



# The Federal Government's Long-Term Fiscal Outlook

## Fall 2012 Update

### GAO's Long-Term Fiscal Simulations

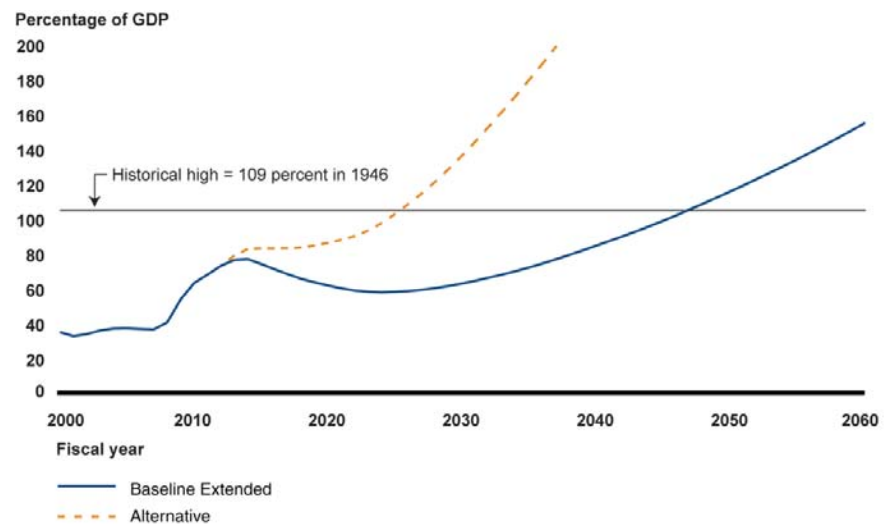
Since 1992, GAO has published long-term fiscal simulations showing federal deficits and debt under different sets of policy assumptions. GAO developed its long-term model in response to a bipartisan request from members of Congress concerned about the long-term effects of fiscal policy. GAO's simulations provide context for consideration of policy options. They are not intended to suggest particular policy choices or to predict the economic impact of any set of choices but to help facilitate a dialogue on this important issue.

GAO regularly updates its simulations as new data become available. This update incorporates the most recent projections released by the Congressional Budget Office (CBO), the Social Security and Medicare Trustees (Trustees), and the Centers for Medicare & Medicaid Services Office of the Actuary (CMS Actuary). As in the past, GAO shows two simulations:

The **Baseline Extended** simulation follows CBO's August 2012 baseline, which generally reflects current law for the first 10 years. The baseline includes the effects from the discretionary spending limits and automatic enforcement procedures put in place by the BCA. After the first 10 years, this fiscal constraint is maintained; revenue and spending other than interest on the debt and large entitlement programs (Social Security, Medicare, and Medicaid) are held constant as a share of GDP. Over the long term, revenue as a share of GDP is higher and discretionary spending lower than historical averages.

GAO's simulations continue to illustrate that the federal government is on an unsustainable long-term fiscal path. In both the Baseline Extended and Alternative simulations, debt held by the public grows as a share of gross domestic product (GDP) over the long term as shown in figure 1. While the timing and pace of growth varies depending on the assumptions used, neither set of assumptions achieves a sustainable path. In the Baseline Extended simulation, which assumes current law, including the discretionary spending limits and other spending reductions contained in the Budget Control Act (BCA) of 2011 and expiration of certain tax cuts enacted in 2001 and 2003, debt as a share of GDP declines in the short term before turning up again. In the Alternative simulation, in which these laws are assumed to not take full effect, federal debt as a share of GDP grows throughout the period. Discretionary spending limits alone do not address the fundamental imbalance between estimated revenue and spending, which is driven largely by the aging of the population and rising health care costs. The Patient Protection and Affordable Care Act (PPACA) slows the growth of health care spending and federal debt under the Baseline Extended simulation, in which cost-containment mechanisms are assumed to be fully implemented and effective. However, some have questioned whether these mechanisms can be sustained over the long term; this is reflected in GAO's Alternative simulation.

**Figure 1: Debt Held by the Public under Two Fiscal Policy Simulations**



Source: GAO.

