insurance concern, which occurs when insured individuals act in ways that increase risks or costs. For instance, whether disability insurance would discourage employment among some has been a long-standing issue.[52]

Social insurance can also help protect individuals with low incomes that may struggle to afford private insurance. Such coverage, however, requires a redistribution of resources from higher income contributors or from general revenues raised from taxpayers. Higher contributions or taxes may distort economic incentives and efficiency.[53] The balance between providing social insurance protections and minimizing effects on economic incentives has played an important role in the design of mandatory spending programs.

Progressive Era Reforms

Progressive-era reforms and research efforts of the first decades of the 20th century that addressed work conditions, unemployment, disability, and old-age pensions at the state level, influenced later federal initiatives.[54] Progressivism may be described more as a collection of disparate state and local level initiatives rather than a unified movement. One common thread, however, was a more scientific approach to government and social conditions. For instance, social surveys conducted in Pittsburgh in the first decade of the 20th century linked poverty and industrial accidents, spurring leading reformers and labor unions to call for compulsory social insurance, which helped lead to workers' compensation programs in most states.[55] A Federal Employees' Compensation Act of 1908, advocated by President Theodore Roosevelt, provided federal employees in hazardous occupations with some insurance benefits in case of injury.[56]

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[50] Abe Bortz, "Lecture on the History of Social Security," Social Security Administration Special Study 1, n.d., https://www.ssa.gov/history/bortz.html.

[51] For instance, see Leo Wolman, "Unemployment Insurance," in *Business Cycles and Unemployment*, (McGraw-Hill: New York, 1923), pp. 302-304.

[52] For example, English poor laws sought to distinguish between able-bodied and deserving "impotent poor." See Sidney and Beatrice Webb, *English Local Government: English Poor Law History*, (London: Longmans, 1927), Part 1, The Old Poor Law.

[53] How social insurance payroll taxes affect labor supply also depends on how workers value future benefits.

[54] Paul Starr, *The Social Transformation of American Medicine*, (New York: Basic Books, 1982), pp. 237-240. See also U.S. Department of Labor, *History Part 6: Progressive Ideas*, website, https://www.dol.gov/dol/aboutdol/history/mono-regsafepart06.htm.

[55] Crystal Eastman, *Work-Accidents and the Law* (New York: Survey Associates, 1910); https://www.russellsage.org/sites/default/files/Eastman%26Kellog_Work%20Accidents_0.pdf. See also David Rosner and Gerald Markowitz, "The Struggle over Employee Benefits: The Role of Labor in Influencing Modern Health Policy," *Milbank Quarterly*, vol. 81, no. 1 (2003), pp. 45-73.

[56] Act of May 30, 1908. See Willis J. Nordlund, "The Federal Employees' Compensation Act," *Monthly Labor Review*,

Social Security and the New Deal

While progressive-era social and labor reforms affect state programs, major changes in federal social programs did not occur until the Great Depression and the New Deal initiatives of the Franklin D. Roosevelt Administration. **Figure 3** shows trends in direct federal outlays, measured as a percentage of GDP, for education, public welfare, health and hospitals, and veterans' services.[57]

An increase in federal spending for education and public welfare are evident after 1933, although increases in funding for veterans were far larger. Until the mid-1970s, outlays on veterans' services exceeded spending on other categories shown in **Figure 3**. Moreover, education spending before the 1960s mostly reflected funding for veterans education benefits.[58] The changes in direct federal outlays shown in **Figure 3**, however, were less dramatic than the establishment of an old-age pension system and a joint federal-state system of unemployment insurance.

The Social Security Act of 1935 (P.L. 74-271), which established a system of old-age pensions, was the central measure of the New Deal.[59] The act also gave states incentives to set up unemployment insurance systems, which by 1937, every state had created.[60] In addition, the act provided matching funds to states for maternal and infant care, rehabilitation for children with disabilities, and aid for dependent children younger than 16 years.[61]

September 1991, https://www.bls.gov/mlr/1991/09/art1full.pdf.

[57] Direct outlays exclude spending from trust fund programs, such as Social Security, and intergovernmental transfers. Outlays in those categories are presently supported by a mixture of discretionary and mandatory funding.

[58] Census Bureau, *Historical Summary of Governmental Finances in the United States, Topical Studies*, vol. 4, no. 3, 1957, https://www2.census.gov/govs/pubs/cog/1957/1957_vol4_no3_hist_stats.pdf.

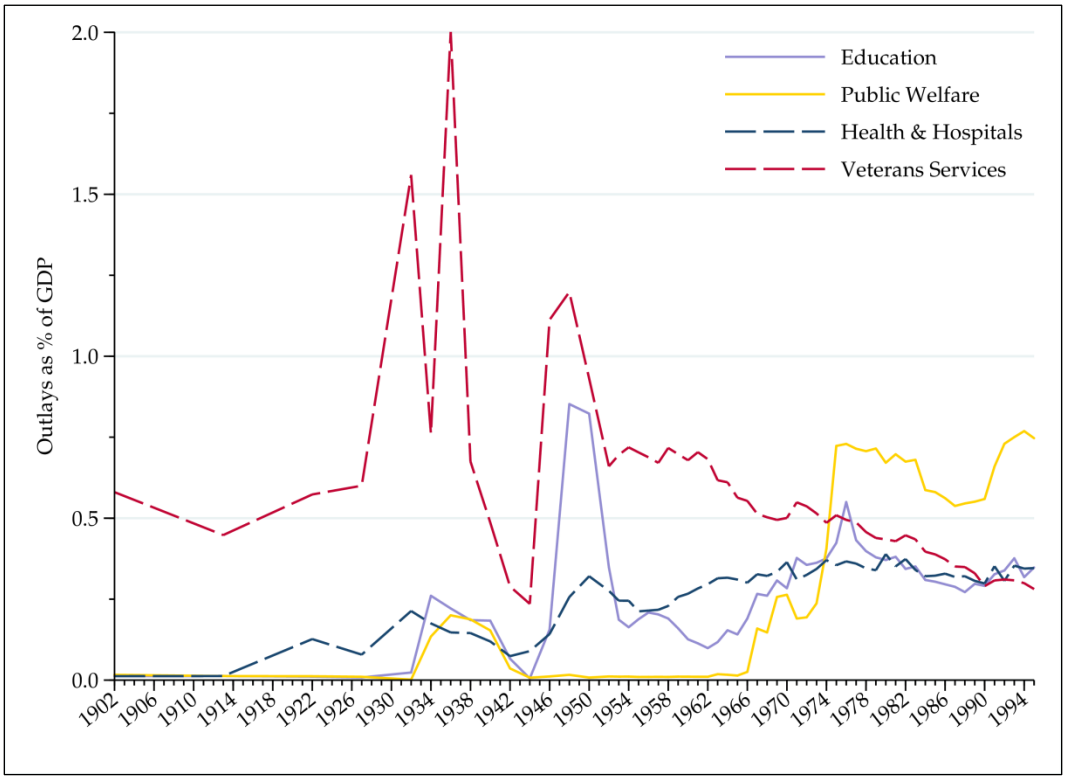
[59] Wilbur J. Cohen, "The Development of the Social Security Act of 1935: Reflections Some Fifty Years Later," *Minnesota Law Review*, vol. 68 (1983-1984), pp. 379-408.

[60] Social Security Administration, Office of Retirement and Disability Policy, "Unemployment Insurance Program Description and Legislative History," *Annual Statistical Supplement 2012*, https://www.ssa.gov/policy/docs/statcomps/supplement/2012/unemployment.html.

[61] Starr, pp. 269-270.

Figure 3. Federal Direct Outlays for Selected Social Functions, FY1902-FY1995

As a percentage of GDP



Source: *Historical Statistics of the United States: Millennial Edition* (Cambridge Univ. Press, January 2006), Table Ea171-219, "Federal government expenditure, by function: 1902-1995"; and Samuel H. Williamson, 'What Was the U.S. GDP Then?' MeasuringWorth, August 2013.

Notes: Data available annually since FY1952 and biannually from FY1932-FY1952. Before that, data are available for 1902, 1913, 1922, and 1927. Figure shows interpolations where data unavailable. Direct outlays exclude intergovernmental transfers and trust fund programs such as Social Security. These series were discontinued after 1995 due to Census Bureau resource constraints.

The old age insurance benefits provided by Social Security were financed by employer and employee contributions, rather than through general revenues.[62] President Roosevelt contended that putting the Social Security program on a contributory basis would bar future efforts to repeal or curtail the program.[63] Funding for the unemployment insurance program was also designed to work on a contributory basis.[64] The reliance on the contributory principle reflected not only an intention to distinguish those programs from tax-funded welfare, but also the financial condition of the federal government in the 1930s. Unlike the late 19th century, in which a high protective tariff generated sufficient revenues to fund broadly distributed pension benefits and federal

[62] Anthony J. Badger, *The New Deal: The Depression Years, 1933-1940*, (New York: Hill & Wang, 1989), pp. 227-235.

[63] Cohen (1983-1984), p. 385.

[64] President Roosevelt contended that "We must not allow this type of [unemployment] insurance to become a dole through the mingling of insurance and relief. It is not charity. It must be financed by contributions, not taxes." Address to the Advisory Council of the Committee on Economic Security on the Problems of Economic and Social Security," November 14, 1934, https://www.ssa.gov/history/fdrstmts.html#fireside1.

budget surpluses in most years, federal receipts during the Great Depression were well below previous levels and the federal deficit was rising.

