IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
SOUTHERN DIVISION
NO. 7:23-CV-897

IN RE:

CAMP LEJEUNE WATER LITIGATION

This Document Relates To:

ALL CASES

APPENDIX TO LOCAL CIVIL RULE 56.1(a)(2) OPPOSING STATEMENT OF UNDISPUTED MATERIAL FACTS

The United States respectfully files the attached materials under Local Civil Rule 56.1 and Rule 56 of the Federal Rules of Civil Procedure. All other materials cited in the United States' Local Civil Rule 56.1(a)(2) Opposing Statement of Undisputed Material Facts have been filed as part of the Joint Appendix or as attachments to Plaintiffs' Statement of Material Facts. The United States stands ready to file any additional materials at the Court's request.

Exhibit	Description
A	Ford Dep. Ex. 8 (VA 2026 Budget-in-Brief)
B	Young Dep. Ex. 6 (Medicare 2025 Annual Trustees' Report)
C	Piper Dep. Ex. 10 (VBA Disability Ratings Schedule)
D	Selections from the Transcript of the Deposition of Plaintiff Mousser[1]
E	01368_MCELHINEY_VBA_0000012791
F	01553_TUKES_DPRIS_0000000320
G	CLJA_USA_YOUNT_0000000139-41

[1] The United States files an excerpt for the convenience of the Court.

Dated: June 2, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on June 2, 2026, I electronically filed the foregoing using the Court's Electronic Case Filing system, which will send notice to all counsel of record.

<u>/s/ David R. Ortiz</u>
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Exhibit A

U.S. DEPARTMENT OF VETERANS AFFAIRS

FY 2026 BUDGET SUBMISSION

Budget in Brief

May 2025

Overview

President Trump is committed to balancing the Budget, while providing necessary funding for critical non-defense discretionary priorities like caring for the Nation's Veterans, their families, caregivers, and survivors. The 2026 President's Budget request and 2027 Advance Appropriations (AA) request for the Department of Veterans Affairs (VA) will provide the funding to deliver the world-class care and benefits Veterans have earned. The Budget provides increased funding for healthcare services tailored to Veterans' needs both at VA medical centers and in the community. It prioritizes care for our most vulnerable Veterans, including those experiencing homelessness or at-risk of suicide. It accelerates VA's Electronic Health Record Modernization (EHRM) effort, moving the Department from a decades-old legacy system to a modern system that is interoperable with the Department of Defense (DoD) and other Federal and community care partners. And finally, the Budget eliminates nonessential programming and bureaucratic overhead that does not directly serve the Veteran.

In short, President Trump's 2026 Budget request will allow VA to continue making historic reforms to refocus the Department on its core Veterans First mission: providing the best possible care and services to Veterans, families, caregivers and survivors.

The total 2026 request for VA is $441.2 billion including all funds, both discretionary and mandatory, a $40.3 billion (+10%) increase above the 2025 enacted level (including collections and the Recurring Expenses Transformational Fund). This includes a discretionary budget request of $134.6 billion, a $5.3 billion (+4%) increase above 2025 (excluding collections). Combined with $52.7 billion from the mandatory Cost of War Toxic Exposures Fund (TEF), the total request is $187.2 billion for operational needs. Additionally, the discretionary Recurring Expenses Transformational Fund (RETF, or Transformational Fund, TF)[1] will provide $900 million for major construction projects.

The 2026 mandatory benefits funding request is $248.1 billion, an increase of $11.7 billion (+5.0%) above 2025. In addition, there is $400 million for Major Medical Facility leases made available by the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117-168).

VA anticipates supporting 455,874 Full-Time Equivalent Employees (FTE) in 2026 using all funding sources.

The 2027 Medical Care Advance Appropriation (AA) request includes a discretionary funding request of $122.3 billion. The 2027 mandatory AA request is $262.1 billion for Veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities) and $51.7 billion for the TEF.

[1] The Consolidated Appropriations Act, 2016 (P.L. 114-113) created the RETF, allowing VA to transfer unobligated balances of expiring non-emergency discretionary funds in any account to the RETF as directed in the Act.

The 2026 request will provide the resources necessary to meet VA's commitment to deliver timely access to world-class health care and earned benefits to Veterans. The request fully funds operation of the largest integrated health care system in the United States, with over 9.2 million Veterans expected to be enrolled for medical services in 2026. In 2026, it will also provide disability compensation benefits to over 7 million Veterans and their survivors and administers pension benefits for over 200,000 Veterans and their survivors. The 2026 request will also support:

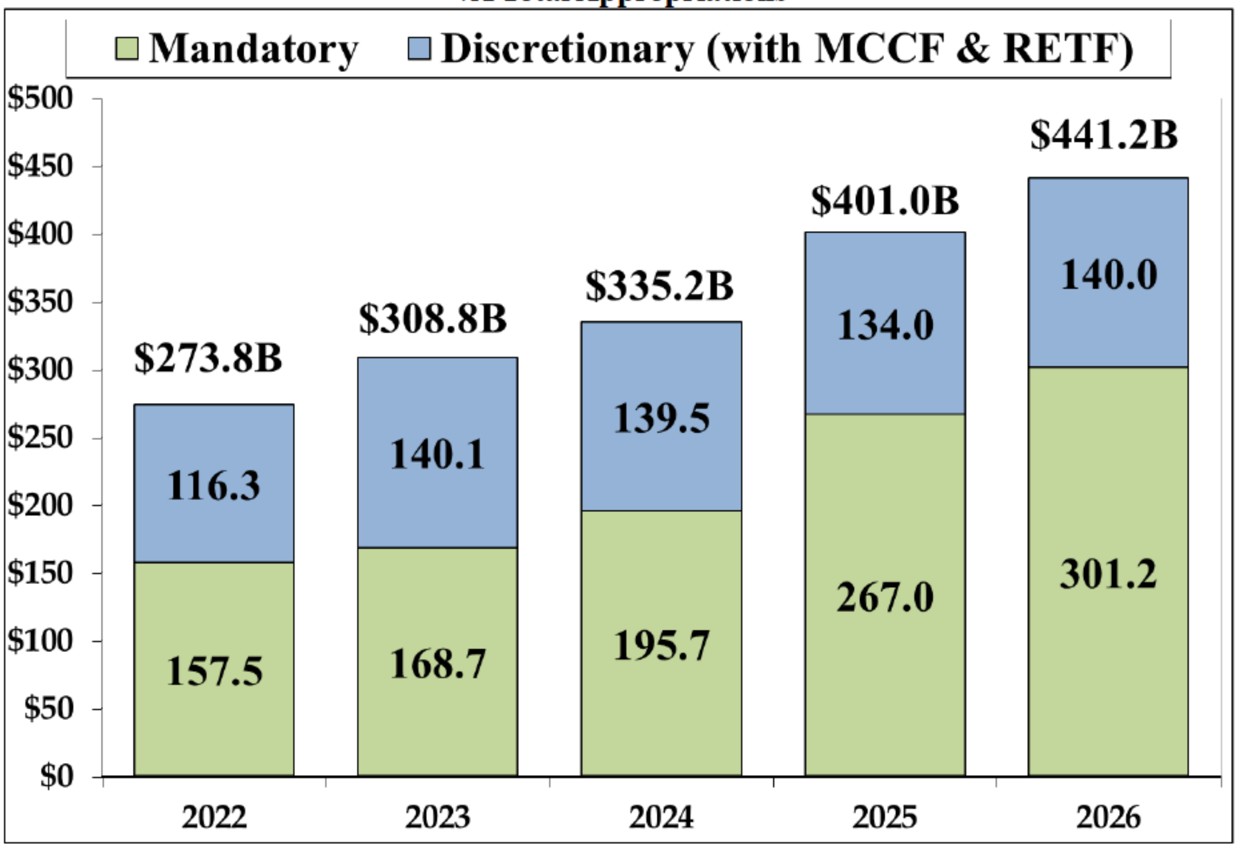
- 7.5 million unique patients treated by VA estimated for 2026.
- 162.6 million outpatient visits estimated for 2026.
- $3.0 billion for construction (all funds, base discretionary and RETF).
- Education assistance programs serving over 1.1 million trainees.
- Veteran Readiness and Employment (VR&E) benefits for more than 189,000 Veterans.
- Loan Guaranty Service (LGY) credit benefits with a portfolio of 4.2 million active home loans.
- Interment of an estimated 135,394 Veterans and eligible family members in VA national cemeteries by the National Cemetery Administration (NCA).

