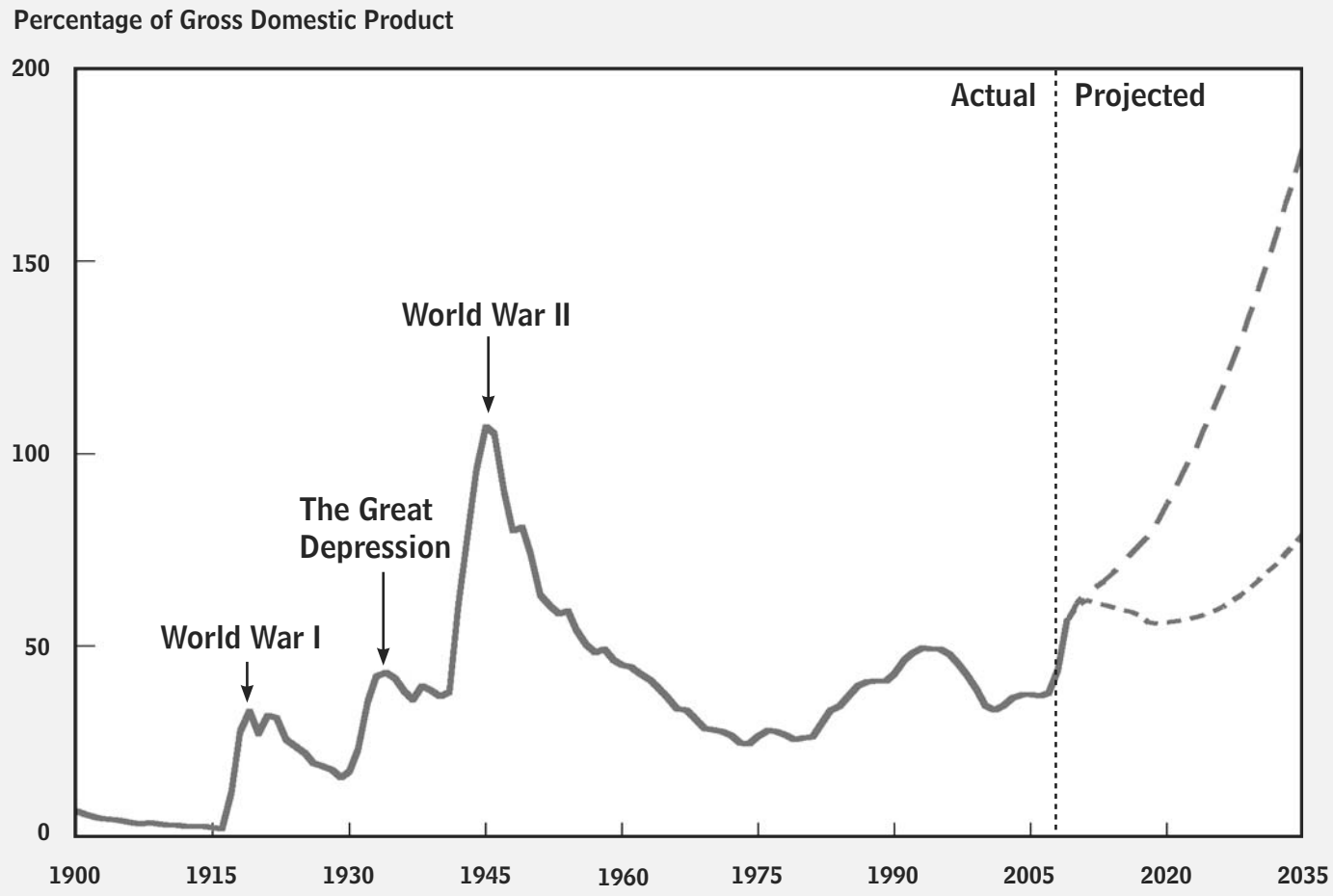
Exhibit 3

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

The Long-Term Budget Outlook



Federal Debt Held by the Public Under CBO's Two Budget Scenarios

JUNE 2009

CHAPTER

2

The Long-Term Outlook for Medicare, Medicaid, and Total Health Care Spending

Spending for health care in the United States has been growing faster than the economy for many years, posing a challenge not only for the federal government's two major health insurance programs, Medicare and Medicaid, but also for the private sector. Measured as a percentage of the nation's gross domestic product, total spending for health care increased from 4.7 percent in 1960 to 15.2 percent in 2007, the most recent year for which data are available.[1] Total spending for Medicare and Medicaid (which for the latter includes both federal and state spending) rose from 1.7 percent of GDP in fiscal year 1975 to 5.7 percent in fiscal year 2008. Over the same period, net federal spending for the two programs rose from 1.2 percent of GDP to 4.1 percent.[2]

The growth of health care spending in the long term will be determined primarily by growth in the cost of medical care per person. The aging of the population will also contribute to future spending growth, especially for Medicare, which will cover a growing number of beneficiaries as baby boomers become eligible for the program and life expectancy continues to rise. Those demographic trends are also projected to increase costs for Medicaid by boosting the demand for long-term care. The Congressional Budget Office projects, however, that spending for Medicare and Medicaid will increase much more rapidly than will their enrollments—because the programs' costs per beneficiary are growing faster than the economy.