Note: Data are from GAO's Fall 2012 simulations based on the Trustees' assumptions for Social Security and the Trustees' and the CMS Actuary's assumptions for Medicare.

Significant actions to change the long-term fiscal path must be taken and the design of these actions should take into account concerns about the

In the **Alternative** simulation, expiring tax provisions are extended to 2022, and the alternative minimum tax (AMT) exemption amount is indexed to inflation through 2022; revenues are then brought back to the historical average as a share of GDP. For the first 10 years, discretionary spending reflects the original caps set by the BCA but not the lower caps triggered by the automatic enforcement procedures. Over the long term, discretionary spending and revenue are held at historical averages.

The Baseline Extended simulation follows the Trustees' 2012 intermediate projections for Social Security and Medicare and CBO's June 2012 long-term projections for Medicaid adjusted to reflect excess cost growth consistent with the Trustees' Medicare projections. In the Alternative simulation, Medicare spending is based on the CMS Actuary's alternative projections that assume reductions in Medicare physician rates do not occur as scheduled under current law and that certain cost-containment mechanisms intended to slow the growth of health care cost are not sustained over the long term. GAO also shows the outlook using CBO's long-term projections for Social Security and the major health entitlements; the results are consistent with GAO's simulations based largely on the Trustees' projections.

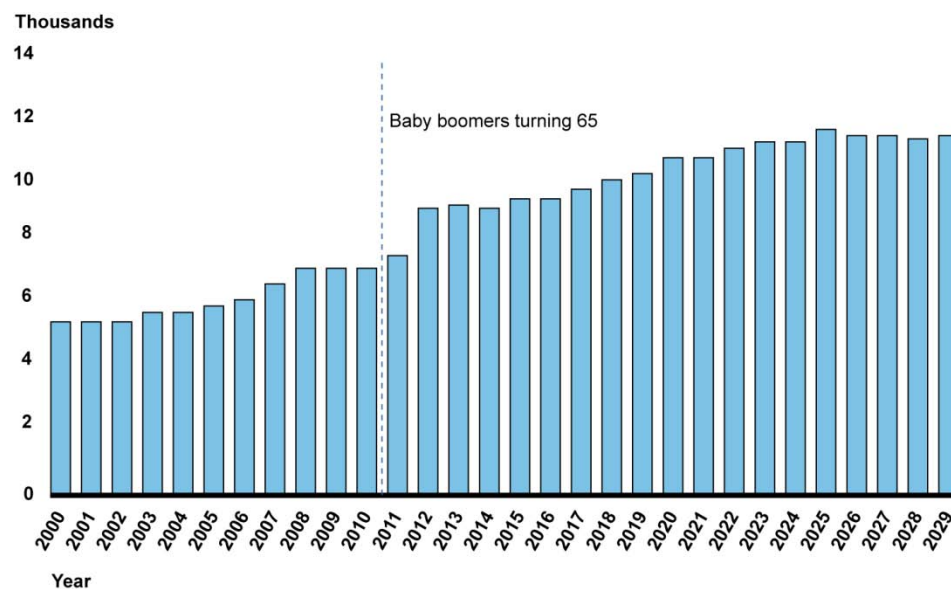
Additional information on the fiscal outlook and federal debt is available at [www.gao.gov/special.pubs/longterm/](http://www.gao.gov/special.pubs/longterm/).

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near-term impact on economic growth. In the near term, for example, the Baseline Extended simulation reflects a number of fiscal policy changes contained in current law that are projected to sharply reduce spending and raise revenue from their current levels beginning in 2013. CBO, the Federal Reserve Board Chairman, and others project that such drastic fiscal tightening—commonly referred to as the “fiscal cliff”—could disrupt economic growth. In the Alternative simulation, historical trends and past policy preferences are assumed to continue; revenue is lower and spending is higher than in the Baseline Extended simulation. While CBO projects that continuation of such policies would prevent disruptions to the economy in the very near term, it would lead to higher debt over the long term.