There are an estimated 17.9 million Veterans living in the United States, its territories, and other locations. These Veterans, their families, caregivers and survivors are the heart of America, having dedicated their lives to serving and sacrificing for this country in times when they were needed most. VA will continue to work with Federal, state, and local partners, including Veterans Service Organizations (VSO) to best utilize the funds requested.

VA Funding

Funding for VA has increased significantly, with total funding growing by $167.4 billion (+61.1%) since 2022, as shown below.

VA Total Appropriations

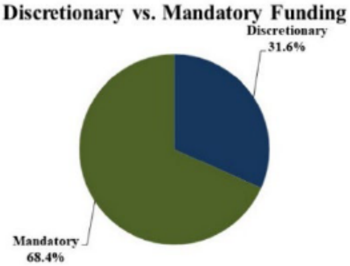


Funding History

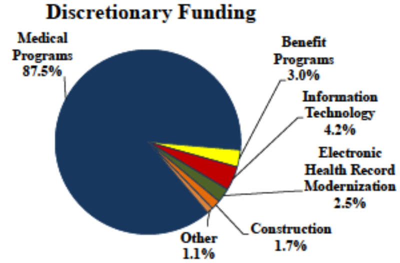
($ in Billions)	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Mandatory	92.5	105.5	112.3	110.9	124.7	137.7	157.5	168.7	195.7	267.0	301.2
Discretionary	70.9	74.3	81.6	86.6	92.0	104.6	113.3	135.0	135.0	129.2	134.6
Medical Collections (MCCF)	3.5	3.5	3.5	3.9	3.4	3.1	3.9	4.1	3.8	4.4	4.6
Transformational Fund (RETF)							-0.8	1.0	0.7	0.3	0.9
Total VA	**166.9**	**183.3**	**197.4**	**201.4**	**220.1**	**245.4**	**273.8**	**308.8**	**335.2**	**400.9**	**441.2**

Note: Mandatory funding includes $2.1 billion provided by the Veterans Choice Act 2017 and $7.3 billion in 2018, as well as resources provided in the PACT Act, annual appropriations acts, and Fiscal Responsibility Act of 2023 (FRA) for TEF. Funding excludes American Rescue Plan (2021) and the Disaster Relief Supplemental (2025). Totals may not add due to rounding.

Discretionary vs. Mandatory Funding



Discretionary Funding



FY 2026 Request

Regular Appropriations, Collections, Department of Defense (DoD) Transfers, and RETF

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	Change 2026 vs. 2025 $	Change 2026 vs. 2025 %
Discretionary Funding [1]					
Medical Services	69,018	69,129	57,120	(12,009)	-17.4%
Medical Community Care	30,342	22,555	34,000	11,445	50.7%
Medical Support and Compliance	10,750	11,719	12,090	371	3.2%
Medical Facilities	8,949	9,548	11,730	2,182	22.9%
Subtotal, Medical Care Appropriations	**119,059**	**112,951**	**114,940**	**1,989**	**1.8%**
Bridging Rental Assistance for Veteran Empowerment (BRAVE)	-	-	1,100	1,100	-
Subtotal, Medical Care + BRAVE	**119,059**	**112,951**	**116,040**	**3,089**	**2.7%**
Medical Care Collections Fund	3,847	4,389	4,580	191	4.4%
Subtotal, Medical Care + BRAVE with MCCF	**122,907**	**117,339**	**120,620**	**3,281**	**2.8%**
Medical and Prosthetic Research	943	935	943	8	0.9%
Electronic Health Care Record Modernization	874	1,322	3,495	2,173	164.5%
Information Technology Systems	6,386	6,227	5,908	(319)	-5.1%
Board of Veterans' Appeals	272	277	277	(0)	0.0%
General Operating Expenses, Veterans Benefits Administration	3,869	3,899	3,879	(20)	-0.5%
National Cemetery Administration	480	480	497	17	3.5%
General Administration	470	448	440	(8)	-1.8%
Construction, Major Projects	881	961	1,871	910	94.6%
Construction, Minor Projects	692	692	232	(460)	-66.5%
Grants for State Extended Care Facilities	171	171	171	-	0.0%
Grants for Construction of Veterans Cemeteries	60	60	60	-	0.0%
Office of Inspector General	296	296	296	-	0.0%
Loan Administration and Subsidy	320	320	280	(40)	-12.5%
DoD transfers to Joint Accounts (JALFHCC and JIF)	187	178	180	3	1.4%
Subtotal, Non-Medical Care	**15,901**	**16,265**	**18,529**	**2,264**	**13.9%**
Subtotal, Discretionary without MCCF	**134,960**	**129,216**	**134,569**	**5,353**	**4.1%**
Subtotal, Discretionary (with MCCF)	**138,808**	**133,605**	**139,149**	**5,544**	**4.1%**
Recurring Expenses Transformational Fund (RETF) [2]	**676**	**320**	**900**	**580**	**181.5%**
Total, Discretionary (with MCCF and RETF)	**139,484**	**133,924**	**140,049**	**6,125**	**4.6%**
Mandatory Funding [3]					
Total, Mandatory	**195,697**	**267,009**	**301,165**	**34,156**	**12.8%**
Total Funding					
Total VA (Disc & Mand) without MCCF or RETF	**330,658**	**396,225**	**435,734**	**39,509**	**10.0%**
Total VA (Disc & Mand) with MCCF	**334,505**	**400,614**	**440,314**	**39,700**	**9.9%**
Total, Disc & Mand Funding (with MCCF and RETF)	**335,181**	**400,934**	**441,214**	**40,281**	**10.0%**

1. Discretionary Funding includes non-emergency appropriations provided in annual Appropriations Acts and in the 2026 President’s Budget Request. The Disaster Relief Supplemental Appropriations Act, 2025, P.L. 118-158, is not included.
2. RETF line displays the estimated resources available in the RETF. These resources do not score as budget authority.
3. Mandatory Funding includes mandatory appropriations provided in annual Appropriations Acts, PACT Act, the Fiscal Responsibility Act and the Full-Year Continuing Appropriations and Extensions Act, 2025.

Mandatory Funding Details

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	Change 2026 vs. 2025 $	Change 2026 vs. 2025 %
Mandatory Funding					
Mandatory Benefits					
Compensation and Pensions	164,136	212,553	227,240	14,687	6.9%
Veterans Insurance and Indemnities	134	135	132	(4)	-2.7%
Readjustment Benefits	9,424	18,264	20,372	2,108	11.5%
Credit Reform Upward Reestimates and Subsidy	1,637	5,405	348	(5,057)	-93.6%
Housing Liquidating Account	(2)	(3)	(2)	0	-
Subtotal, Mandatory Benefits	**175,329**	**236,354**	**248,089**	**11,735**	**5.0%**
PACT Act Section 707 (Major Medical Facility Leases) [1]					
Medical Facilities	100	200	400	200	100.0%
Cost of War Toxic Exposures Fund [2]					
Medical Services	9,525	11,884	35,370	23,486	197.6%
Medical Community Care	6,802	15,694	14,030	(1,664)	-10.6%
Medical Support and Compliance	850	-	400	400	-
Medical and Prosthetic Research	46	59	57	(2)	-3.4%
Information Technology Systems	1,243	1,364	1,385	21	1.6%
Board of Veterans' Appeals	4	-	-	-	-
General Operating Expenses, Veterans Benefits Administration	1,769	1,426	1,401	(25)	-1.7%
General Administration	29	20	33	13	66.4%
Contingency Reserve	0	9	-	(9)	-100.0%
Subtotal, Cost of War Toxic Exposures Fund	**20,268**	**30,455**	**52,676**	**22,221**	**73.0%**
Subtotal, PACT Act	**20,368**	**30,655**	**53,076**	**22,421**	**73.1%**
Total, Mandatory	**195,697**	**267,009**	**301,165**	**34,156**	**12.8%**

1. Section 707 of the PACT Act appropriated funds for major medical facility leases for 2023 and annually for subsequent years through 2031.
2. The Consolidated Appropriations Act, 2023, appropriated $5.0 billion to the TEF in 2023; the Fiscal Responsibility Act of 2023 appropriated $20.3 billion to the TEF in 2024 and $24.5 billion to the TEF in 2025 and the Full-Year Continuing Appropriations and Extensions Act, 2025, provided an additional $6 billion for TEF in 2025.