Social insurance programs were expanded in the 1950s and 1960s. Social Security was extended to pay providers to cover certain medical costs incurred by aged, blind, and disabled beneficiaries starting in 1950.[65] A Social Security Disability Insurance (SSDI) program was established in 1956.[66] Initially, SSDI provided cash benefits to disabled workers older than 50. Over time, benefits were made available to dependents and a broader range of disabled persons.[67] The Kerr-Mills Act of 1960 (P.L. 86-778),[68] a forerunner of Medicaid, supported state programs that paid providers for health care of the "aged, blind, or permanently and totally disabled," as well as low-income elderly individuals.[69] Less than 2% of the elderly, however, were covered by Kerr-Mills programs in 1965.[70] In 1959, Congress authorized a two-year food stamp program, which was not implemented until the John F. Kennedy Administration began to operate pilot programs in 1961.[71] The Food Stamp program, now called the Supplemental Nutrition Assistance Program (SNAP), was made permanent in 1964.[72]

President Lyndon Johnson and the Great Society

In 1965, the Lyndon B. Johnson Administration worked with Ways and Means Committee Chairman Wilbur Mills to create the Medicare program, which provided health insurance for nearly all Americans over age 65. A major aim of the program was to shield the elderly, who had little access to workplace-based health insurance, from the costs of medical and hospital care. The Social Security Amendments of 1965 (P.L. 89-97) included titles that established a compulsory hospital insurance program (Part A) with a voluntary physician services plan (Part B).[73] In addition, the Act established Medicaid, which was designed as a joint federal-state program as was the Kerr-Mills program.

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[65] Social Security Amendments of 1950 (P.L. 81-831), 1956 (P.L. 84-880), 1960 (P.L. 86-778). See Wilbur J. Cohen, "Reflections on the Enactment of Medicare and Medicaid," *Health Care Financing Review*, Annual Supplement 1985, pp. 3-11. Certain other groups, including low-income children deprived of parental support and their caretaker relatives, the elderly, the blind, and individuals with disabilities, also became eligible for Medicare benefits.

[66] Social Security Amendments of 1956 (P.L. 84-880). See Testimony of Edward D. Berkowitz, in U.S. Congress, House Committee on Ways and Means, Subcommittee on Social Security, *Challenges Facing Social Security Disability Program*, 106th Cong., 2nd sess., July 13, 2000, Serial 106-94 (Washington: GPO, 2001); https://www.ssa.gov/history/edberkdib.html.

[67] John R. Kearney, "Social Security and the 'D' in OASDI: The History of a Federal Program Insuring Earners Against Disability," *Social Security Bulletin*, vol. 66, no. 3, 2005/2006, https://www.ssa.gov/policy/docs/ssb/v66n3/v66n3p1.html.

[68] Title VI of the Social Security Amendments of 1960.

[69] Judith D. Moore and David G. Smith, "Legislating Medicaid: Considering Medicaid and its Origins," *Health Care Financing Review*, vol. 27, no. 2 (winter 2005), pp. 45-52, available at http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/05-06Winpg45.pdf.

[70] Moore and Smith, p. 47. A 1963 Senate report found that less than 1% of the elderly had received benefits from the program. See U.S. Congress, Senate Special Committee on Aging, *Medical Assistance for the Aged: The Kerr-Mills Program 1960-1963*, committee print, 88th Cong., 1st sess., October 1963 (Washington: GPO, 1963), https://www.aging.senate.gov/imo/media/doc/reports/rpt263.pdf.

[71] P.L. 86-341was enacted on September 21, 1959. See U.S. Department of Agriculture, Food and Nutrition Service, "A Short History of SNAP," web page, November 20, 2014, http://www.fns.usda.gov/snap/short-history-snap.

[72] The Food Stamp Act of 1964 (P.L. 88-525) was enacted on August 31, 1964.

[73] See CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

In 1972, existing Social Security provisions to aid the blind and those with permanent and total disabilities through grants-in-aid to states were revamped into the Supplemental Security Income (SSI) program, which began in January 1974.[74] SSI benefits, unlike Social Security, were paid from federal general revenues. Other legislation in 1972 authorized automatic cost-of-living increases in Social Security benefits.[75] The 1972 amendments also expanded Medicare coverage to those younger than 65 with permanent disabilities or end-stage renal disease (ESRD).

In the 1970s, Congress and the Gerald R. Ford Administration turned to the tax code as a means of support low-income households.[76] A temporary earned income tax credit (EITC) was enacted as part of a broader package of tax reductions (P.L. 94-12) enacted in response to the 1974-1975 recession and was made permanent in 1978 (P.L. 95-600). Initially, the EITC was designed to offset Social Security and Medicare payroll taxes for low-income working households, although the credit was expanded and modified several times in later years.

New Programs and Maturing of Existing Programs Accelerated Costs

In FY1962, three years before the creation of Medicare and Medicaid, less than 30% of all federal spending was mandatory. At that time, Social Security accounted for about 13% of total federal spending or about half of all mandatory spending.[77] In the 1960s and 1970s, as Social Security became a more actuarially mature program serving a growing number of retirees, outlays rose—which previous projections had anticipated. The steepness of the rise in health costs following the first years of the Medicare and Medicaid programs, driven by accelerating health care prices and an increase in the volume of covered services, was not as clearly anticipated.[78] **Figure 4** shows trends in mandatory outlays for budget functions within the Human Resources category from FY1962 through FY1982.

[74] The Social Security Amendments of 1972 (P.L. 92-603) were enacted on October 30, 1972. See Robert M. Ball, "Social Security Amendments of 1972: Summary and Legislative History," Social Security Bulletin, March 1973, https://www.ssa.gov/history/1972amend.html. See also CRS Report 94-486, *Supplemental Security Income (SSI)*, by William R. Morton. See also Cohen (1983-1984), p. 381.

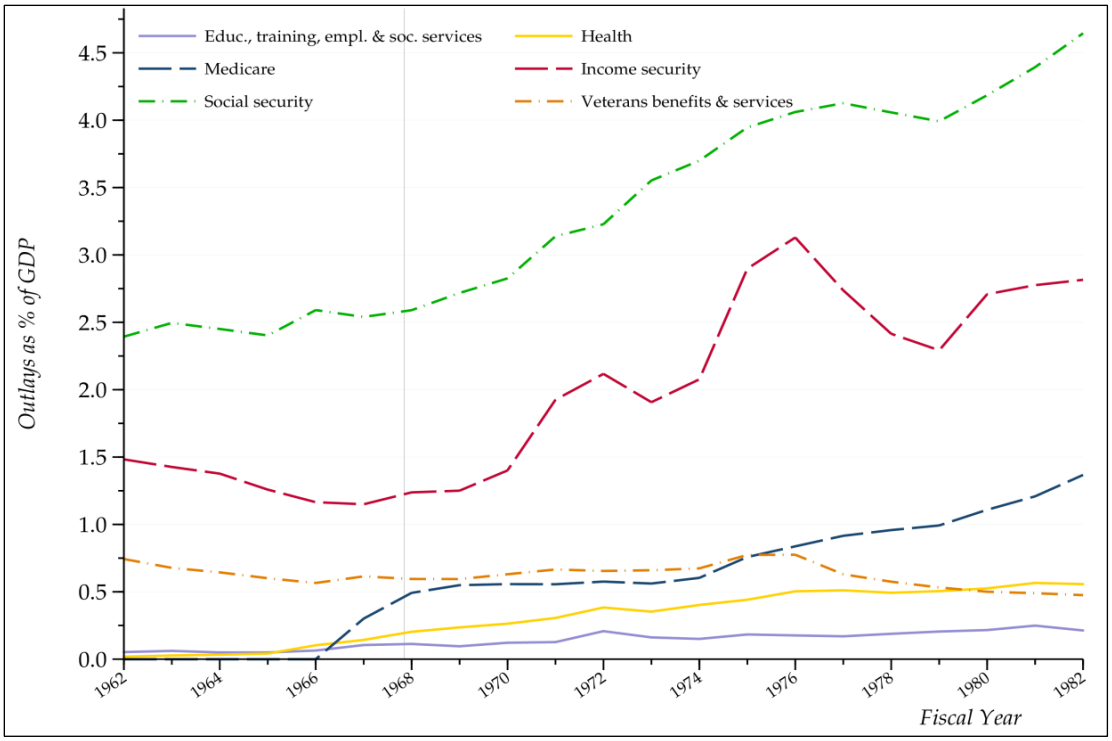
[75] P.L. 92-336 was enacted on July 1, 1972.

[76] See CRS Report R43805, *The Earned Income Tax Credit (EITC): An Overview*, by Gene Falk and Margot L. Crandall-Hollick.

[77] Offsetting receipts are not taken into account for the cost of individual programs in this and subsequent calculations in order to provide comparability to the figures in **Figure 4**. In 2013, offsetting receipts totaled $306 billion or 13% of total spending on mandatory programs.

[78] See U.S. Congress, Senate Committee on Finance, *Medicare and Medicaid: Problems, Issues, and Alternatives*, committee print, 91st Cong., 1st sess., 1970, S. Prt. 362-2.

Figure 4. Mandatory Outlays by Human Resources Budget Function FY1962-FY1982, as a % of GDP



Source: CRS calculations based on OMB data from the FY2017 budget submission.

Notes: The health care budget function includes Medicaid as well as other public health programs, research and training, as well as consumer and occupational safety and health programs.