In both GAO simulations spending for the major health and retirement programs will increase in coming decades, putting greater pressure on the rest of the federal budget. For the first few decades this spending is driven largely by the aging of the population. The oldest members of the baby-boom generation are already eligible for Social Security retirement benefits and for Medicare, and, as shown in figure 2, the number of baby boomers turning 65 is projected to grow in coming years from an average of about 7,600 per day in 2011 to more than 11,000 per day in 2029.

**Figure 2: Daily Average Number of People Turning 65 Each Year**



Source: GAO analysis of U.S. Census Bureau data.

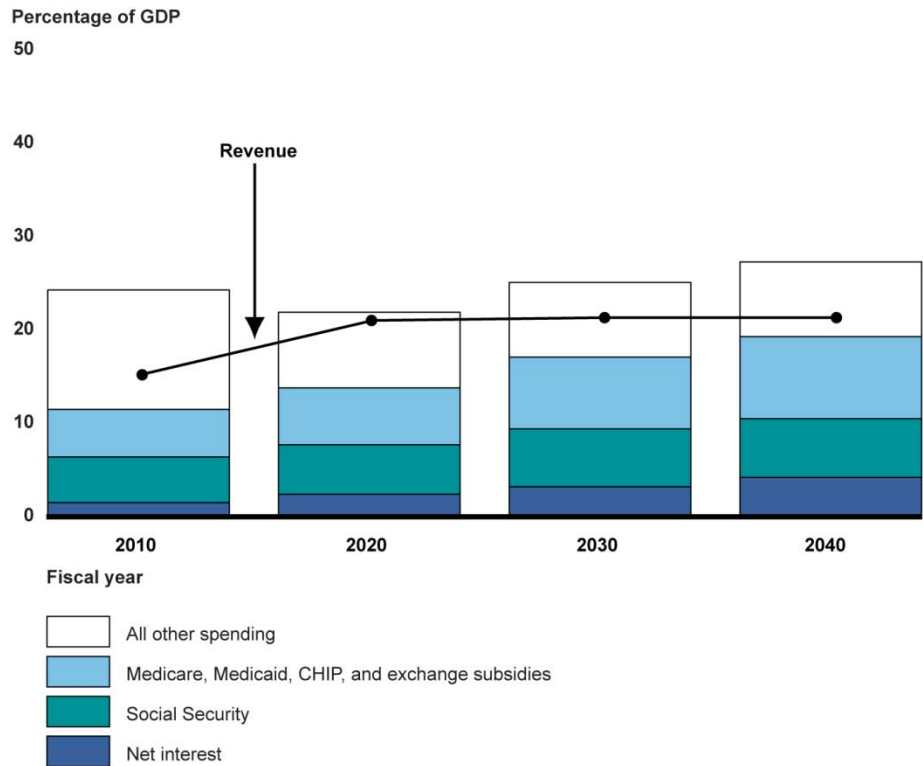
Note: Data are from the U.S. Census Bureau's National Population Projections. For this analysis, we used data from the low net international migration series.

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Health care spending has been growing faster than the overall economy and is expected to continue growing as more members of the baby-boom generation become eligible for federal health programs and the cost of caring for each enrollee increases. If PPACA is implemented as currently written and is effective, it would have a major effect on slowing the rate of growth in federal health care spending as shown in our Baseline Extended simulation. In this simulation, spending on Medicare and Medicaid, the Children’s Health Insurance Program (CHIP), and exchange subsidies grows from 5 percent of GDP in 2010 to over 7 percent by 2030. If, however, the cost containment measures are not sustained over the long term—a concern expressed by the Trustees, the CMS Actuary, the CBO, and others—spending on federal health care programs grows much more rapidly. Spending on Medicare and Medicaid, CHIP, and exchange subsidies under the Alternative simulation grows to over 8 percent of GDP by 2030.

Figures 3 and 4 below show revenue and the composition of spending in the Baseline Extended and Alternative scenarios moving forward. In the Baseline Extended simulation, not only is health care spending growth slower, but revenue as a share of the economy is higher and discretionary spending lower than at any point in the last 50 years. Even in this simulation, revenue covers little more than spending on Social Security, Medicare, Medicaid, CHIP, exchange subsidies, and interest in 2040 (see fig. 3). There is little room for “all other spending,” which includes not only national defense, homeland security, veteran’s health care, and investment in highways and mass transit, but also smaller entitlement programs such as farm price supports and student loans.