Mandatory funding for Compensation and Pensions will provide $220.3 billion in disability compensation benefit payments to over 7.0 million Veterans and their survivors and $3.1 billion in pension benefit payments to over 200,000 Veterans and their survivors. Readjustment Benefits funding will provide $16.2 billion in education and job training benefits to over 1.1 million Veterans and qualified dependents. VA's life insurance programs will provide coverage to over 5.5 million Veterans. Funding for VA's credit programs will support nearly 595,300 new guaranteed loans within a portfolio of 3.7 million active loans.

Cost of War Toxic Exposures Fund (TEF) Details

"The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022" or the "Honoring our PACT Act of 2022" (PACT Act, P.L. 117–168) represents the most significant expansion of VA health care and disability compensation benefits for Veterans exposed to burn pits and other environmental exposures in 30 years. As part of the PACT Act, Congress authorized the TEF to fund increased costs above 2021 funding levels for health care and benefits delivery for Veterans exposed to a number of environmental hazards to ensure there is sufficient funding available to cover these costs, without shortchanging other elements of Veteran medical care and benefit delivery. The budget includes a request for $52.7 billion in mandatory funding for the TEF in 2026 which will support an estimated 191,433 FTE, as shown in the tables below. Further details for the TEF are provided in each office description.

TEF Appropriation

Accounts ($ in millions)	2022 Enacted	2023 Enacted	2024 Enacted	2025 Enacted with Transfer	2026 Request
Medical Care	34	3,822	17,177	27,578	49,800
Medical Research	1	2	46	59	57
Office of Information Technology	123	656	1,243	1,364	1,385
Board of Veterans' Appeals	10	1	4	-	-
Veterans Benefits Administration	302	482	1,769	1,426	1,401
General Administration	30	37	29	20	33
Contingency Reserve	-	-	-	9	-
Total Budget Authority	**500**	**5,000**	**20,268**	**30,455**	**52,676**

TEF FTE

All Funding Sources	2022 Enacted	2023 Enacted	2024 Enacted	2025 Enacted with Transfer	2026 Request
Medical Care	-	-	88,563	69,066	184,179
Medical Research	-	6	93	164	213
Office of Information Technology	-	12	31	50	50
Board of Veterans' Appeals	-	-	-	-	-
Veterans Benefits Administration	-	6,004	8,154	8,418	6,907
General Administration	-	45	56	84	84
Total FTE	**-**	**6,067**	**96,897**	**77,782**	**191,433**

Combined Appropriation

The VA manages base discretionary funds and mandatory TEF and PACT Act section 707 medical facilities funds in accordance with the legal parameters for both funding streams. The combined funds, as shown below, represent the total appropriated funds to support VA operations.

Combined Appropriation, Base Discretionary, TEF and PACT Section 707

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	Change 2026 vs. 2025 $	Change 2026 vs. 2025 %
All Funding Sources					
Medical Services	78,543	81,013	92,490	11,477	14.2%
Medical Community Care	37,144	38,249	48,030	9,781	25.6%
Medical Support and Compliance	11,600	11,719	12,490	771	6.6%
Medical Facilities	9,049	9,748	12,130	2,382	24.4%
Subtotal, Medical Care Appropriations	**136,336**	**140,729**	**165,140**	**24,411**	**17.3%**
Bridging Rental Assistance for Veteran Empowerment (BRAVE)	-	-	1,100	1,100	-
Subtotal, Medical Care + Homeless Appropriations	**136,336**	**140,729**	**166,240**	**25,511**	**18.1%**
Medical Care Collections Fund	3,847	4,389	4,580	191	4.4%
Subtotal, Medical Care + BRAVE with MCCF	**140,184**	**145,117**	**170,820**	**25,703**	**17.7%**
Medical and Prosthetic Research	989	994	1,000	6	0.6%
Electronic Health Care Record Modernization	874	1,322	3,495	2,173	164.5%
Information Technology Systems	7,629	7,591	7,293	(298)	-3.9%
Board of Veterans' Appeals	276	277	277	(0)	0.0%
General Operating Expenses, Veterans Benefits Administration	5,638	5,325	5,280	(45)	-0.8%
National Cemetery Administration	480	480	497	17	3.5%
General Administration	499	468	473	5	1.1%
Construction, Major Projects	881	961	1,871	910	94.6%
Construction, Minor Projects	692	692	232	(460)	-66.5%
Grants for State Extended Care Facilities	171	171	171	-	0.0%
Grants for Construction of Veterans Cemeteries	60	60	60	-	0.0%
Office of Inspector General	296	296	296	-	0.0%
Loan Administration and Subsidy	320	320	280	(40)	-12.5%
DoD transfers to Joint Accounts (JALFHCC and JIF)	187	178	180	3	1.4%
TEF Contingency Reserve	0	9	-	(9)	-100.0%
Subtotal, Non-Medical Care	**18,992**	**19,142**	**21,405**	**2,263**	**11.8%**
Subtotal, All Funding Sources without MCCF	**155,329**	**159,871**	**187,645**	**27,774**	**17.4%**
Subtotal, All Funding Sources (with MCCF)	**159,176**	**164,260**	**192,225**	**27,965**	**17.0%**
Recurring Expenses Transformational Fund (RETF)	**676**	**320**	**900**	**580**	**181.5%**
Total, All Funding Sources (with MCCF and RETF)	**159,852**	**164,579**	**193,125**	**28,546**	**17.3%**

VA Staffing

The 2026 budget request supports 455,874 FTE (from all funding sources), a decrease of 2,964 from the 2025 enacted level. Most of the decrease, 2,042 FTE, is in the Veterans Benefits Administration (VBA). The 2026 budget assumes there will be no pay increase for civilian employees in calendar year 2026.

Full-Time Equivalent Employees (FTE)

Accounts All funding sources	2024 Enacted	2025 Enacted with Transfers	2026 Request	Change 2026 vs. 2025 #	 %
Medical Services	304,066	302,474	302,474	-	0.0%
Medical Support & Compliance	67,674	67,003	67,003	-	0.0%
Medical Facilities	27,487	26,523	26,523	-	0.0%
Subtotal, Medical Care	399,227	396,000	396,000	-	0.0%
DoD-VA Health Care Sharing Incentive Fund	29	25	25	-	0.0%
Joint DoD/VA Demonstration Fund	2,536	2,593	2,593	-	0.0%
Medical Research	3,796	3,871	3,778	(93)	-2.4%
Canteen Service	2,100	2,100	2,100	-	0.0%
Subtotal Veterans Health Administration FTE	**407,688**	**404,589**	**404,496**	**(93)**	**0.0%**
Electronic Health Record Modernization	200	313	313	-	0.0%
Information Technology	8,024	7,922	6,992	(930)	-11.7%
Board of Veterans Appeals	1,368	1,405	1,320	(85)	-6.0%
Veterans Benefits Administration	33,178	33,443	31,401	(2,042)	-6.1%
National Cemetery Administration	2,306	2,317	2,355	38	1.6%
General Administration	3,165	3,459	3,703	244	7.1%
Inspector General	1,126	1,170	1,070	(100)	-8.5%
Franchise Fund	2,208	2,685	2,685	-	0.0%
Supply Fund	1,128	1,535	1,539	4	0.3%
Total FTE	**460,391**	**458,838**	**455,874**	**(2,964)**	**-0.6%**

Includes FTE funded by the TEF.

Secretarial Vision

The 2026 budget request for the VA represents President Trump's strong commitment to ensuring Veterans, their families, caregivers, and survivors receive the care and benefits they have earned.

This budget request puts Veterans first. Too often in the past, VA wasted taxpayer dollars on non-mission-critical programs. Those days are over. Today at VA, the mission is the Veteran. This budget will enable the Department to improve health care and benefits for VA beneficiaries, increase productivity, eliminate waste and bureaucracy. It provides resources to care for our most vulnerable Veterans, those experiencing homelessness or at-risk of suicide. This request also enables VA to modernize its aging facilities and systems, allowing the Department to provide world class care to those who have put their lives on the line for our country. And finally, this budget will provide the health care choices Veterans were promised under the MISSION Act.

At his inauguration in January, President Trump said, "… our country was forged and built by the generations of patriots who gave everything they had for our rights and for our freedom." The 2026 budget request honors those patriots by supporting historic reforms to refocus the Department on its core mission: providing the best possible care and services to Veterans, families, caregivers, and survivors. This budget includes key investments to:

<u>Deliver quality, timely and convenient access to care and benefits for every eligible Veteran, family member, caregiver, and survivor</u>

Job #1 at VA is making sure Veterans are getting the benefits and health care they have earned. This budget increases medical care funding by $24.4 billion (+17.3%) from the 2025 enacted level (base discretionary, TEF, and PACT section 707 facilities funds combined) for health care services tailored to Veterans' needs. We are going to provide Veterans with quality health care choices they have earned by streamlining access to community care providers while maintaining and improving VA's direct health care capabilities. Veterans who qualify for access to care with local community providers will be empowered to make the choice to see them rather than being forced to drive unreasonable distances to access the nearest VA medical facility. The budget includes $1.5 billion in medical funding to improve access for mental health residential rehabilitation treatment programs. The budget request also provides robust support for rural Veterans and sustains health care for women Veterans.