CBO projects that without significant changes in policy, total spending for health care will be 31 percent of GDP by 2035 and will increase to 46 percent by 2080. Total spending for Medicare is projected to increase to 8 percent of GDP by 2035 and to 15 percent by 2080. Total spending for Medicaid is projected to increase to 5 percent of GDP by 2035 and to 7 percent by 2080.

Overview of the U.S. Health Care System

A combination of private and public sources finances health care in the United States. Most Americans under the age of 65 have private health insurance that they obtained through an employer. According to CBO's estimates, in 2010, about 56 percent of that population (150 million people) will have employment-based coverage, and about 5 percent (13 million people) will have private coverage purchased directly from an insurer.[3] At any given time during that year, in CBO's estimation, about 50 million people (19 percent of the nonelderly population) will be uninsured. In 2010, CBO projects, about 100 million people will be covered by Medicare and Medicaid, the two main sources of public financing for health care.

1. National health expenditures in 2007 totaled 16.2 percent of GDP. However, the concept of "total spending for health care" used in this report comprises spending for health services and supplies as defined in the national health expenditure accounts maintained by the Centers for Medicare and Medicaid Services. That spending includes all expenditures on personal health care, governments' administrative costs and public health activities, and the net costs of private health insurance. It excludes two categories of spending that are part of national health expenditures: amounts invested in research and in structures and equipment.

2. Those figures are net of premiums paid by Medicare beneficiaries and amounts paid by the states representing part of their share of the savings from shifting some Medicaid spending for prescription drugs to Part D of Medicare.

3. Some of those classified as having employment-based insurance will also have directly purchased coverage.

In 2007, total spending for health care (spending for health services and supplies) amounted to nearly $2.1 trillion, or 15.2 percent of the nation's GDP. Some 54 percent of that amount was financed privately; the rest of the spending came from public sources. Payments by private health insurers were the largest component of private spending, making up 37 percent of total expenditures on health care. Consumers' out-of-pocket expenses, which include payments made to satisfy deductibles, copayments for services covered by insurance, and payments for services not covered by insurance, accounted for 13 percent of those expenditures.[4] Other sources of private funds, such as philanthropy and certain employers (those that maintain on-site clinics for their workers), accounted for 4 percent of total health care spending.

Federal spending for Medicare made up 21 percent of total health care expenditures in 2007, and federal and state spending for Medicaid, 16 percent. A variety of other public programs accounted for 10 percent of total spending. Such programs included those run by state and local governments' health departments, the Department of Veterans Affairs, and the Department of Defense; workers' compensation programs; and the Children's Health Insurance Program.

From 1975 to 2007, the share of total health care spending that was financed privately shrank slightly, dropping from 59 percent to 54 percent, while the share that was financed publicly expanded correspondingly, increasing from 41 percent to 46 percent. During that period, consumers' out-of-pocket payments fell from 31 percent of total expenditures to 13 percent, and payments by private insurers rose from 25 percent to 37 percent.

Overview of the Medicare Program

Medicare provides federal health insurance for 45 million people who are elderly or disabled (the elderly make up about 85 percent of enrollees) or who have end-stage renal disease or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). People become eligible for Medicare on the basis of age when they reach 65; disabled individuals become eligible for Medicare 24 months after they become eligible for benefits under Social Security's Disability Insurance program.

Part A of Medicare, or Hospital Insurance, covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B, or Supplementary Medical Insurance, covers medical equipment and services provided by physicians and other practitioners and by hospitals' outpatient departments. Part B also covers a limited number of drugs, most of which must be administered by injection in a physician's office.[5] Depending on the circumstances, home health care may be covered under either Part A or Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a voluntary prescription drug benefit to the program, which became available in 2006 as Part D of Medicare.

The various parts of the program are financed through different means. Part A benefits are financed primarily by a payroll tax (2.9 percent of taxable earnings), the revenues from which are credited to the Hospital Insurance (HI) Trust Fund. The fund in turn pays for benefits and administrative costs under Part A and makes other authorized expenditures. For Part B, premiums paid by beneficiaries cover about one-quarter of its outlays, and general revenues cover the rest.[6] Enrollees' premiums under Part D are set to cover about one-quarter of the cost of the basic prescription drug benefit. However, receipts from premiums cover less than one-quarter of Part D's total cost because some of the federal outlays for it (such as subsidies for low-income beneficiaries and for employers

4. Out-of-pocket payments do not include the premiums that people pay for health insurance because premiums fund the payments that insurers provide, which are already included in the measure of private spending.

5. Certain other drugs are also covered under Part B, including oral cancer drugs if injectable forms are available, oral antinausea drugs that are used as part of a cancer treatment, and oral immunosuppressive drugs that are used after an organ transplant.

6. The standard premiums are set each year to cover 25 percent of projected average expenditures under Part B. For 2009, the standard monthly Part B premium is $96.40. Since 2007, higher-income beneficiaries have been required to pay higher premiums. For 2009, the income thresholds at which people are responsible for paying those higher premiums (which will be indexed for inflation in future years) are annual income of more than $85,000 for single individuals and income greater than $170,000 for couples. CBO estimates that about 5 percent of beneficiaries will pay the higher premiums in 2009. However, because of low inflation, most beneficiaries' premiums will remain at $96.40 through 2012, CBO projects. (See "Effect of a Zero Social Security COLA on Part B Premiums in Medicare," *CBO Director's Blog*, April 23, 2009, www.cbo.gov.)