**Figure 3: Potential Fiscal Outcomes: Revenues and Composition of Spending in the Baseline Extended Simulation**

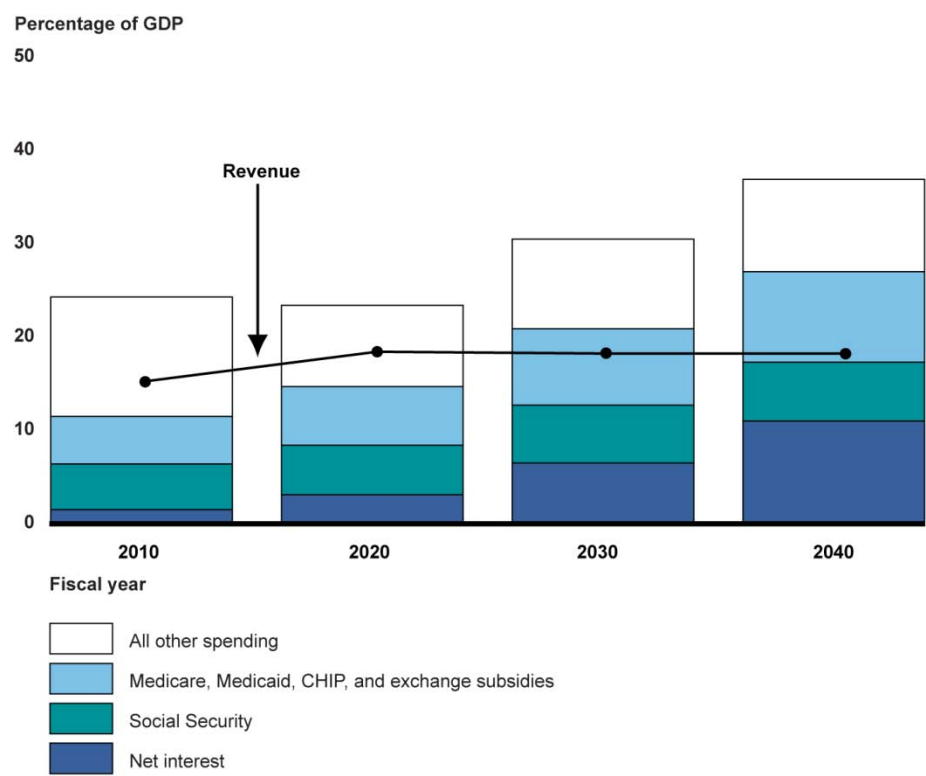


Source: GAO.

Notes: Data are from GAO's Fall 2012 simulations based on the Trustees' assumptions for Social Security and Medicare.

As figure 4 shows, if the federal government continues on the current path, as assumed in the Alternative simulation, and borrows from the public to finance the growing imbalance between revenue and spending, by 2040 more than half of all federal revenue will go to net interest payments. Overall, our simulations illustrate the difficult trade-offs that policymakers will have to consider in order to put the federal government on a more sustainable path.

**Figure 4: Potential Fiscal Outcomes: Revenues and Composition of Spending in the Alternative Simulation**



Source: GAO.

Notes: Data are from GAO's Fall 2012 simulations based on the Trustees' assumptions for Social Security and the CMS Actuary's assumptions for Medicare.

## Balancing Near-Term and Long-Term Considerations

One measure of the challenge over the long term is the "fiscal gap." The fiscal gap represents the difference, or gap, between revenue and noninterest spending over a certain period, such as 75 years, that would need to be closed in order to achieve a specified debt level at the end of the period. From the fiscal gap, one can calculate the size of action

needed—in terms of tax increases, spending reductions, or, more likely, some combination of the two—to close the gap.

For example, to keep debt held by the public as a share of GDP in 2086 from exceeding its level at the beginning of 2012 (roughly 68 percent of GDP) in our Alternative simulation, the fiscal gap is 8.3 percent of GDP (see table 1). This means that revenue would have to increase by 46 percent or noninterest spending would have to be reduced by about 32 percent (or some combination of the two) on average over the 75-year period. Even more significant changes would be needed to reduce debt to lower levels.