<u>End Veteran homelessness</u>

This budget includes $1.1 billion to support President Trump's commitment to end Veteran homelessness through the Bridging Rental Assistance for Veteran Empowerment (BRAVE) program. This new funding and authority would empower VA with responsibility for programs and financial support helping homeless and at-risk Veterans with rental assistance and initiate an innovation authority to pilot efforts to enhance the services and living arrangement options available to different cohorts of Veterans to improve their outcomes. It would augment VA's existing case management and support services to help Veterans regain self-sufficiency. Additionally, the budget includes $3.5 billion (+$251 million, +8% from 2025) for continued support to Veterans Health Administration homeless programs, including permanent housing support services, transitional housing, and Supportive Services for Veteran Families (SSVF).

Prevent Veteran suicide by reaching vulnerable Veterans and bringing them into VA

Too often, we lose Veterans who have no contact with VA but might have benefitted from VA services. The 2026 budget request includes $613 million (+$30.7 million, +5% from 2025) for suicide prevention outreach to ensure VA is reaching as many Veterans as it can. This funding will support the Veterans Crisis Line (VCL), extension of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant program, and various other suicide prevention initiatives.

Accelerate Electronic Health Record Modernization (EHRM) implementation

VA's accelerated rollout of the Federal Electronic Health Record system is a top priority for this Administration. The 2026 budget request includes $3.5 billion (+$2.2 billion, +164% from 2025) for EHRM. This effort is vital in moving the Department from a decades-old legacy system to a modern one that is interoperable with the DoD and other federal partners, as well as participating community care providers. It will allow clinicians to easily access a Veteran's full medical history anywhere they seek care.

Modernize VA systems and infrastructure

VA has over 1,000 distinct Information Technology (IT) systems, including many legacy systems, some of which are decades old and outdated. The budget protects VA's core-mission systems that deliver health care, benefits, and memorial affairs services to America's veterans. It also reduces spending on duplicative legacy systems and pauses procurement of new systems until VA can conduct a full review of them. The 2026 budget provides $7.3 billion (-$298 million, -4% compared to 2025, base discretionary and TEF combined) for IT investments.

Delivering benefits to Veterans

The budget provides $5.2 billion (-$19 million, 0% from 2025 base discretionary and TEF combined) to support delivery of benefits at the VBA. This funding combined with the efforts to reduce waste and unnecessary overhead will support VA's goal to achieve a record reduction in the disability compensation benefits claims backlog by the end of December 2025 and to develop and implement an automation plan for the disability claims process by July 4, 2026.

Honoring the Final Salute

The request includes $497 million (+$17 million, +4% from 2025) for National Cemetery Administration (NCA) operations and $60 million (no change from 2025) in grants for states, counties, territories, and tribal organizations for the establishment, expansion, improvement, or operations and maintenance of Veterans cemeteries.

Legislative Proposals

Advancing Veterans' Services and Modernizing VA Authorities

Legislative proposals are described in detail in Volume 1 of the 2026 Budget Submission. The 2026 legislative proposals collectively reflect a comprehensive strategy to modernize and expand the Department's capacity to serve Veterans and their families. The proposals will enhance health care access and quality, improve benefits and financial protections for Veterans, modernize VA operations and oversight, strengthen cemeteries and memorial benefits.

Veterans Health Administration Medical Care and Support to Homeless Veterans

Discretionary and Mandatory Appropriations and Collections

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	2027 Advance Request
Discretionary				
Medical Services	69,018	69,129	57,120	59,858
Medical Community Care	30,342	22,555	34,000	38,700
Medical Support & Compliance	10,750	11,719	12,090	12,000
Medical Facilities	8,949	9,548	11,730	11,700
Subtotal, Medical Care Discretionary [1/2/3/]	**119,059**	**112,951**	**114,940**	**122,258**
Mandatory				
Medical Services	9,525	11,884	35,370	36,542
Medical Community Care	6,802	15,694	14,030	14,500
Medical Support & Compliance	850	-	400	700
Subtotal, Toxic Exposures Fund (TEF)	**17,177**	**27,578**	**49,800**	**51,742**
PACT Act Section 707 (Medical Facility Leases)	100	200	400	450
Subtotal, Mandatory (TEF & Section 707)	**17,277**	**27,778**	**50,200**	**52,192**
Total Medical Care (Disc & Mandatory)	**136,336**	**140,729**	**165,140**	**174,450**
Medical Care Collections Fund (MCCF) [4/]	**3,847**	**4,389**	**4,580**	**4,753**
Bridging Rental Assistance for Veteran Empowerment (BRAVE)	**-**	**-**	**1,100**	**-**
Total Medical Care with MCCF and BRAVE	**140,183**	**145,117**	**170,820**	**179,203**

1. Includes only non-emergency discretionary appropriations provided in annual Appropriations Acts.
2. 2025 Enacted is post-transfer among VA accounts but is prior to transfers to the joint VA-DoD health care accounts.
3. 2026 Request shows proposed cancellations & transfers among VA accounts but prior to transfers to joint VA-DoD accounts.
4. MCCF is prior to transfer to the Joint VA-DoD Medical Facility Demonstration Fund.

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfer	2026 Request	2027 Advance Request
Medical Services	222,349	236,074	120,858	114,840
Medical Support & Compliance	60,828	64,337	64,440	62,562
Medical Facilities	27,487	26,523	26,523	26,523
Toxic Exposures Fund	88,563	69,066	184,179	192,075
Total Medical Care FTE	**399,227**	**396,000**	**396,000**	**396,000**

*Medical Services and Medical Support and Compliance includes Choice Sec 801 FTE in 2024 and 2025.

In total, the Medical Care funding request for discretionary and mandatory appropriations, combined, is $165.1 billion in 2026, an increase of $24.4 billion (17.3%) above 2025 Enacted with Transfers. The 2027 Medical Care funding request for discretionary and mandatory appropriations, combined, is $174.5 billion, an increase of $9.3 billion (5.6%) above the 2026 request.

In 2026, the budget requests discretionary appropriations of $114.9 billion for VA Medical Care, reflecting a proposed cancelation of $16.5 billion of the $131.4 billion enacted as 2026 advance appropriations in the Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4). For 2027, the budget requests $122.3 billion in discretionary advance appropriations for VA Medical Care. The budget also requests mandatory appropriations in the TEF to ensure that there is sufficient funding available to cover costs associated with providing health care and benefits to Veterans exposed to environmental hazards. In 2026, the budget requests $49.8 billion in TEF funding for medical care, and in addition, includes a 2027 advance appropriation TEF request of $51.7 billion for medical care. The budget includes $400 million for 2026 and $450 million for 2027 which was appropriated in section 707 of the PACT Act (P.L. 117-168) for major medical facility leases. Combined, the budget includes mandatory funding of $50.2 billion in 2026 and $52.2 billion in 2027 for VA Medical Care.

Appropriations for Medical Care

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	Change 2026 vs. 2025 $	Change 2026 vs. 2025 %
Discretionary Funding					
Medical Services	69,018	69,129	57,120	(12,009)	-17.4%
Medical Community Care	30,342	22,555	34,000	11,445	50.7%
Medical Support and Compliance	10,750	11,719	12,090	371	3.2%
Medical Facilities	8,949	9,548	11,730	2,182	22.9%
Subtotal, Medical Care Discretionary	**119,059**	**112,951**	**114,940**	**1,989**	**1.8%**
Mandatory Funding					
Medical Services	9,525	11,884	35,370	23,486	197.6%
Medical Community Care	6,802	15,694	14,030	(1,664)	-10.6%
Medical Support and Compliance	850	-	400	400	-
Subtotal, Toxic Exposures Fund (TEF)	**17,177**	**27,578**	**49,800**	**22,222**	**80.6%**
Medical Facilities, PACT Act Section 707	100	200	400	200	100.0%
Subtotal, PACT	**100**	**200**	**400**	**200**	**100.0%**
Total Mandatory Funding	**17,277**	**27,778**	**50,200**	**22,422**	**80.7%**
Combined funds, Discretionary and Mandatory					
Medical Services	78,543	81,013	92,490	11,477	14.2%
Medical Community Care	37,144	38,249	48,030	9,781	25.6%
Medical Support and Compliance	11,600	11,719	12,490	771	6.6%
Medical Facilities	9,049	9,748	12,130	2,382	24.4%
Total, Discretionary and Mandatory	**136,336**	**140,729**	**165,140**	**24,411**	**17.3%**

VHA Depends on Multiple Funding Sources

Multiple Funding Sources: VA Medical Care depends on multiple funding sources each year. The annual discretionary appropriation and other discretionary funding (primarily medical care collections) account for approximately 70% of estimated obligations in 2026, while the TEF and other mandatory funding provided by the PACT Act (primarily for medical facility leases) account for the remaining 30%. The 2026 budget describes planned obligations against all sources of funding. The 2026 medical care estimated total obligations level is $171.2 billion, and the 2027 medical care estimated total obligations level is $179.1 billion.