Rising Mandatory Spending Spur Cost Control Initiatives in 1970s and 1980s

Rising outlays for entitlement programs spurred interest in cost control measures in the 1970s and early 1980s. By FY1975, mandatory spending accounted for 46% of federal outlays, up from 31% a decade earlier. Cost concerns helped lead to the defeat of Carter Administration proposals to reform and expand welfare programs.[79] In 1977, President Carter proposed limits on the growth of hospital revenues and capital expenditures.[80] In 1979, he proposed a similar measure[81] as well as a broader national health insurance plan. Congress approved none of those proposals.[82]

At the start of the Ronald Reagan Administration, however, Medicare rules were changed to pay hospitals set amounts (with various formula adjustments) depending on patient diagnoses, rather

[79] Dennis Ventry, "The Collision of Tax and Welfare Politics: The Political History of the Earned Income Tax Credit 1969-1999," *National Tax Journal*, v. 53, no. 4, December 2000, pp. 999-1001.

[80] Hospital Cost Containment Act of 1977 (S. 1391 and H.R. 6575). See U.S. Congress, Senate Committee on Human Resources, Subcommittee on Health and Scientific Research, *The Hospital Cost Containment Act of 1977: An Analysis of the Administration's Proposals*, 95th Cong., 1st sess., July 1977, C.Prnt. (Washington: GPO, 1977).

[81] Hospital Cost Containment Act of 1979 (H.R. 2626, S. 570) and the National Health Plan Act (H.R. 5400, S. 1812).

[82] For a discussion of legislative action on health policy and national health insurance proposals, see Starr, pp. 411-415. Presidents Nixon and Truman had also proposed national health insurance plans.

than on the cost-plus basis previously used.[83] While Medicare outlays continued to rise, their trajectory was well below that projected before those payment reforms.

The Reagan Administration and congressional allies enacted sweeping changes in omnibus measures using reconciliation procedures—which allowed measures to pass the Senate on simple majority votes—that were considered novel at the time.[84] The Omnibus Budget Reconciliation Act of 1981 (OBRA '81; P.L. 97-35) made significant cuts in certain Social Security benefits and in income support programs.[85] Also in 1981, President Reagan and House Speaker Tip O'Neill reached an agreement to study the financial condition of the Social Security program and agreed to form a commission headed by Alan Greenspan.[86] Recommendations of the Greenspan Commission were enacted in 1983, which were projected to balance Social Security benefits and revenues over the next 75 years.[87]

Growing budget deficits, resulting from higher defense spending and tax cuts, and measures designed to reduce them such as the 1985 Gramm-Rudman-Hollings (GRH) legislation,[88] constrained mandatory program spending through the 1980s. The GRH budgetary framework was superseded by the 1990 Budget Enforcement Act (BEA; P.L. 101-508), which imposed pay-as-you-go (PAYGO) requirements that also served to limit new initiatives to expand mandatory spending above baseline levels.

Figure 5 shows trends in mandatory outlays for budget functions within the Human Resources category from FY1977 through FY2021. The effects of the 1981-1982 recession appear in Social Security and income support outlays, while mandatory outlays in most other categories grew at about the same rate as the economy in the 1980s. Medicare outlays continued to rise in the 1980s, although at a slower rate after hospital payment reforms were adopted.

In 1993, the William J. Clinton Administration developed a proposal for a national health insurance system, which failed to achieve congressional approval. A more limited proposal to create a State Children's Health Insurance Program (CHIP) was enacted as part of the Balanced Budget Act of 1997 (BBA 1997; P.L. 105-33), which also cut payments to many Medicare providers and other health programs.[89] A temporary fall in Medicare outlays as a share of GDP

[83] Rick Mayes, "The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System," *Journal of the History of Medicine and Allied Sciences*, vol. 62, no. 1, 2007, pp. 21-55.

[84] Stuart E. Eizenstat, "The Hill's Budget Stampede," *Washington Post*, June 21, 1981, pp. C1-2. See also U.S. Congress, Senate Committee on the Budget, *Committee on the Budget: 1974-2006*, 109th Cong., 2nd sess., 2006, S.Doc. 109-24 (Washington: GPO, 2006), pp. pp. 44-46. For details on reconciliation procedures, see CRS Report 98-814, *Budget Reconciliation Legislation: Development and Consideration*, by Bill Heniff Jr.

[85] John William Ellwood, "Congress Cuts the Budget: The Omnibus Reconciliation Act of 1981," *Public Budgeting & Finance*, spring 1982, pp. 50-64. See also *The Reagan Record: An Assessment of America's Changing Domestic Priorities*, John L. Palmer and Isabel V. Sawhill, eds., (Cambridge, MA.: Ballinger Books, 1984); and David A. Stockman, *The Triumph of Politics*, (New York: Harper & Row, 1986).

[86] The National Commission on Social Security Reform was appointed in September 1981 and issued a report in January 1983 (https://www.ssa.gov/history/reports/gspan.html). Greenspan had chaired the Ford Administration's Council of Economic Advisors and later served at the head of the Federal Reserve. Commission recommendations were incorporated into the Social Security Amendments of 1983 (P.L. 98-21, https://www.ssa.gov/history/1983amend.html).

[87] Imbalances that were outside of the 75-year window extending from 1983 are now within the 75-year window extending from 2016. As noted above, the Social Security program faces financial challenges in the coming decade.

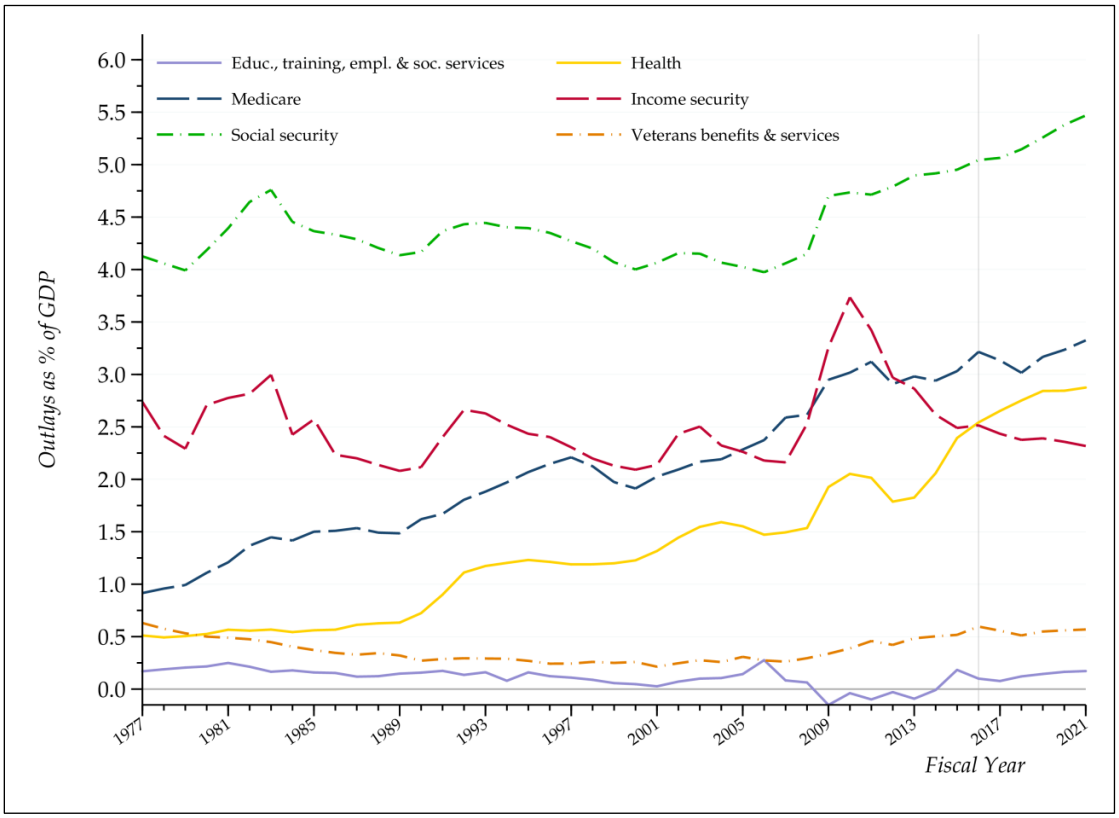
[88] Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), P.L. 99-177.

[89] See CRS Report 98-802, *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97,* P.L. 105-33*)*, by Jennifer O'Sullivan, et al. Some of the cuts proposed in the act were later cancelled or delayed.

after 1997 can be seen in **Figure 5**. A child tax credit was also introduced at the same time through a separate measure (P.L. 105-34).

The William J. Clinton Administration also reached an agreement with Congress in 1996 to transform the Aid to Families with Dependent Children (AFDC) into the Temporary Assistance for Needy Families Program (TANF), which imposed work and duration limits on cash welfare programs.[90] In addition, funding to states was largely converted into block grants and states were given greater latitude to determine eligibility and program design.[91]

Figure 5. Mandatory Outlays by Human Resources Budget Functions FY1977-FY2021, as a % of GDP



Source: CRS calculations based on OMB data from the FY2017 budget submission.

Notes: See notes for Figure 2. The health care budget function here includes the State Children's Health Insurance Program (CHIP). In some years, postsecondary federal loan programs were estimated to have negative subsidies under FCRA rules. Levels for FY2017 through FY2021 reflect Administration proposals.

[90] Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRAWORA; P.L. 104-193). For a review of recent research, see James P. Ziliak, "Temporary Assistance for Needy Families," in *Economics of Means-Tested Transfer Programs*, ed. Robert Moffitt (NBER and University of Chicago Press, 2015).

[91] See CRS Report RL32748, *The Temporary Assistance for Needy Families (TANF) Block Grant: A Primer on TANF Financing and Federal Requirements*, by Gene Falk.