**Table 1: Federal Fiscal Gap under Our Simulations**

Scenario	Fiscal gap 2012–2086 (percentage of GDP)	Average percentage change required to close gap			
		If action is taken today		If action is delayed until 2022	
		Solely through increases in revenue	Solely through decreases in noninterest spending	Solely through increases in revenue	Solely through decreases in noninterest spending
Baseline Extended	2.1	10.0	9.4	11.8	10.9
Alternative	8.3	46.0	32.3	54.7	37.2

Source: GAO.

Note: Data are from GAO's Fall 2012 simulations based on the Trustees' assumptions for Social Security and the Trustees' and CMS Actuary's assumptions for Medicare.

When considering action to address the longer-term fiscal challenge, it is important to recognize the current state of the economy. With this in mind, policy changes could be designed to phase in over time allowing for the economy to fully recover and for people to adjust to the changes. However, the longer action is delayed the greater the risk that the eventual changes will be disruptive and destabilizing. Table 1 illustrates how much greater fiscal policy changes would have to be if no actions were taken for the next decade. Under our Alternative simulation, waiting 10 years would increase the fiscal gap to nearly 10 percent of GDP—meaning a revenue increase of more than 54 percent or a noninterest spending cut of about 37 percent or some combination of the two would be required to bring debt held by the public back to its level in 2012 by 2086.

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## Concluding Observations

Addressing the long-term fiscal challenge will likely require difficult choices affecting both revenue and spending. In addition, the need to act soon to develop a plan for addressing the long-term fiscal imbalance must be balanced with concerns about the near-term impact of policy decisions. Action now would allow for the greatest range of options to address the fiscal imbalance and strengthen the economy for the long term. Many of the long-term drivers highlighted in past updates, including health care cost growth and the aging population, have already begun to affect the federal budget. These are challenges for which there are no quick or easy solutions.

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## Changes since the Last Update

This update incorporates CBO's August 2012 baseline projections that follow current law at the time.<sup>1</sup> This includes updated projections for Medicaid, CHIP, and exchange spending consistent with the Supreme Court's recent decision about PPACA. As a result of the decision, CBO and the staff of the Joint Committee on Taxation (JCT) decreased their estimates of federal spending for Medicaid and increased their estimates of federal spending on health insurance exchange subsidies. CBO and JCT's projections reflect an assessment of the probabilities of different outcomes. CBO notes, however, that what states decide to do regarding the Medicaid expansion under PPACA is highly uncertain and depends in part on how flexible executive branch agencies will be regarding the choices that states have.

Consistent with our past practice, spending on Medicaid, CHIP, and exchange subsidies in our simulations follows CBO's baseline projections for the first 10 years. After that, growth in spending for these programs is based on CBO's long-term projections adjusted to reflect excess cost growth consistent with the 2012 Medicare Trustees' intermediate projections. Overall, the net effect of the changes in spending on Medicaid, CHIP, and exchange subsidies in the 10-year baseline do not significantly change the results of our simulations because the reduced costs of covering fewer individuals in state Medicaid programs is partially offset by increased costs of the exchange subsidies.

Beginning with this update, we also revised our method for developing an excess cost growth rate for Medicaid, CHIP, and exchange subsidies consistent with the Trustees intermediate projections. In prior updates, our excess cost growth assumption, while based on growth for the U.S. health sector as a whole, was affected by productivity adjustments and other cost containment mechanisms for Medicare. For this update, we

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<sup>1</sup>The CBO report is available at <http://www.cbo.gov>.

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removed the effects of productivity adjustments and other cost containment mechanisms for Medicare from our estimates of excess cost growth for Medicaid, CHIP, and exchange subsidies. Excess cost growth for these programs is now 0.8 percent in the Baseline Extended simulation, or 0.2 percentage points higher than it was in our previous update, and tracks more closely with private insurance. This is in the same range as CBO's long-term projections for excess cost growth for Medicaid, CHIP, and exchange subsidies. Unlike our prior update where excess cost growth for Medicaid, CHIP, and exchange subsidies differed in the Baseline Extended and Alternative simulations depending on assumptions about Medicare spending, the same rate is used in both simulations for this update.