Funding Source, Total Obligations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	2027 Advance Request
Discretionary	121,804	122,187	120,544	126,458
American Rescue Plan	0	-	-	-
Toxic Exposures Fund	17,353	31,262	49,800	51,742
PACT Leases (Sec 705 & 707)	99	534	886	855
All other (Choice, others)	9	321	-	-
Total, Obligations by Funding Source	**139,267**	**154,305**	**171,229**	**179,055**

Carryover: Congress recognizes the complexities of estimating medical funding needs several years into the future. The annual budget request is for a single amount by appropriation account, but Congress provides VA with certain flexibilities to carry over funds from one year to the next to help smooth out funding and provide additional funding flexibility if needed. The 2026 budget assumes minimal carryover of discretionary funding ($1.6 billion, or 1% of 2025 estimated discretionary funds) from 2025 into 2026 to address requirements in 2026, although actual carryover into 2026 may change based on final execution. In addition, the 2026 budget assumes carryover of funding appropriated by the PACT Act for major medical facility and enhanced use leases. By plan, these leases can take several years to execute and thus a certain amount of the PACT Act lease funds show as carryover from year to year.

Expected Annual Unobligated Balance at Year End (Carryover)

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	2027 Advance Request
Discretionary	6,756	1,572	90	90
American Rescue Plan	20	20	20	20
Toxic Exposures Fund	3,684	-	-	-
PACT Leases (Sec 705 & 707)	2,089	1,754	1,269	864
All other (Choice, others)	321	-	-	-
Total, Unobligated Balance at Year End	**12,870**	**3,346**	**1,378**	**973**

Obligations from all Sources: These multiple funding sources managed across fiscal years enable VA to continue to deliver health care to all Veterans, as shown in the table below for obligations by account category.

Total Medical Care Obligations by Account Category

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	2027 Advance Request
Medical Services	82,367	89,459	97,048	99,832
Medical Community Care	36,555	41,978	48,842	54,037
Medical Support and Compliances	11,433	12,506	12,505	12,699
Medical Facilities	8,912	10,362	12,834	12,487
Total, Obligations by Account	**139,267**	**154,305**	**171,229**	**179,055**
% change, year over year	10%	11%	11%	5%

Modeling Health Care Needs

VA uses three actuarial models to support formulation of most of the VA health care budget, to conduct strategic and capital planning, and to assess the impact of potential policies and changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Model, and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model.

The EHCPM, which was first developed in 1998, is a sophisticated health care demand projection model that uses actuarial methods and approaches to project Veteran demand for VA health care. The EHCPM projects enrollment, utilization, and expenditures for the enrolled Veteran population in more than 140 categories of health care services 20 years into the future. In projecting future Veteran demand for VA health care, the EHCPM accounts for the unique characteristics of the Veteran population and the VA health care system, as well as environmental factors that impact Veteran enrollment and use of VA health care services.

The 2024 EHCPM (Base Year 2023) was used to build the 2026 and 2027 Medical Care budget request. The 2024 EHCPM was updated using workload through 2023 to reflect information on the enrollee population and their utilization of VHA health care. In addition, the 2024 EHCPM includes a calibration to available 2024 workload and cost data. The 2024 EHCPM supports approximately 86% of the VA Medical Care budget.

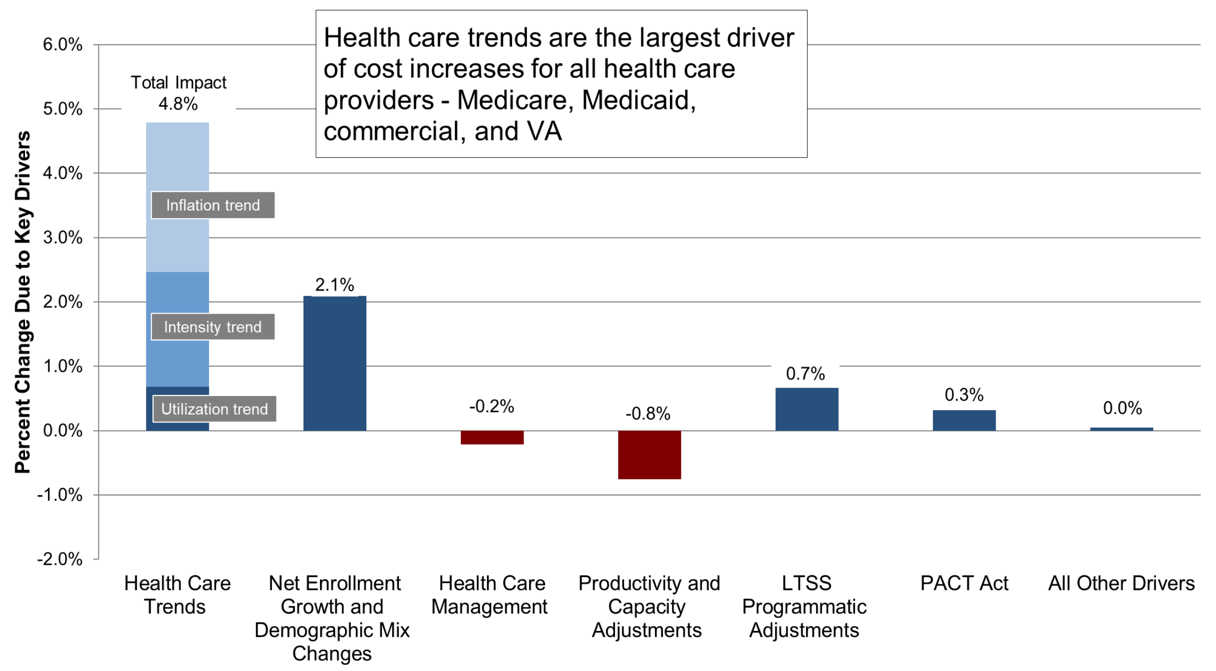
In projecting future Veteran demand for VA health care, the EHCPM accounts for the unique characteristics of the Veteran population and the VA health care system, as well as environmental factors that impact Veteran enrollment and use of VA health care services. Historically, growth in cost requirements to provide care to enrolled Veterans is primarily driven by health care trends, the most significant of which is medical inflation. Health care trends are key drivers of annual cost increases for all health care providers – Medicare, Medicaid, commercial providers, and the VA health care system. Health care trends increase VA's cost of care independent of any growth in enrollment or demographic mix changes. Enrollment dynamics contribute to a portion of the cost growth; however, their impact varies significantly by the type of health care service. An assumption that VA's level of management of health care delivery will improve over time reduces the cost of providing care to enrollees.

The PACT Act, signed August 2022, expanded benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well as new groups of Vietnam Veterans who were exposed to Agent Orange. The 2024 EHCPM projects enrollment and workload changes with increased enrollment eligibility timelines and expanded eligibility based on conditions presumed to be associated with hazardous exposures. The PACT Act affects VHA enrollment by expanding eligibility for selected Veterans and by either introducing or increasing service-connected ratings for some Veterans, which increase the enrollment priority level for which the Veteran is eligible.

Historical growth for many long-term services and supports (LTSS) programs has been accelerating in the past few fiscal years and has significantly exceeded growth that would be expected based on demographic changes and other factors that would typically be captured in the EHCPM, particularly for Home and Community Based Services. The 2024 EHCPM includes increased projected workload of certain services beyond demographic trends to continue through the budget years.

The chart below quantifies the key drivers of the projected increase in cost requirements for 2025 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and health care management and their impact on the resources required to provide health care to enrolled Veterans as well as PACT Act, LTSS programmatic adjustments, and all other drivers are discussed in detail in the Actuarial Models chapter in Volume II.