Budget Surpluses and Budget Cap Expiration Open Door to Program Expansions in the 2000s

In the late 1990s, robust economic growth and limits on federal spending helped generate four years of budget surpluses from FY1998 through FY2002.[92] President Clinton proposed using Social Security surpluses—that is, benefits net of payroll taxes—to pay down federal debt held by the public. Interest savings would then have been used to bolster the Social Security and Medicare trust funds.[93]

In early 2001, President George W. Bush contended that those budget surpluses were too large and proposed $1.6 trillion in tax cuts and a doubling of the Medicare budget over the next decade.[94] Legislation that enacted those tax cuts, which largely followed the Bush Administration proposals, doubled the maximum child tax credit and made it refundable to more households.[95] A supplemental appropriations measure that funded responses to and recovery from the September 11 attacks also waived PAYGO restrictions that might have constrained tax reductions or increases in mandatory spending.[96] Extensions of discretionary spending limits, first created by BEA in 1990, and PAYGO restrictions on tax cuts and mandatory spending therefore expired at the end of FY2002.[97] In 2003, the Bush Administration proposed adding a pharmaceutical drug benefit option to the Medicare program.[98] The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) allowed coverage of outpatient pharmaceutical costs through separate Medicare Part D drug plans or through comprehensive Medicare Advantage plans.

Mandatory Spending in the Great Recession and After

The onset of the Great Recession at the end of 2007 prompted Congress to take a series of responses intended to counteract a steep drop-off in private economic activity and to mitigate the financial distress felt by many households. The Great Recession affected mandatory spending primarily in three ways. First, many households saw incomes fall or had spells of unemployment,

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[92] The Budget Enforcement Act of 1990 (BEA; Title XIII of P.L. 101-508) established statutory caps on discretionary spending and pay-as-you-go (PAYGO) limits that constrained mandatory spending and revenue reductions. The BEA was extended in 1993 and 1997, and lapsed in 2002. See CRS Report RS21378, *Termination of the "Pay-As-You-Go" (PAYGO) Requirement for FY2003 and Later Years*, by Robert Keith.

[93] *FY2001 Budget of the U.S. Government*, p. 16.

[94] President George W. Bush, "Address Before a Joint Session of the Congress on Administration Goals," February 27, 2001; http://www.presidency.ucsb.edu/ws/?pid=29643. See also OMB, *Budget of the U.S. Government FY2002*, Summary Table S-2, p. 224.

[95] Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA; P.L. 107-16). An additional package of tax cuts was enacted in 2003. For details on the child tax credit, see CRS Report R41873, *The Child Tax Credit: Current Law and Legislative History*, by Margot L. Crandall-Hollick.

[96] The Department of Defense and Emergency Supplemental Appropriations Act for Recovery from and Response to Terrorist Attacks on the United States, 2002 (P.L. 107-117) reset the PAYGO scorecard for FY2001 and FY2002, thus preventing a possible sequester.

[97] GAO, Budget Issues: Budget Enforcement Compliance Report, GAO-02-794, June 2002. Also see CRS Report RS21378, *Termination of the "Pay-As-You-Go" (PAYGO) Requirement for FY2003 and Later Years*, by Robert Keith.

[98] Thomas R. Oliver, Philip R. Lee, and Helene L. Lipton, "A Political History of Medicare and Prescription Drug Coverage," *Milbank Quarterly*, vol. 82, no. 2, June 2004, pp. 283–354. Also see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, by Jennifer O'Sullivan et al.

which increased the number of people eligible for benefits provided through mandatory programs. Second, legislation enacted in 2008 to rescue or stabilize financial institutions resulted in outlays that were considered mandatory because those measures were established through authorizing, rather than appropriations, legislation.[99] Third, about one-third (33.9%) of the budgetary costs of the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) were classified as mandatory spending.

Federal Responses to the Financial Crisis

During the financial crisis in 2007 and 2008, many administrative and legislative measures were taken to address instability in housing markets and some financial institutions. For example, the Housing and Economic Recovery Act of 2008 (HERA; P.L. 110-289), enacted at the end of July 2008, included provisions to ensure that government-sponsored enterprises that guaranteed housing mortgages would have adequate capital and internal controls. In September 2008, legal authorities created by HERA were invoked to put the government-sponsored mortgage guarantors Fannie Mae and Freddie Mac, which were facing serious risks of insolvency, into a federal conservatorship.[100] That action required credit guarantees and capital infusions of about $188 billion.[101] In exchange, the U.S. Treasury received senior equity investments in the mortgage giants, which entitled the federal government to special dividends.[102] As of June 2016, the Treasury has received $149 billion in dividend payments from Fannie Mae and $99 billion from Freddie Mac.[103]

Later in September 2008, the failure of the Lehman Brothers investment bank raised concerns of a widening financial crisis. The Emergency Economic Stabilization Act (EESA; P.L. 110-343) was enacted in early October 2008 to provide liquidity to distressed financial institutions. The act made $700 billion available through the Troubled Asset Relief Program (TARP) for liquidity support and financial sector stabilization efforts. In March 2016, CBO estimated that $431 billion was disbursed from TARP, which net of repayments and risk adjustments, cost the federal government $30 billion.[104]

In February 2009, the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5), a package of funding increases, tax cuts, and support for state and local governments, was

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[99] Some of those interventions were in the form of credit support and included issuance of warrants or equity positions to the federal government. The expected costs of credit support and the value of those warrants or equity positions generally increased as the economy recovered, thus mitigating the estimated budgetary costs to the federal government.

[100] This was enabled by the Housing and Economic Recovery Act of 2008 (HERA; P.L. 110-289), enacted on July 30, 2008.

[101] Acting Assistant Treasury Secretary for Legislative Affairs Randall DeValk, letter to Senator Charles Grassley, April 21, 2015; http://online.wsj.com/public/resources/documents/GrassleyResponse04212015.pdf. In January 2010, CBO calculated that mandatory spending linked to Fannie Mae and Freddie Mac in FY2009 totaled $91 billion. See CBO, *Budget and Economic Outlook: FY2010-FY2020*, January 2010, Table 3-3, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/01-26-outlook.pdf.

[102] CBO, *The Effects of Increasing Fannie Mae's and Freddie Mac's Capital*, October 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52089-gse-report.pdf.

[103] See Fannie Mae, "Fannie Mae Reports Net Income of $1.1 Billion and Comprehensive Income of $936 Million for First Quarter 2016, press release, May 5, 2016; http://www.fanniemae.com/resources/file/ir/pdf/quarterly-annual-results/2016/q12016_release.pdf. Also see Freddie Mac, *Freddie Mac Update*, August 2016, p. 11, http://www.freddiemac.com/investors/pdffiles/investor-presentation.pdf.

[104] CBO, *Report on the Troubled Asset Relief Program*, March 2016; https://www.cbo.gov/publication/51378. Costs of TARP were calculated according to Federal Credit Reform Act (FCRA) rules with the additional requirement of risk adjustments.

enacted.[105] According to CBO's initial cost estimate, $267 billion of the total $787 billion cost of the measure were projected to be mandatory outlays.[106] Mandatory spending provisions included increases in funding for Medicaid and SNAP, expansions of refundable tax credits, extended unemployment compensation benefits, and bond subsidies for infrastructure projects and local schools. About 90% of ARRA's budgetary effects were concentrated in FY2009-FY2011.

In 2009, the Barack Obama Administration proposed reforms aimed at reducing the proportion of the U.S. population not covered by health insurance or without adequate access to health care. After extensive discussion and congressional deliberation, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) was enacted in March 2010.[107] ACA created options for expanded Medicaid benefits, extended the State Children's' Health Insurance Program (CHIP), and set up health insurance exchanges to serve those not covered by other public or private health insurance plans, among other provisions.[108] The act also funded a system of refundable premium credits and cost-sharing subsidies that reduce the cost of plans offered on health insurance exchanges to those below certain income thresholds. Outlays for those credits and subsidies are expected to grow in coming years.[109]

Fiscal Retrenchment

In 2010, the large deficits that followed the Great Recession and fiscal responses such as ARRA, led to steep increases in federal debt levels and heighted concerns among some of the sustainability of the federal government's finances. In February 2010, President Obama then set up a National Commission on Fiscal Responsibility and Reform, popularly known as the Bowles-Simpson Commission after its co-chairs,[110] to develop "policies to improve the fiscal situation in the medium term and to achieve fiscal sustainability over the long run."[111] On December 1, 2010, the Fiscal Commission issued a report that proposed broad changes in mandatory spending programs, such as health care payment reforms, changes to Social Security to enhance its ability to pay future benefits, and cuts in other mandatory spending such as federal retirement and agricultural subsidies.[112]

In August 2011, the Budget Control Act (BCA; P.L. 112-25) was enacted, which set up budget enforcement mechanisms designed to achieve $2.1 trillion in savings over coming decade. A

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[105] See CBO, *Budget and Economic Outlook: FY2012 to 2012*, January 2012, Box 1-1, pp. 8-9, http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012_Outlook.pdf.

[106] CBO, *Cost Estimate of the American Recovery and Reinvestment Act of 2009*, as posted on the website of the House Committee on Rules, February 13, 2009, Table 1, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/hr1conference0.pdf.

[107] Other provisions were included in the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

[108] For a summary of ACA provisions, see Henry J. Kaiser Family Foundation, *Summary of the Health Care Reform Act*, April 23, 2013, http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act.

[109] Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2016 to 2026*, August 23, 2016, https://www.cbo.gov/publication/51908.

[110] The co-chairs were former Senator Alan Simpson and Erskine Bowles, former chief of staff to President Clinton.