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## Key Assumptions in Our Federal Simulations

Table 2 lists the key assumptions incorporated in the Baseline Extended and Alternative simulations based on the Trustees' assumptions for Social Security and the Trustees' and CMS Actuary's assumptions for Medicare.



**Table 2: Key Budget Assumptions for Baseline Extended and Alternative Simulations Based on the Social Security and Medicare Trustees' Projections**

Model inputs	Baseline Extended simulation	Alternative simulation
Revenue	CBO's August 2012 baseline that assumes tax cuts will expire as scheduled under current law and that an increasing share of taxpayers will be subject to higher tax rates through 2022; thereafter remains constant at 21.4 percent of GDP (CBO's projection in 2022)	CBO's estimates that assume expiring tax provisions other than the temporary Social Security payroll tax reduction are extended through 2022, and the 2011 alternative minimum tax (AMT) exemption amount is indexed to inflation for years 2012 to 2022; thereafter is phased into the 40-year historical average of 17.9 percent of GDP
Social Security spending	CBO's August 2012 baseline through 2022; thereafter phases into the 2012 Social Security Trustees' intermediate projections	Same as Baseline Extended
Medicare spending	CBO's August 2012 baseline through 2022 that assumes cuts in physician payment rates will occur as scheduled under current law <sup>a</sup> at the time and that the implementation of the Budget Control Act's automatic enforcement procedures reduces spending; <sup>b</sup> thereafter phases into the 2012 Medicare Trustees' intermediate projections in which cost containment mechanisms reduce excess cost growth to 0.2 percentage points on average between 2023 and 2086 <sup>c</sup>	Based on CMS Actuary's alternative scenario that assumes physician payment rates grow by 1 percent annually through 2022 <sup>a</sup> and then gradually transition to a long-term growth rate equal to the per capita increase in overall health spending; spending reductions under the BCA do not occur, <sup>b</sup> and policies that would restrain spending growth are applied fully through 2019 but begin to phase out thereafter; excess cost growth averages 0.8 percentage points between 2023 and 2086 <sup>c</sup>
Medicaid, the Children's Health Insurance Program, and exchange subsidies spending	CBO's August 2012 baseline through 2022; thereafter growth in spending for these programs is consistent with CBO's June 2012 long-term assumptions for the number and age composition of enrollees and the 2012 Medicare Trustees' intermediate assumptions for excess cost growth; excess cost growth averages 0.8 percentage points between 2023 and 2086 <sup>c</sup>	CBO's August 2012 baseline through 2022; thereafter growth in spending for these programs is consistent with CBO's June 2012 long-term assumptions for the number and age composition of enrollees and CBO's alternative assumption that a policy that would slow the growth of per-participant subsidies for health insurance coverage is not in effect and eligibility thresholds are modified to maintain the share of the population eligible for subsidies; as in Baseline Extended, excess cost growth averages 0.8 percentage points between 2023 and 2086 <sup>c</sup>
Other mandatory spending	CBO's August 2012 baseline through 2022, which incorporates the reductions in spending scheduled to occur under the Budget Control Act's automatic enforcement procedures; <sup>b</sup> thereafter remains constant as a share of GDP at 2.4 percent of GDP (implied by CBO's projection in 2022)	CBO's August 2012 baseline adjusted for extension of certain tax credits and to exclude the effects of the Budget Control Act's automatic enforcement procedures through 2022; <sup>b</sup> thereafter is phased back to 2.4 percent of GDP (same as Baseline Extended) by 2025
Discretionary spending	CBO's August 2012 baseline through 2022, which reflects the original caps set by the Budget Control Act, as well as the lower caps triggered by the automatic enforcement procedures; <sup>b</sup> thereafter remains constant at 5.6 percent of GDP (CBO's projection in 2022)	Follows the original caps set by the Budget Control Act but not the lower caps triggered by the automatic enforcement procedures; <sup>b</sup> after 2022 it gradually phases up to 7.5 percent of GDP (the 20-year historical average)

Source: GAO.