Key Drivers of Projected Cost Change, 2025 – 2026



- Scenario BRE3 Modeled Services
- The projections do not include requirements for several activities / programs that are not projected by the VA EHCPM, including administration cost for the Community Care Network contract, non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the Homeless program.

Veteran Patient Workload

VA administers its comprehensive medical benefits package through a patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are available to all enrolled Veterans. VA's goal is to ensure enrolled Veterans receive the finest quality health care, regardless of the treatment program or the location. Enrollment in the VA health care system provides Veterans with the assurance that comprehensive health care services will be available when and where they are needed.

The budget expands health care services for Veterans while bolstering an integrated system of care that both strengthens services within VA and improves VA and Veterans' relationships with community providers. The 2026 request supports the treatment of an estimated 7.7 million patients, a 2.2% increase above the 2025 estimate, and 162.6 million outpatient visits, an increase of 5.5% above the 2025 estimate.

Patients, Enrollees, Treatments and Visits

	2024 Enacted	2025 Enacted	2026 Request	2027 Advance Request
Number of Unique Patients	7,326,761	7,534,168	7,701,915	7,849,623
Number of Unique Veterans Enrolled in VA Health Care	9,152,504	9,204,479	9,232,629	9,261,360
Number of Inpatient -Treated	1,210,025	1,254,316	1,303,860	1,356,152
Number of Outpatient Visits	145,176,000	154,023,000	162,566,000	170,624,000

Medical Care Facilities

As of September 30, 2024, VHA operates a portfolio of approximately 5,717 owned buildings with a total of 153.7 million square feet of space on 15,540 acres of land. The portfolio also includes 1,689 leases with a total of 24.4 million square feet of space. The 2026 request supports the operation and maintenance of these VA hospitals, Community-Based Outpatient Clinics (CBOCs), community living centers, mental health residential rehabilitation treatment facilities (domiciliary), Vet Centers, other sites for outpatient services, and the health care corporate offices.

Installations	2024 Enacted	2025 Enacted	2026 Request	2027 Advance Request
Veterans Integrated Service Networks	**18**	**18**	**18**	**18**
VA Medical Centers (VAMC), Total	**170**	**170**	**170**	**170**
Included in total VAMC:				
VA Hospitals	*142*	*142*	*142*	*142*
Community Living Centers (CLC)	*135*	*136*	*137*	*137*
Mental Health Residential	*123*	*126*	*129*	*131*
VA Medical Center-Based Outpatient	*170*	*170*	*170*	*170*
Health Care Centers (HCC)	**12**	**12**	**12**	**12**
Community-Based Outpatient Clinics	**750**	**755**	**755**	**755**
Included in total CBOC:				
Multi-Specialty CBOC	326	327	327	327
Primary Care CBOC	424	428	428	428
Other Outpatient Service (OOS) Sites	**433**	**433**	**433**	**433**
Included in total OOS:				
Dialysis Centers	*71*	*71*	*71*	*71*
Community Resource and Referral	*33*	*33*	*33*	*33*
Vet Centers	**302**	**302**	**303**	**303**
Mobile Vet Centers	**85**	**85**	**85**	**85**
Vet Center Outstations	**22**	**24**	**27**	**27**

1. Reflects historical data as of September 30, 2024. Data source: VHA site tracking system (VAST).

Medical Care Areas of Focus

The following table provides obligations in areas of focus for VA medical care. Summary explanatory descriptions for selected programs are also provided.

Veteran Medical Care: Key Focus Areas
Total Obligations by Program

Programs ($ in millions)	2024 Enacted	2025 Enacted	2026 Request	2027 Advance Request
Expansion of Mental Health Residential Treatment Programs (MH RRTP)	-	-	1,500	1,500
Pain and Opioid Management / Jason's Law Subtitle A	217	201	232	236
Substance Use Disorder	152	186	232	237
Mental Health	15,690	16,732	18,886	19,530
Suicide Prevention Outreach Programs	560	580	698	713
Rural Health Initiative	315	302	342	349
Veterans Homelessness Programs	3,231	3,231	3,459	3,802
Women Veterans Health Care:				
Program Office & Initiative Budget	98	178	253	258
Women Veterans-Specific Care	986	1,146	1,323	1,530
All Care	12,999	15,112	17,642	20,603
Connected Care	332	422	462	471
Non-Recurring Maintenance (NRM)	2,346	2,627	4,841	3,040

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

VA will expedite access to MH RRTP to enhance access to lifesaving residential treatment through new access standards and improved operational efficiency. This goal is to ensure Veterans have timely access to critical mental health and substance use disorder (SUD) treatment, whether in VA facilities or in the community. The 2026 budget includes $1.5 billion in Medical Community Care funding for MH RRTP care in the community, resulting in higher total 2026 budget request for Medical Community Care. At the same time, VA will increase its internal capacity to deliver high quality residential care, which is supported by the 2026 SUD budget request, which will support the hiring of staff and opening of new beds to allow for efficient utilization of and expedited access to existing VA residential treatment programs. The 2026 SUD budget request also supports full implementation of a regional centralized admissions screening process for MH RRTP to improve overall operational efficiency and the quality of screening procedures. These investments will help get Veterans the care they need when they need it and ultimately save lives.

Pain and Opioid Management Program

The 2026 budget includes a significant investment to address the disproportionate impacts from opioid-related adverse events faced by Veterans. The budget includes $231.5 million for the Pain and Opioid Management Program in support of Subtitle A (Opioid Therapy and Pain Management) as enacted in the Jason Simcakoski Memorial and Promise Act (Jason's Law). Providing Veterans access to pain management services within VA is crucial as pain is the most frequently identified risk factor for Veteran suicide and remains predictive of suicide even after accounting for psychiatric comorbidities. The budget reflects the critical need for increased funding to ensure that VHA can continue to provide comprehensive pain management services to and supports to Veterans, addressing both increasing demand and expanding service reach.

Substance Use Disorder Initiative

The 2026 budget supports efforts to ensure Veterans have access to the full range of SUD treatment from the least intensive services, such as peer specialists and mutual support, to the most intensive services such as inpatient withdrawal management. This budget also supports MH RRTP, which provide a significant portion of intensive services for Veterans with substance use disorders and co-occurring conditions with specialized programs for the treatment of SUD and a requirement that all MH RRTPs address co-occurring SUD. The budget request of $232.3 million supports key efforts in the Administration's State of Drug Policy Priorities, including efforts to reduce the number of overdose fatalities with a focus on fentanyl; increase evidence-based treatment including medications for opioid use disorder; strength peer recovery support; expand access to naloxone; increase the availability of drug test strips; and raise awareness about overdose prevention through educational campaigns and evidence-based prevention programs. Combined, the MH RRTP expansion and SUD budget requests support increased access to MH RRTP care in VA or, when needed, in the community, consistent with timeframes expected by Veterans and their families. VA anticipates opening three MH RRTP programs in 2026 and two in 2027 to provide Veterans with more access to comprehensive treatment and rehabilitation services.

Mental Health and Preventing Veteran Suicide

Funding for mental health treatment, including suicide prevention treatment, is estimated to be $18.9 billion in 2026, and the budget includes $697.8 million for suicide prevention outreach programs. Suicide is a complex issue with no single cause or solution. Addressing suicide requires a comprehensive approach that focuses on community and clinical interventions beyond individual care that focuses exclusively on mental health. Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. Some Veterans may not receive any health care services from VA, which highlights VA alone cannot end Veteran suicide. This requires a nationwide effort.

The budget proposes to extend and expand the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) to enable an anticipated 125 grantees in 45 states, the District of Columbia, American Samoa, Guam, and Puerto Rico to provide suicide prevention outreach and education across the nation to targeted at-risk populations with a projection of serving 14,000 eligible individuals and their family members with direct services.

In alignment with National Strategy for Preventing Veteran Suicide, SSG Fox SPGP assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts. VHA's National Strategy for Preventing Veteran Suicide provides a framework for coordinating lanes of effort across the nation and ensures coordination of efforts with other federal agencies, state and local governments, health care systems, academic affiliates, and community organizations with the shared goal to reduce suicide rates among Veterans, and all U.S. citizens. In this mission, VHA's untiring and relentless efforts to engage needs, innovate strategies, and serve the welfare of others will continue to serve as a model, and central foundation for the nation as to how to best address suicide as a national public health issue.