[111] Executive Order 13531, "National Commission on Fiscal Responsibility and Reform," February 18, 2010; 75 FR 7927, February 23, 2011. The Senate had declined establishment of a "Bipartisan Task Force for Responsible Fiscal Action" in January 2011 (S.Amdt. 3299 to H.J.Res. 45).

[112] National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, report, December 1, 2010, https://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf. The report, however, did receive the supermajority vote necessary for approval. Several commissioners issued their own fiscal proposals as well.

bipartisan Joint Select Committee on Deficit Reduction (popularly known as the "Super Committee") was charged with developing a plan to reduce deficits by at least $1.2 trillion over the decade. The committee, however, reported no plan by its November 23, 2011 deadline, thus triggering backup enforcement mechanisms. Those mechanisms include sequestration of non-exempt mandatory spending, although the bulk of BCA spending reductions affect discretionary spending. Social Security and most mandatory programs are exempt from sequestration, although Medicare patient care expenses are subject to a 2% reduction. OMB anticipates that $12.6 billion in Medicare expenses and $6.1 billion in other mandatory spending will be sequestered in FY2017.[113] Sequestration of mandatory spending has been extended through FY2025.[114]

Automatic Stabilizers and Macroeconomic Policy

Mandatory spending plays an important role in fiscal policy and can promote macroeconomic stability. During economic downturns, government revenues fall and expenditures rise as more people become eligible for mandatory programs such as unemployment insurance and income security programs, causing deficits to increase or surpluses to shrink. Outlays for other programs that are less sensitive to economic conditions may still help promote macroeconomic stability because they are a relatively constant component of aggregate demand. Such "automatic stabilizers" provide a countercyclical fiscal stimulus in the short run without the need for new legislative action. In past economic downturns, however, Congress has responded by changing spending and tax policy in ways aimed at counteracting recession.

The role of "automatic stabilizers" has been a focus of research and discussion in fiscal policy for many years.[115] Some argue that tax policy provides a more effective route for countercyclical fiscal action because it provides a faster and administratively simpler way to support aggregate demand. Moreover, because changing programmatic rules for mandatory programs often requires significant lead times, some argue that changes in mandatory programs might be too slow to counteract impending recessions and might largely serve to stimulate demand only after recovery has started.[116] Others contend that spending multipliers for government spending are usually estimated to exceed those for tax cuts,[117] and that the risk of a persistent downturn may justify measures that take longer to implement, but that can be targeted to more vulnerable populations.

Automatic Stabilizers and Mandatory Spending in the Great Recession

During the 2007-2009 financial crisis and ensuing Great Recession, mandatory spending rose sharply, as can be seen in **Figure 1** and **Figure 2**. Trends in just a few components of mandatory spending explain much of that increase, while other types of mandatory spending more or less

[113] OMB, *Report to the Congress on the Joint Committee Reductions for FY2017*, February 9, 2016, https://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration/sequestration_preview_report_fy17_house.pdf.

[114] The Bipartisan Budget Act of 2015 (P.L. 114-74) effected the latest extension.

[115] For a review of this research, see Xavier Debrun and Radhicka Kapoor, "Fiscal Policy and Macroeconomic Stability: Automatic Stabilizers Work, Always and Everywhere," IMF working paper WP/10/11, May 2010, https://www.imf.org/external/pubs/ft/wp/2010/wp10111.pdf.

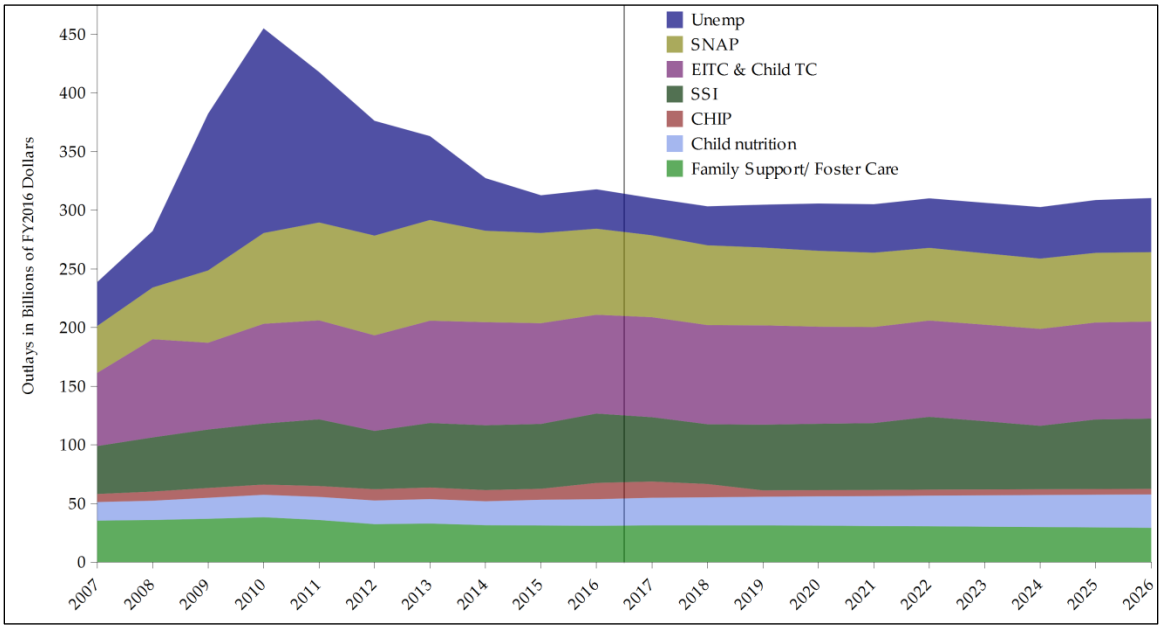
[116] Some tax measures adopted to stimulate the economy during recession have persisted after recovery. For example, bonus depreciation was made available after September 11, 2011 until the end of 2004, and again from 2008 through 2019. See Baker Tilly Virchow Krause, LLP, "Extension and Modification of Bonus Depreciation Rules and Qualified Improvement Property Provisions, January 18, 2016, http://www.bakertilly.com/insights/bonus-depreciation.

[117] For a literature review, see CRS Report RL33657, *Running Deficits: Positives and Pitfalls*, by D. Andrew Austin.

followed existing trajectories. The spike in mandatory spending during the Great Recession also reflects extraordinary financial interventions such as the conservatorship of Fannie Mae and Freddie Mac and TARP, which could be described as asset exchanges or credit support programs having little in common with other types of mandatory spending. Those interventions probably helped stabilize the economy by limiting financial contagion rather than through direct support of aggregate demand.

Figure 6 shows trends in constant dollar ($FY2016) outlays for mandatory income security programs and the State Children's Health Insurance Program (CHIP). Among those programs, the increase and later decline in federal spending on unemployment insurance is most prominent. Funding for SNAP was increased during the Great Recession, but to a lesser extent than unemployment insurance. The decline in SNAP funding after the Great Recession was also much slower than the decline in unemployment insurance spending after FY2010.

Figure 6. Income Security and CHIP Outlays, FY2007-FY2026



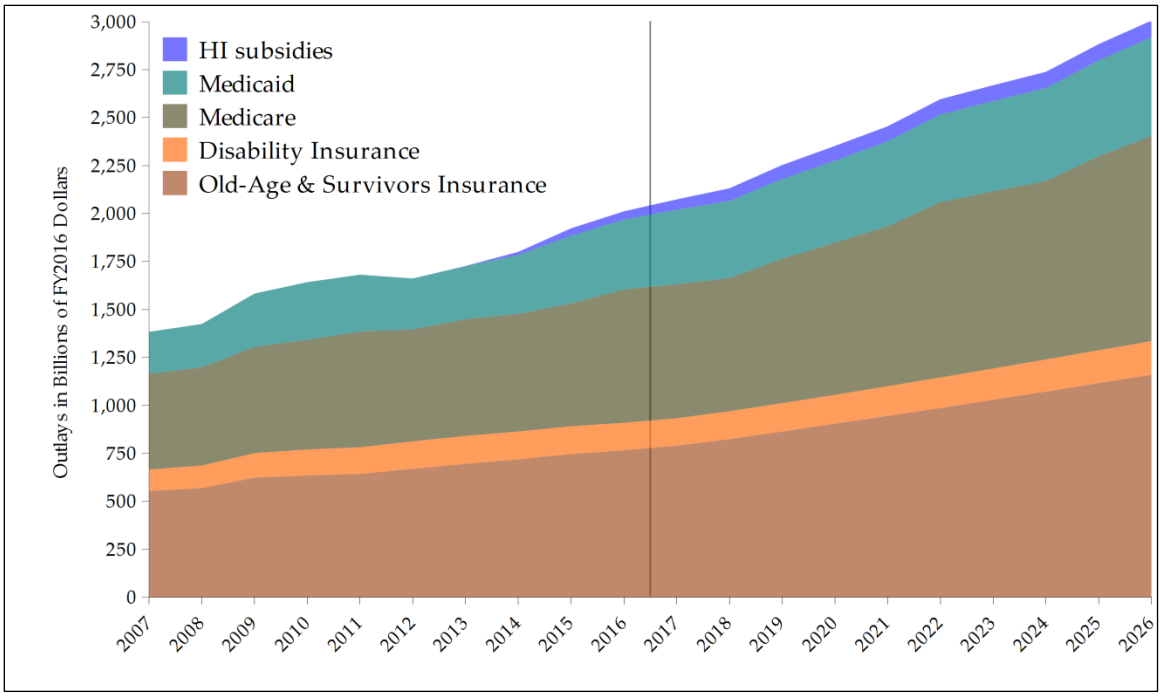
Source: CRS analysis of CBO data, various years.