Notes: CBO's projections are from *An Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022* (August 2012) and CBO's *The 2012 Long-Term Budget Outlook* (June 2012). Trustees projections are from *The 2012 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* and *The 2012 Annual Report of the*

*Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which were both issued on April 23, 2012. Projections from the CMS Actuary are based on *Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers* (May 18, 2012). We assume that Social Security and Medicare benefits are paid in full regardless of the amounts available in the trust funds.

<sup>a</sup>Physician payment rates are scheduled to be reduced by roughly 27 percent at the start of 2013. Since 2003, Congress has taken a series of legislative actions to override scheduled reductions in physician payment rates that would otherwise occur under law. Physician fee updates set by Congress have averaged 0.9 percent per year over this period.

<sup>b</sup>The Budget Control Act established limits on discretionary budget authority for 2012 through 2021. It also specified additional limits on discretionary spending and automatic reductions in mandatory spending, including Medicare, that begin to take effect in January 2013 and are intended to reduce projected deficits by an additional \$1.2 trillion.

<sup>c</sup>Excess cost growth refers to the annual growth rate of health care spending per enrollee in excess of the annual growth rate of potential GDP, adjusted for demographic characteristics.

Table 3 shows the key economic assumptions that underlie all of our simulations. GDP is held constant across simulations and does not respond to changes in fiscal policy. Also, the implied interest rate on federal debt held by the public in our simulations is held constant over the long term even when deficits climb. With large budget deficits, there could be a rise in the rate of interest and a more rapid increase in federal interest payments than our simulations display.

**Table 3: Key Economic Assumptions Underlying All of Our Long-Term Federal Simulations**

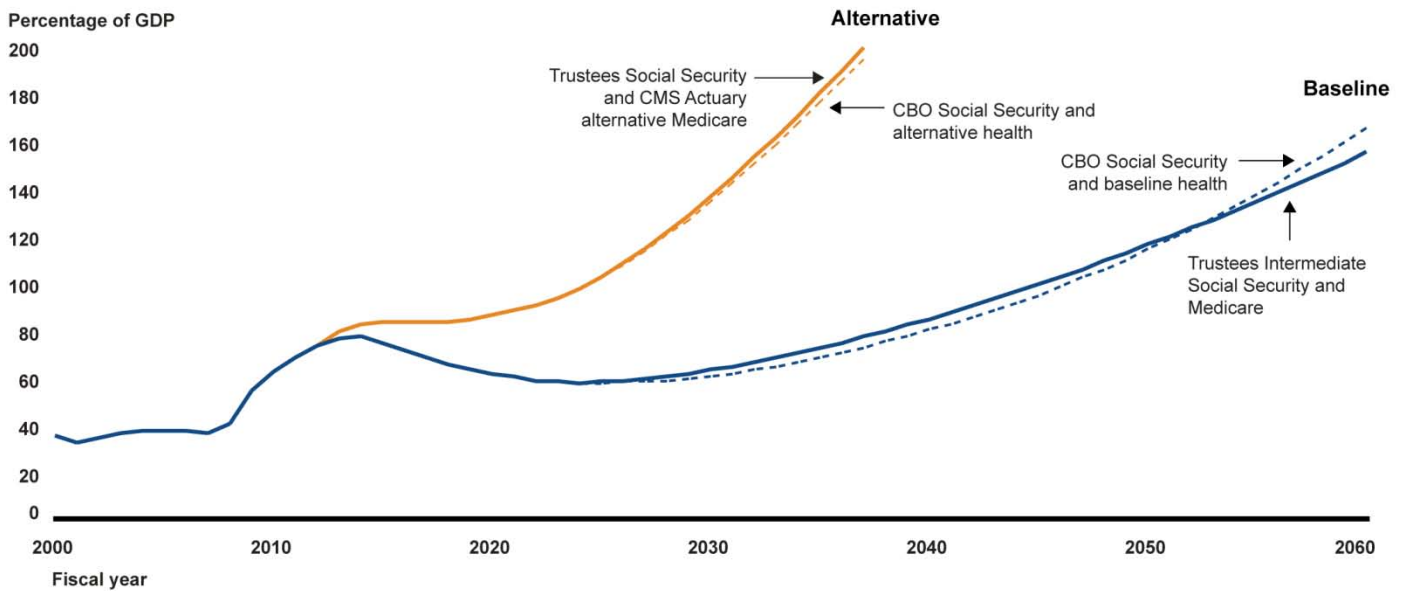
<b>Model inputs</b>	<b>All simulations</b>
Real GDP growth	CBO August 2012 baseline through 2022; thereafter averages 2.1 percent based on the intermediate assumptions of the 2012 Social Security and Medicare Trustees Reports
Inflation (percentage change in GDP price index)	CBO August 2012 baseline through 2022; 2 percent thereafter (CBO's projection in 2022)
Interest rate (on debt held by the public)	Rate implied by CBO's August 2012 baseline net interest payment projections through 2022; phasing to 5.2 percent in 2025 and then constant thereafter (based on CBO's June 2012 long-term projection)