Rural Health

The budget includes robust investment of $342.0 million in funding to support the VHA Office of Rural Health, which conducts, coordinates, promotes, and disseminates research on issues that affect Veterans who reside in rural communities. The funding also supports operation of five Veterans Rural Health Resource Centers that identify, formulate, and develop best practices to enhance the delivery of health care to Veterans living in rural areas. These efforts support rural Veterans, who receive more of their health care from VHA. Of 4.4 million rural Veterans, 61% are enrolled in VHA, compared to 41% of 13.8 million urban Veterans.

Homeless Programs

The VA budget request of $3.5 billion for Veterans Homeless Programs is a decisive step forward in fulfilling the President's commitment to end and prevent Veteran homelessness. It reflects best practices informed by years of measurable outcomes and empowers VA to meet today's urgent needs with proven, community-based solutions. By sustaining over 850 grantee partnerships nationwide, supporting more than 11,000 transitional beds, serving Veterans in every state, and integrating housing with health, legal, and employment services, this budget ensures no Veteran is left behind. Additionally, VA efforts to end Veteran homeless will include a new appropriation account, the Bridging Rental Assistance for Veteran Empowerment (BRAVE) program, described below.

The budget strengthens the full continuum of VA's homeless response across critical operational pillars: effective outreach, immediate interim housing, permanent housing, clinical treatment and legal services, employment and long-term housing stability, upstream prevention, and ongoing optimization, transparency, and accountability. Importantly, some services are inclusive of Veteran families, ensuring that spouses, children, and other dependents are supported as full participants in the housing journey.

The request reflects both long-standing commitments and evolving realities—ensuring that VA is prepared to address increasing demand in homelessness assistance resources, reach more unsheltered and vulnerable Veterans, and sustain the remarkable 52% decline in Veteran homelessness over the past 15 years. Notably, Veterans are the only homeless subpopulation that has achieved such a significant reduction, and VA will continue its efforts to prevent and end Veteran homelessness.

Women's Health

The budget requests $229.7 million for women's health programs to proactively and strategically expand women's specific services for the fastest growing cohort of users of VA health care. The women Veteran population is the fastest growing demographic within the VA and is anticipated to grow from 800,000 women Veterans enrolled in VA health care in 2020 to over 1.2 million by 2030. The budget supports implementation of high-quality, comprehensive women's health care at all sites of care across VA to provide services to meet the unique needs of women Veterans. This includes funding support for frontline women's health providers and staff, clinical equipment needs, hands-on training in clinical skills, and maternity care coordination.

Access to Care

Since the enactment of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 15-182), VA has significantly expanded Veteran access to health care. The Veterans Community Care Program, launched on June 6, 2019, has been a cornerstone of this effort. As of March 2025, VHA have provided over 39.6 million community care referrals to more than 5.4 million Veterans.

In addition, the enactment of Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117-168), enabled VA to expand its reach and provide health care to even more Veterans. Since the PACT Act was signed into law in August 2022, nearly 900,000 Veterans have enrolled in VA health care. The combined results of empowering Veterans to choose providers authorized by the MISSION Act, in conjunction with the expanded enrollment following enactment of the PACT Act, has resulted in VA delivering 78.8 million appointments in VA facilities along with 53.6 million appointments in the community since August of 2022. This unprecedented enrollment and care delivery growth has resulted in the greatest number of Veterans receiving the world-class health experiences they have earned.

Quality of Care

VA is a trusted Veteran health care provider, furnishing high-quality care that surpasses our private sector counterparts. Veterans notice the difference. In 2024, VA internal survey data showed an unprecedented trust rate of 92% in the Department's health service delivery, surpassing our private sector counterparts. Nearly 70% of VA hospitals have received 4 or 5 stars in the Overall Hospital Quality Star Ratings by the Centers for Medicare and Medicaid Services, compared to 41% of non-VA hospitals. This achievement highlights VHA's opportunity to further enhance care for Veterans.

Bridging Rental Assistance for Veteran Empowerment (BRAVE)

As part of the Administration's effort to end veteran homelessness, the Bridging Rental Assistance for Veteran Empowerment (BRAVE) proposal seeks legislative authority to oversee and administer rental assistance to enable VA to oversee the full spectrum of needed supports for veterans experiencing or at-risk of homelessness, including activities to transition from the current Housing and Urban Development - VA Supportive Housing program. BRAVE will also include new pilot authorities for VA to initiate innovative activities to improve the prevention, support, treatment, long-term care or return to independence for veterans and their families. The Budget requests $1.1 billion in FY 2026 in discretionary funding, with up to $100 million available for pilot programs. BRAVE is a separate appropriation that will be administered by VHA but is distinct from the funding within the medical care accounts.

Veterans Health Administration Medical and Prosthetic Research

Appropriation and Other Resources

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Medical and Prosthetic Research Appropriation	943	935	943
Toxic Exposures Fund (Mandatory)	46	59	57
Subtotal Intramural Research Total	**989**	**994**	**1,000**
VERA Research Support (Medical Care Support)[1]	836	788	850
Extramural Funding (Other Federal and Non-Federal Funds)	511	497	497
Reimbursements	56	82	82
Total Budgetary Resources	**2,393**	**2,360**	**2,429**

1. Through the Veterans Equitable Resource Allocation (VERA), Research Support includes funding from Medical Services, Medical Support and Compliance, and Medical Facilities Appropriations to support Research.

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Medical and Prosthetic Research Appropriation	3,703	3,707	3,565
Toxic Exposures Fund (Mandatory)	93	164	213
Total FTE	**3,796**	**3,871**	**3,778**

Includes Direct and Reimbursable FTE.

The 2026 request for the Medical and Prosthetic Research appropriation is $943 million, an increase of $8 million from 2025. Additionally, VA requests $57 million in the Toxic Exposures Fund, a decrease of $2 million or 3% below 2025 level, to support medical and other research relating to exposure to environmental hazards. The requested funding level invests in areas where VA Research, a critical component of VHA's function and a contributor to the Nation's knowledge about disease and disability, can make the largest impact of scientific discovery to improve Veterans' health. This request will enable the Office of Research and Development (ORD) to fund approximately 3,094 intramural research projects (an increase of 106 projects over the 2025 estimate) and support 3,778 FTE.

VA Research uses a combination of VA appropriated funds and other resources to deliver on our promise to improve Veterans' health through medical research which includes intramural research, Veterans Equitable Resource Allocation (VERA) support, extramural funding, and reimbursable resources. In 2026, grants from other federal organizations, such as the National Institutes of

Health, DoD, and the Centers for Disease Control and Prevention, combined with funding from other non-federal sources, is estimated to total $497 million.

Request Highlights

VA Research is uniquely positioned to address the health care needs of Veterans through biomedical and health systems research, leveraging its capabilities and resources as part of the largest integration health care system in the country. The requested funding focuses on areas where Veteran needs and VA research capabilities align to improve Veteran outcomes, while also balancing resource needs across the administration.

Key investments that support the VA Secretary's priorities include:

- **Military Environmental Exposure (MEE)**
  Expand translational MEE Research involving laboratory, epidemiology, and medical investigations. By using Scientific MEE experts, including core scientific capabilities in data science, biospecimen collection and use, and exposure assessment, ORD will improve the quality of first-time research proposals to improve MEE Research. Rare cancers will continue to be a focus of MEE research.

  Additionally, and in accordance with Section 501 of the PACT Act, ORD will continue efforts with the Toxic Exposure Research Work Group (TERWG). The TERWG consists of members from VA, DoD, Department of Health and Human Services, and other federal partners involved in research activities regarding the health consequences of toxic exposures experienced during active military, naval, air, or space service.

- **Suicide Prevention and Mental Health**
  Supports mental health and suicide prevention research, including the Commander John Scott Hannon Mental Health Care Improvement Act (Hannon Act). Specific funding priorities in the 2026 request include an enterprise-level effort for a precision health approach toward suicide prevention that is modeled after other ORD activities. The goal is to provide a VA-wide platform that allows for phenotyping suicide risk, testing interactions between phenotypes and interventions, and rolling out clinical trials to test precision medicine hypotheses derived from observational study. Data collected could be augmented with survey and real-time assessments allowing for surveillance of suicidality and establish a central resource that responds to Veterans in need.

- **Ending Veteran Homelessness**
  Veterans experiencing homelessness have worse health outcomes, including premature mortality, when compared to their housed peers. In addition to having complex social needs, homeless, and homeless-experienced Veterans generally have complex high rates of chronic medical illness, psychiatric problems, and substance-use disorders. To meet the President's promise to end homelessness, ORD investigators will continue to partner with VHA's Homeless Programs Office, the National Center for Homeless Veterans, Office of Rural Health, VA's Quality Enhancement Research Initiative, and other federal agencies. ORD may

also support planning and evaluating innovative pilots to be funded through the Bridging Rental Assistance for Veteran Empowerment proposal. Expected outcomes will build knowledge on tools and strategies for preventing homelessness; promote housing retention and economic security for current homeless-experienced Veterans; and improve medical and mental health care for homeless and homeless-experienced Veterans.