Notes: Amounts are deflated using the GDP price index to constant FY2016 dollars. FY2016 levels are estimated and later years are CBO current-law baseline projections.

Figure 7 shows inflation-adjusted spending for the two Social Security programs, Old Age and Survivors Insurance (OASI) and Disability Insurance (DI), along with Medicare, Medicare, and subsidies for people purchasing health insurance coverage through exchanges created by ACA. The trend of Medicaid outlays bumped up during the Great Recession, in part because ARRA temporarily increased the federal cost share.[118] Trajectories of other programs appear less affected by the business cycle.

[118] See CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*, coordinated by Cliff Binder. The federal cost share is formally known as the federal medical assistance percentage (FMAP).

Figure 7. Social Security and Health Program Outlays, FY2007-FY2026



Source: CRS analysis of CBO data, various years.

Notes: Amounts are deflated using the GDP price index to constant FY2016 dollars. FY2016 levels are estimated and later years are CBO current-law baseline projections. HI subsidies are provided as part of ACA.

Mandatory Spending Prospects

Projections for the Next Decade

Over the next decade, mandatory spending is projected to continue rising, reaching 15% of GDP in FY2026, while discretionary spending is projected to fall to 5.3% of GDP in that year, its lowest level in modern times. By FY2019, if current trends continue, the sum of Medicare and Medicaid outlays would exceed all discretionary outlays. Moreover, Social Security outlays would also exceed discretionary outlays by FY2023, according to CBO baseline projections.[119] **Table 1** presents historical data and August 2016 CBO current-law baseline estimates for components of mandatory spending.

[119] CBO, *An Update to the Budget and Economic Outlook: 2016 to 2026*, Table 1-2, August 2016, https://www.cbo.gov/publication/51908.

Table 1. Mandatory Outlays, FY2013-FY2026, CBO Baseline Projections

Billions of dollars

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Social Security	**808**	**845**	**882**	**910**	**944**	**999**	**1061**	**1128**	**1199**	**1274**	**1352**	**1434**	**1520**	**1609**
Old-Age & Survivors Insurance	668	703	738	766	799	849	906	967	1,030	1,097	1,167	1,240	1,317	1,397
Disability Insurance	140	142	144	144	145	150	155	161	169	177	185	194	202	212
Major Health Programs	**861**	**925**	**1,031**	**1,118**	**1,169**	**1,210**	**1,309**	**1,394**	**1,484**	**1,619**	**1,681**	**1,740**	**1,890**	**2,019**
Medicare[a]	585	600	634	696	708	716	790	848	910	1,017	1,048	1,076	1,194	1,289
Medicaid	265	301	350	365	393	415	437	459	483	508	534	562	591	621
Health insurance subsidies & related spending	1	15	38	43	54	67	76	81	86	89	93	97	100	103
State Children's Health Insurance Program	9	9	9	14	14	12	6	6	6	6	6	6	6	6
Income Security	**340**	**311**	**300**	**304**	**300**	**301**	**314**	**321**	**327**	**339**	**342**	**345**	**359**	**368**
Earned income, child, and other tax credits[b]	84	86	85	84	86	87	89	89	89	91	93	96	98	100
Supplemental Nutrition Assistance Program	83	76	76	74	71	70	70	69	69	69	69	69	70	71
Supplemental Security Income	53	54	55	59	56	53	59	61	62	69	66	63	70	72
Unemployment compensation	69	44	32	34	32	34	38	43	45	47	49	51	53	56
Family support and foster care[c]	32	31	31	31	32	32	33	33	33	34	34	35	35	35
Child nutrition	20	20	22	23	24	25	26	27	28	29	30	32	33	34
Federal Civilian and Military Retirement	**153**	**158**	**161**	**164**	**164**	**164**	**173**	**179**	**185**	**196**	**197**	**199**	**206**	**219**
Civilian[d]	92	94	97	98	100	104	107	110	114	118	122	126	130	134
Military	54	55	57	62	58	55	61	63	64	71	68	64	72	73
Other	7	8	7	4	5	5	5	5	6	7	8	9	5	11
Veterans[e]	**80**	**87**	**92**	**109**	**108**	**102**	**112**	**116**	**120**	**134**	**130**	**125**	**140**	**145**
Income security	66	71	76	89	87	84	95	98	102	114	110	104	117	121
Other	14	16	16	20	21	18	17	18	18	20	21	21	23	24

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Other Programs	**95**	**57**	**88**	**67**	**86**	**90**	**89**	**89**	**87**	**86**	**85**	**84**	**84**	**87**
Agriculture	24	19	13	14	19	19	16	15	15	15	15	15	15	15
MERHCF[f]	8	9	10	10	10	11	11	12	13	13	14	14	15	16
Deposit Insurance	4	-14	-13	-12	-11	-13	-10	-11	-11	-11	-12	-13	-14	-15
Fannie Mae and Freddie Mac[g]	0	0	0	0	3	2	1	1	0	1	1	1	1	2
Higher education	-26	-12	22	5	-7	-4	-2	0	1	1	1	1	1	0
Other	84	54	56	51	73	75	73	72	69	67	67	66	65	69
Offsetting Receipts	**-305**	**-281**	**-258**	**-235**	**-234**	**-251**	**-261**	**-266**	**-279**	**-296**	**-308**	**-323**	**-347**	**-353**
Medicare[h]	-93	-95	-94	-104	-115	-124	-131	-142	-151	-164	-173	-182	-198	-215
Federal share of Federal employees' retirement	-66	-65	-68	-69	-69	-70	-72	-74	-76	-78	-80	-83	-85	-87
Fannie Mae and Freddie Mac[g]	-97	-74	-23	-14	0	0	0	0	0	0	0	0	0	0
MERHCF	-9	-8	-7	-7	-7	-8	-8	-9	-9	-10	-10	-11	-11	-12
Natural Resources	-15	-14	-11	-8	-9	-12	-12	-12	-12	-12	-13	-14	-14	-15
Other	-25	-25	-55	-33	-34	-38	-38	-30	-30	-31	-32	-33	-40	-25
Total Mandatory Outlays	**2,032**	**2,096**	**2,297**	**2,437**	**2,538**	**2,614**	**2,798**	**2,961**	**3,123**	**3,353**	**3,479**	**3,604**	**3,851**	**4,095**

Source: CBO, *An Update to the Budget and Economic Outlook: 2016 to 2026*, August 2016, and *Budget and Economic Outlook*, January 2014 and January 2015.

Notes: Totals and subtotals shown in bold. Items may not sum to totals due to rounding. Figures for FY2013-FY2015 are actual; figures for FY2016 are estimated; figures for FY2017-FY2025 are projected.

a. Excludes offsetting receipts.

b. Includes outlays for the American Opportunity credit and other tax credits.

c. Includes Temporary Assistance for Needy Families (TANF), the Child Support Enforcement program, the Child Care Entitlement program, and other programs.

d. Includes Civil Service, Foreign Service, Coast Guard, and other, smaller retirement programs as well as annuitants' health benefits.

e. Income security includes veterans' compensation, pensions, and life insurance programs. Other benefits are primarily education subsidies.

f. MERHCF is the Department of Defense Medicare-Eligible Retiree Health Care Fund, including TRICARE For Life.

g. The Administration records cash payments from Fannie Mae and Freddie Mac to the Treasury as offsetting receipts, while Treasury's payments to those entities are recorded as outlays (if any). CBO, however, treats the operations of these entities similar to other federal credit agencies and estimates their net lifetime cost (i.e., a subsidy cost adjusted for market risk) and records that as outlays for the program. The above table reflects the Administration's methodology for FY2014 and FY2015. Beginning in FY2016, the table reflects CBO's estimate of net lifetime costs of the guarantees that those entities will issue and of the loans that they will hold.

h. Includes Medicare premiums and amounts paid by states from savings on Medicaid prescription drug costs.

Much of the projected increase in mandatory spending stems from rising per capita health care costs and the demographic effects of an aging population. Baby Boomers will continue to retire over the coming decade, and the proportion of retirees over age 85—whose health care needs are typically greater than younger retirees—has been rising steadily, thus increasing the expected flow of federal benefits. While the growth of health care costs per beneficiary has moderated in the past decade, concerns remain that health care cost growth could again accelerate.[120]

To large extent, the direct fiscal effects of the Great Recession are no longer evident in mandatory spending trends. The extraordinary financial support programs, such as the Troubled Asset Relief Program (TARP), are no longer active, although the U.S. Treasury does receive dividends from Fannie Mae and Freddie Mac. Federal outlays on unemployment insurance are well below peak levels of FY2010. If the U.S. economy were to experience a future recession, mandatory spending would probably rise faster than current projections indicate.

Mandatory Spending in the Long Term

Long-term trends in mandatory spending to large extent will be shaped by the aging of the Baby Boom generation—that is, those born after the end of World War II and before the early 1960s. Census Bureau projections of the U.S. resident population through 2060, shown in **Figure 8** indicate a growing proportion aged 65 or more.

Table 2 presents the data same and also provides projections for the native-born population, which are less affected by assumptions of future immigration trends and policies.[121] For both the resident and native-born populations, the proportion of those aged 85 or older is projected to double by 2040.

The increasing share of retirees in the U.S. population will also have implications for economic growth.[122] While long-range projections of economic growth rates are highly uncertain, some economists expect that future growth rates will be lower than in past decades.[123] Most advanced economies face similar or even more severe demographic challenges.[124]

Health care sector price trends also will play a central in determining the trajectory of mandatory spending. Some health economists note that health care prices are higher in the United States than in other advanced economies.[125] In addition, trends in income and wealth inequality are also likely to affect mandatory spending aimed at helping vulnerable and low-income populations.