Source: GAO.

A more detailed description of the federal model and key assumptions can be found at <http://www.gao.gov/special.pubs/longterm/fed/aboutlongterm.html>.

The simulation results depend largely on what is assumed about growth in large entitlement programs. As in previous updates, we also show the Baseline Extended simulation using both Trustees and CBO estimates for long-term spending on Social Security and major health entitlement programs (Medicare, Medicaid, and others). In addition, we show the Alternative simulation using different assumptions about certain health care cost-containment provisions based on CBO and CMS Actuary alternative projections. As figure 5 shows, the results are not materially different. The outlook under either set of assumptions is unsustainable.

**Figure 5: Debt Held by the Public under Fiscal Policy Simulations with Different Assumptions for Major Entitlement Programs**



Source: GAO.

Table 4 shows the CBO assumptions incorporated into the simulations that were used in the comparison shown in figure 5.

**Table 4: Key Budget Assumptions Underlying Our Simulations Using CBO’s Spending Projections for Major Entitlement Programs**

Model inputs	Baseline Extended simulation	Alternative simulation
Social Security spending	CBO’s August 2012 baseline through 2022; thereafter based on CBO’s June 2012 long-term projections for Social Security	Same as Baseline Extended
Medicare spending	CBO’s August 2012 baseline through 2022; thereafter based on CBO’s June 2012 long-term projections under its extended-baseline scenario that assumes policies that would restrain spending growth are not in effect after 2029 and excess cost growth averages 1.2 percentage points per year over the long term <sup>a</sup>	Based on CBO’s projections under its alternative fiscal scenario that assumes physician payment rates are maintained at 2012 levels through 2022; spending reductions under the BCA do not occur; policies to restrain growth are not in effect after 2022; and excess cost growth averages 1.3 percentage points per year over the long term <sup>a</sup>
Medicaid, the Children’s Health Insurance Program, and exchange subsidies spending	CBO’s August 2012 baseline through 2022; thereafter based on CBO’s June 2012 long-term projections under its extended-baseline scenario which follows current law and assumes that excess cost growth for Medicaid and CHIP averages 0.7 percentage points per year over the long term <sup>a</sup>	CBO’s August 2012 baseline through 2022; thereafter CBO’s June 2012 projections under its alternative fiscal scenario in which a policy that would slow the growth of per-participant subsidies for health insurance coverage is assumed not to be in effect; eligibility thresholds are assumed to be modified to maintain the share of the population eligible for subsidies; and excess cost growth for Medicaid and CHIP is assumed to average 0.7 percentage points per year over the long term <sup>a</sup>

Source: GAO.

Notes: CBO’s projections are from *An Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022* (August 2012) and CBO’s *The 2012 Long-Term Budget Outlook* (June 2012). CBO assumes that full benefits are paid regardless of the amounts available in the trust funds.

<sup>a</sup>Excess cost growth refers to the annual growth rate of health care spending per enrollee in excess of the annual growth rate of potential GDP, adjusted for demographic characteristics.

This product is part of a body of work on federal debt and the long-term fiscal challenge. Related products can be found at <http://www.gao.gov/special.pubs/longterm/index.html>.

We conducted our work from September 2012 to December 2012 in accordance with all sections of GAO’s Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

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