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[120] PriceWaterhouseCoopers Health Research Institute, *Medical Cost Trend: Behind the Numbers 2016*, June 2015, https://commissiononcare.sites.usa.gov/files/2016/01/20151116-05-Medical_Cost_Trend-Behind_the_Numbers_2016_PWC.pdf.

[121] The annual change in the foreign-born population is projected to taper gradually from 2.2% in 2015 to 0.7% in 2060. Trends in the native-born population can be projected using tools of demographic analysis. Projecting trends in the foreign-born population requires wider assumptions about future immigration policies. Moreover, estimates of the foreign-born population may be less reliable than those for the native-born population.

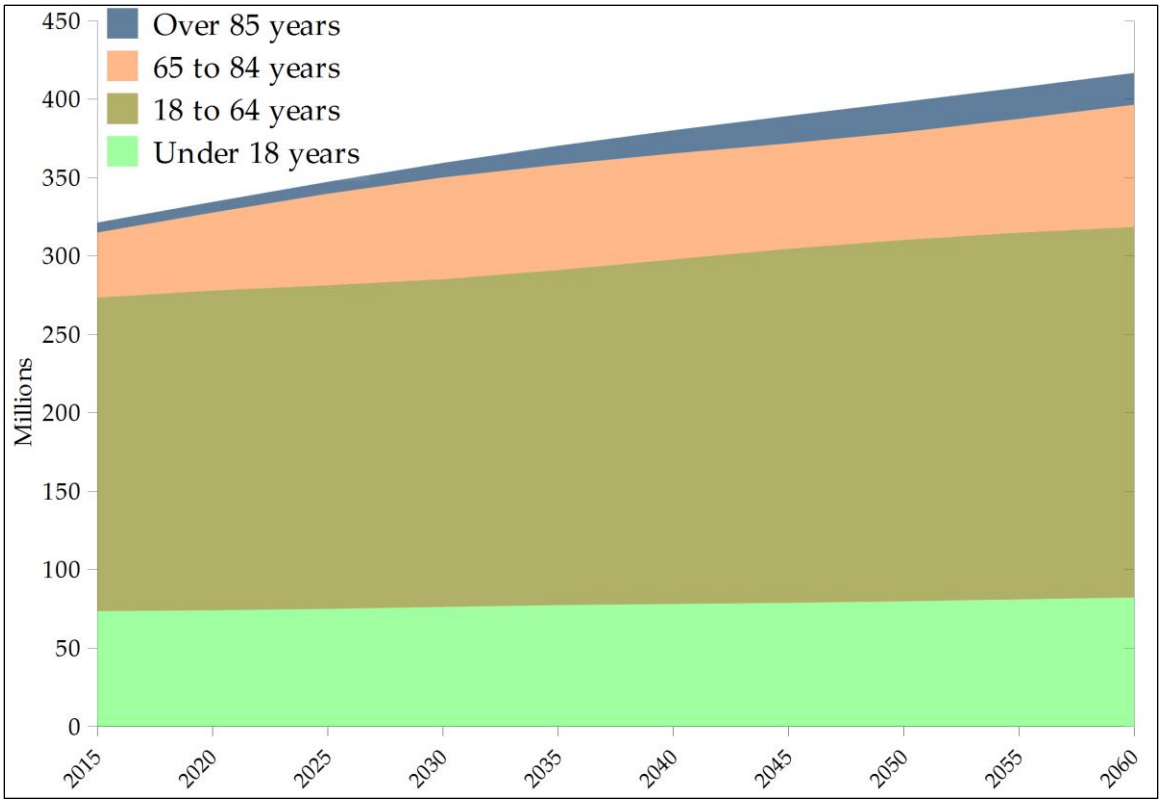
[122] "Labor Force Projections to 2024: the Labor Force is Growing, but Slowly," *Monthly Labor Review*, December 2015, http://www.bls.gov/opub/mlr/2015/article/labor-force-projections-to-2024-1.htm.

[123] Lawrence H. Summers, "The Age of Secular Stagnation: What It Is and What to Do About It," *Foreign Affairs*, February 2016, https://www.foreignaffairs.com/articles/united-states/2016-02-15/age-secular-stagnation.

[124] Wan He, Daniel Goodkind, and Paul Kowal, *An Aging World: 2015*, International Population Reports, P95/16, (Washington, DC: U.S. Census Bureau, 2016), ch. 2, https://www.census.gov/content/dam/Census/library/publications/2016/demo/p95-16-1.pdf.

[125] Luca Lorenzoni, Annalisa Belloni, and Franco Sassi, "Health-Care Expenditure and Health Policy in the USA versus Other High-Spending OECD Countries," *Lancet*, vol. 384, July 1, 2014, pp. 83–89.

Figure 8. U.S. Resident Population Projections by Age Group, 2015-2060



Source: Census Bureau, Population Division, Projections NP2014-T3; http://www.census.gov/population/projections/data/national/2014/summarytables.html.

Table 2. U.S. Population Projections by Age Group and Nativity, 2015-2060

Percentage of Total

U.S. Native-Born Population Projections										
Age Category	**2015**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**
Under 18 years	26%	25%	25%	24%	24%	24%	24%	24%	23%	23%
18 to 64 years	60%	58%	57%	55%	55%	56%	56%	56%	56%	55%
65 to 84 years	13%	15%	17%	18%	18%	17%	16%	16%	16%	17%
Over 85 years	2%	2%	2%	3%	3%	4%	4%	5%	5%	4%
U.S. Resident Population Projections										
Age Category	**2015**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**
Under 18 years	23%	22%	22%	21%	21%	21%	20%	20%	20%	20%
18 to 64 years	62%	61%	59%	58%	58%	58%	58%	58%	57%	57%
65 to 84 years	13%	15%	17%	18%	18%	18%	17%	17%	18%	19%
Over 85 years	2%	2%	2%	3%	3%	4%	4%	5%	5%	5%

Source: Census Bureau, Population Division, Projections NP2014-T3 and NP2014-T4, December 2014.

Fiscal Imbalances in Coming Decades

The federal government faces significant fiscal imbalances in coming decades, in large part reflecting the gap between expected mandatory outlays and federal revenues. According to CBO's extended baseline projections, Social Security outlays would account for 6.3% of GDP in FY2046, while Medicare would account for another 5.7%. While Social Security outlays as a share of GDP would stabilize in the mid-2030s according to those projections, the share of Medicare outlays would continue to grow.[126]

CBO estimated that maintaining the current ratio of federal debt held by the public to GDP (75.4% in FY2016), would require an immediate adjustment of 1.7% of GDP achieved by some combination of spending reductions and revenue increases.[127] Outlays will be an estimated 21.1% of GDP and revenues will be 17.8% in FY2016. Thus, a 1.7% of GDP adjustment in FY2016 would imply a 9.3% increase in revenues or an 8.2% cut in spending. Reducing the debt-to-GDP ratio would require additional adjustments.

Social Security and the Federal Budget

The structure of the Social Security program is expected to affect the federal budget in coming decades. The inflow of Social Security payroll taxes net of benefits payments are invested in special Treasury securities held by the two Social Security trust funds (OAS and DI). Interest paid on those securities augments Social Security revenues. In return for issuing those securities, the U.S. Treasury's general fund receives cash that has helped offset deficits generated in the rest of the federal government.

Social Security: A Stand-Alone Program?

Paying from the trust funds underlines a distinction between Social Security's finances and those of the rest of the government. For example, from the 1930s through the 1960s, trust fund data were often presented separately from other federal budget data.[128] The 1967 President's Commission on Budget Concepts recommended a unified budget concept that integrated trust fund program accounts into budget presentations, an approach used in later budget proposals.[129] Nonetheless, those trust fund accounts retained their separate identity.[130] In 1985, Congress sought to emphasize that separate identity by defining Social Security benefit payments and payroll taxes and contributions as off-budget.[131]

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[126] CBO, *The 2016 Long-Term Budget Outlook*, July 2016, p. 12, https://www.cbo.gov/publication/51580.

[127] Ibid., p. 12.

[128] Ronald W. Johnson, "Evolution of Budget Concepts in the President's Message: 1923-1968," in *Staff Papers and Other Materials Reviewed by the President's Commission on Budget Concepts*, (Washington, DC), October 1967.

[129] *Report of the President's Commission on Budget Concepts*, (Washington, DC: GPO), October 1967.

[130] "In theory, trust funds do not *belong* to the Federal Government; the Federal Government acts only as a *trustee* for them." Ibid., pp. 25-27.

[131] Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177). The U.S. Postal Service was also defined as being off-budget. The term "off-budget" has also been used in other ways in federal budgeting.

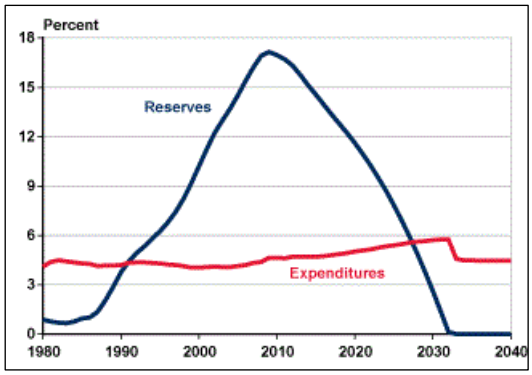
Trust Funds Facing Exhaustion

After changes recommended by the 1983 Greenspan Commission were adopted, Social Security trust fund balances began to grow, as shown in **Figure 9**.[132] The 1990s and the next decade also coincided with the peak earning years of many of the Baby Boomers. The inflow of Social Security payroll taxes exceeded benefits payments, leading to off-budget surpluses, which offset on-budget deficits, thus reducing total deficits.

In FY2016, Social Security revenues, including interest on reserves, slightly exceeded outlays.[133] In coming years, however, as Social Security outlays are projected to exceed revenues, thus requiring a drawdown of reserves. As the Social Security redeems its special Treasury securities, the U.S. Treasury must then draw financial resources from elsewhere, via reduced spending on other programs, higher taxes, or additional borrowing. Once reserves are exhausted, benefits would be adjusted to a level supportable from incoming payroll tax revenues, probably about 75% of previous levels. That reduction of benefits, while continuing to provide substantial support to beneficiaries, would likely require significant adjustments in the finances of many households.

Figure 9. Social Security Outlays and Reserves

As percentage of GDP, 1980-2040



Source: David Pattison, "Social Security Trust Fund Cash Flows and Reserves," *Social Security Bulletin*, vol. 75, no. 1, 2015.

Notes: Shows combined OASI and DI trust fund reserves and expenditures.

Issues for Congress

The scale and growth of mandatory spending raises several challenges for Congress, in addition to issues raised by the operation and design of programs funded by mandatory spending. If Congress sought to address fiscal imbalances, it would be difficult to avoid either significant changes in mandatory spending programs or federal revenue policy. Discretionary spending, according to current projections, is slated to continue shrinking as a share of the federal budget and as a share of GDP. Further reductions in discretionary spending could help narrow fiscal imbalances, although those reductions are unlikely to be large enough to close fiscal gaps without

[132] The Social Security OASI and DI trust funds are separate, but are combined here to simplify the analysis. According to the 2016 Trustees Report, the DI trust fund is expected to exhaust its reserves in 2023 and the OASI trust fund is expected to exhaust its trust fund in 2035. See Social Security Administration, *A Summary of the 2016 Annual Reports*, website, updated July 12, 2016; https://www.ssa.gov/OACT/TRSUM/index.html. The DI trust fund, according to CBO projections, would be exhausted in 2022, the OASI trust fund would be exhausted in 2030, and a combined OASDI trust fund would be exhausted in 1929. See CBO, *CBO's 2016 Long-Term Projections for Social Security: Additional Information*, December 21, 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52298-socialsecuritychartbook.pdf.

[133] OMB, FY2017 Budget, *Historical Tables*, Table 1.2, https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/hist01z1.xls.

other policy changes. Net interest costs, the remaining portion of the federal outlays, reflect federal debt levels and interest rates.

Fiscal Strategies

Policymakers could impose higher tax rates or introduce new types of taxes, such as a federal VAT, to support higher mandatory spending in the future.[134] Higher tax levels, however, could affect economic performance, unless measures were designed to enhance the efficiency of the tax system. Policymakers could also pare back mandatory spending by restricting eligibility for benefits or lowering benefit levels, or through measures that limited excess cost growth in the health care and other sectors that supply goods and services that the government buys. Limiting eligibility and benefits could affect some vulnerable households, while past efforts to control health care costs have had mixed success.

Generational Equity

Some argue that providing higher levels of public support to the elderly is justified on equity grounds because future economic growth will raise living standards of younger generations. As economic growth rates have lagged below historical norms in recent years, such arguments may have become less compelling.

Demographic Shifts and Social Cohesion

Future changes in demographics and in the social structure of the U.S. population could affect support for funding of social insurance and other mandatory spending programs. Some political scientists have documented increasing levels of social and political polarization in recent decades, while economists have noted increasing levels of income and wealth inequality.[135] Those trends may have complex effects on future policy decisions regarding the structure and extent of mandatory spending that would be difficult to predict.

Budget Process Reform Proposals

Some budget experts have proposed changes in congressional budget procedures that would encourage Congress to assess and adjust mandatory spending as well as tax expenditures on a periodic basis.[136] Within current budgetary procedures, the budget reconciliation process provides one way to adjust mandatory spending that avoids certain procedural hurdles. In the 1980s reconciliation was used extensively to modify mandatory spending programs. Changes in how Congress reauthorizes programs or agencies would also affect mandatory spending.

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[134] Most western European countries have more extensive social insurance programs than the United States. Tax revenues as a share of GDP are also higher in those countries, and include value added taxes (VATs) that tend to make tax systems less progressive. The level of public benefits or social supports also tends to vary more widely across the United States because of the federal structure that devolves many policy decisions to state governments than most other economically advanced countries, most of which have more centralized political structures.

[135] Nolan McCarty, Keith T. Poole, and Howard Rosenthal, *Polarized America: The Dance of Ideology and Unequal Riches*, (Cambridge, Mass.: MIT Press, 2006). Emmanuel Saez and Gabriel Zucman, "Wealth Inequality in the United States since 1913: Evidence from Capitalized Income Tax Data," *Quarterly Journal of Economics*, vol. 131, no. 2, May 2016, pp. 519-578.

[136] Alice B. Rivlin and Peter Domenici, "Proposal for Improving the Congressional Budget Process," Bipartisan Policy Center working paper, July 2015, https://www.brookings.edu/wp-content/uploads/2016/07/BPC-Economy-Proposal-for-Improving-the-Congressional-Budget-Process-July.pdf.

Programmatic Reforms or Grand Bargain?

Congress also faces a choice whether to focus on reforms of specific programs or to seek a "grand bargain" that would include diverse budgetary and tax policy changes in a single legislative package. Broad packages of proposals may have the advantage that more instruments are available to address distributional concerns, so that sacrifices can be shared in ways that support comprise. The 2010 Bowles-Simpson Commission and the 2011 Joint Select Committee on Deficit Reduction considered sweeping changes to the federal budget, but were unable to craft proposals with broad support in Congress.

Focusing on a narrower set of programs may have the advantage of allowing more careful consideration of how changes would affect beneficiaries, taxpayers, other levels of government, and other stakeholders. Many mandatory programs have complex financial and administrative structures, and many programs involve state and local governments. In particular, some argue that potential reforms of Social Security should be considered apart from broader budgetary discussions because the program's finances were designed to derive from earmarked payroll taxes, rather than from general revenues.

Mandatory programs may differ in how difficult they are to change. The technical challenges of modifying a program that operates mainly through cash transfers without the involvement of state governments, such as Social Security, may be relatively straightforward compared to the technical challenges of modifying programs that are jointly administered with states, or which interact with the health care system.

How Much Risk Should the Federal Government and Households Bear?

In the 19th century, the federal government protected its citizens from a much narrower set of risks. Social insurance programs established in the 20th century have helped shield individuals and families from some of the risks of ill health, disability, poverty, unemployment, and old age. Some have raised concerns that risks borne by households have risen since the 1980s, while others contend that federal fiscal imbalances pose risks for households in the future.[137]

Over the past century, Congress has balanced concerns for social protection with the need to maintain federal finance in a prudent manner, and to minimize adverse effects on economic incentives. Some contend greater social protections warrant an expansion of mandatory programs and spending. Others argue that paring back some social programs would motivate individuals to mitigate risks using their own resources, and that a reduction in mandatory spending would improve the federal government's fiscal condition.

How narrowly or broadly to target mandatory spending programs is a related policy choice. More narrowly targeted eligibility or benefit criteria can help direct scare resources to individuals and families most in need. Sharply drawn eligibility or benefit criteria, however, can lead to unequal treatment of families or persons in nearly similar situations. Moreover, the phaseout of benefits—such as when benefits are reduced when a household's income rises above a certain threshold—can increase implicit marginal tax rates on affected households, which may affect incentives to work.[138] More gradual phaseouts of benefits can mitigate those effects, but raise program costs

[137] Jacob S. Hacker et al., "The Economic Security Index: A New Measure for Research and Policy Analysis," *Review of Income and Wealth*, vol. 60, 2014, pp. S5–S32.

[138] CBO, Effective Marginal Tax Rates for Low- and Moderate-Income Workers in 2016, November 19, 2015,

and may deliver benefits to families or persons who might not need federal assistance. Some researchers have noted that mandatory spending programs, such as Social Security, were designed to minimize the use of income thresholds to engender broader public support.[139]

Pace of Fiscal Change is Important Choice for Congress

Congress also faces choices on the pace of reforms intended to bring federal finances closer to a sustainable basis. Sudden changes in income support or social insurance programs, however, can disrupt household's financial plans.[140] Sudden changes in tax policies likewise can impose severe adjustment costs on business and households. Delays in addressing those fiscal imbalances, aside from countercyclical measures, allow the scale of fiscal challenge to grow and may require even more painful adjustments—either in expenditure reductions, revenue increases, or some combination of those measures—at some future date.[141]

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https://www.cbo.gov/publication/50923.

[139] According to Cohen (1983-1984, p. 407), President Franklin Roosevelt "supported and justified the use of contributory payroll taxes to finance the insurance programs as 'the' method that would assure continuation and support of a statutory and political 'right' of individuals to receive benefits without an income or 'needs' test in time of financial constraints."

[140] For one analysis of the effects of abrupt changes in retirement benefits, see Andries De Grip, Maarten Lindeboom, and Raymond M. Montizaan, "Shattered Dreams: The Effects of Changing the Pension System Late in the Game," *Economic Journal*, vol. 122, March 2012, pp. 1-25.

[141] Alan J. Auerbach and William G. Gale, "Once More Unto the Breach: The Deteriorating Fiscal Outlook," Brookings Institution working paper, February 2016, http://www.taxpolicycenter.org/sites/default/files/alfresco/publication-pdfs/2000627-once-more-unto-the-breach.pdf.