- **Investing in Artificial Intelligence (AI) in Research**
  AI supports the real-world impact of VA research by providing a mechanism for directly translating new evidence into practice and pilot testing novel tools and solutions to revolutionize clinical care. ORD is actively involved in leading groundbreaking, interdisciplinary research in AI through novel discoveries in data science, implementation science, systems science, and science of Veteran and other stakeholder engagement to create, validate, and apply computable biomedical knowledge in real-world practice.

- **Psychedelic Assisted Treatment for Mental Health Conditions**
  VA is committed to safely exploring all avenues that promote the health of our Nation's Veterans.

- **Traumatic Brain Injury (TBI) Research**
  In accordance with requirements in the Hannon Act, Section 305, ORD will continue TBI research to improve the accuracy of diagnosing remote TBI, enhance chronic care of TBI and its complex comorbidities, and develop treatments for the longer-term consequences most relevant to Veterans. ORD continues to focus on developing objective tools and resources to improve the diagnosis and monitoring of brain health in Veterans who have sustained a TBI that can be integrated within the larger VA health care system. ORD will also focus on improving the medical, mental health, and rehabilitative needs of Veterans with a lifetime history of one or more TBIs.

Electronic Health Record Modernization

Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
EHR Contract	725	725	2,177
Infrastructure Support	356	356	660
Program Management	253	253	658
Total Appropriated	**1,334**	**1,334**	**3,495**
Rescission of prior year funding	(460)	(13)	-
Total Appropriations	**874**	**1,322**	**3,495**

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Total FTE	**200**	**313**	**313**

The budget request includes $3.495 billion for the Veterans Electronic Health Record (EHR), an increase of $2.173 billion (164%) relative to the 2025 enacted level. This request includes:

- **$2.177 billion for EHR Contract –** This funding level supports VA's Electronic Health Record Modernization Integration Office (EHRM-IO) sustainment and operations of 6 live sites and deployment of 13 additional sites expected to go-live in 2026 (19 total live sites). Site operations include post go-live support including but not limited to help desk, release management, end user training, veteran portal, and application management services. 2026 will require continued hosting of EHRM data with capacity increases to support the additional live sites and associated Veterans Integrated Services Networks (VISNs), as well as enterprise and site-based licensing and hardware renewals. Beyond sustaining live sites, EHRM-IO will begin implementations at 26 VA Medical Centers (VAMCs) with expected go-lives in 2027. This intensive timeline will support the program's goal of completing deployments at all sites as early as 2031.

- **$660 million for Infrastructure Readiness –** Funds will ensure that the planned 26 additional sites are prepared to receive the Federal EHR with increased interface development and sustainment, deployment of end user devices, critical testing, and security services such as forward deployed servers and joint security architecture maintenance. In addition, as more sites go-live through 2026, continued data syndication, cloud services, identity and access management, integration support, and healthcare technology management will be required across the enterprise to allow a smooth transition.

- **$658 million for Project Management Office (PMO)** – The funding will support personnel supporting the increased number of deployments planned for 2026 and effective change management as the Federal EHR system is implemented throughout the nation. The request also supports hiring experts to oversee and manage the technical, functional, and project-based work necessary for ongoing support and expansion of the Federal EHR. Additionally, EHRM will provide support for the Federal Electronic Health Record Modernization (FEHRM) program office. The funding level includes federal staff pay, contract support staff, funding for travel, training, equipment, and supplies.

Office of Information and Technology

Discretionary and Mandatory Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Discretionary			
IT Systems	6,401	6,401	5,908
2024 Rescission and 2025 Transfer	(15)	(174)	-
Subtotal, Discretionary Appropriation	**6,386**	**6,227**	**5,908**
Mandatory			
Toxic Exposures Fund (Mandatory)	1,243	1,364	1,385
Subtotal, Mandatory Appropriation	**1,243**	**1,364**	**1,385**
Total, Appropriation	**7,629**	**7,591**	**7,293**

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Direct and Reimbursable (Discretionary)	7,993	7,872	6,942
Toxic Exposures Fund (Mandatory)	31	50	50
Total FTE	**8,024**	**7,922**	**6,992**

For 2026, VA requests $7.3 billion to support enterprise-wide IT operations, modernization, and cybersecurity—reflecting a $298 million (−3.9%) decrease from 2025 enacted levels. This includes $5.9 billion in discretionary funding through the IT Systems appropriation, a decrease of $319 million (−5.1%). The request sustains essential IT operations while making targeted investments in high-impact areas such as modernization, cybersecurity, and artificial intelligence (AI).

The request also includes $1.4 billion in mandatory funding from the Toxic Exposures Fund (TEF), an increase of $21 million (1.5%) over 2025. TEF resources continue to fund mission-critical technology solutions that support PACT Act implementation, improving access to health care and benefits for Veterans exposed to toxic substances. Combined, these funding streams ensure VA can maintain a secure, modern, and resilient IT foundation to support the full lifecycle of Veteran services.

Smarter, Not Bigger: A Modern IT Budget for a Modern VA Mission

VA's 2026 request for IT reflects a fiscally responsible, performance-based investment strategy that prioritizes Veteran outcomes, mission delivery, and digital transformation. This request embodies a strategic shift—not toward a bigger IT budget, but a smarter, more agile one. Aligned with the Secretary's *Veterans First* vision, the 2026 request preserves core operations while still modernizing infrastructure readiness, cybersecurity, and AI, all within constrained fiscal limits.

Investing Smarter: Delivering Technology that Serves Veterans First

The 2026 IT budget reflects a focused strategy to modernize, protect, and deliver Veteran services through three mission-critical priorities: modernization, cybersecurity, and AI. These themes directly support the Secretary's *Veterans First* initiative by advancing digital solutions that increase access, improve outcomes, and ensure accountability across all Veteran-facing programs. Each dollar requested is tied to tangible performance outcomes and designed to maximize return on investment in a fiscally constrained environment.

Modernization is essential to delivering seamless, consistent care and benefits. VA's largest modernization efforts—Infrastructure Readiness Program (IRP) and Financial Management Business Transformation (FMBT)—are foundational to reliable service delivery. IRP ($277 million, +93.9%) targets the aging infrastructure that limits system performance, delays service to Veterans and increases long-term operational costs. FMBT ($135 million, +50.1%) accelerates the deployment of VA's integrated financial and acquisition system (iFAMS), ensuring VA can track every dollar, strengthen internal controls, and deliver faster, more transparent support to field operations. Without continued investment, VA risks losing ground on audit readiness, further straining IT systems that Veterans and employees rely on daily.

Cybersecurity is not optional—it's mission-critical. VA will invest $762 million (-11.7%) in cybersecurity, including $187 million (+107.7%) for Zero Trust Architecture (ZTA). This investment directly supports the Secretary's *Veterans First* strategy by protecting Veteran data and digital services from rising cyber threats while meeting mandatory compliance with OMB Memoranda M-21-31 and M-24-14. The alternative is clear: without ZTA, VA's interconnected systems remain vulnerable, and the risk of disruption to care delivery, benefits processing, and claims adjudication grows significantly.

Artificial Intelligence (AI) presents one of the most promising frontiers for improving the Veteran experience. The 2026 request includes $29 million (+130%) to scale mission-aligned AI use cases—like automating claims decisions, triaging digital interactions, and analyzing operational data. These investments reduce delays, improve accuracy, and relieve pressure on an already burdened workforce. VA's approach to AI insures a safe, secure, and trustworthy adoption.

These strategic investments form the backbone of VA's ability to deliver timely, secure, and high-quality services to Veterans. However, realizing their full impact requires more than just the right priorities—it requires the ability to fund and manage them effectively. As VA continues to modernize, longstanding limitations in funding structure now pose significant risks to execution, equity, and outcomes. Addressing these challenges begins with understanding how current funding streams create operational imbalance across the enterprise.

Appropriation Language: A Smarter Funding Structure for Smarter Technology

VA is not asking for more money—we're asking for smarter authority to use what we have. The 2026 request proposes removing the three statutory subaccounts (Development, Operations & Maintenance, and Pay & Associated Costs) from the IT Systems appropriation. These rigid categories restrict our ability to manage funding based on changing needs across the enterprise. Removing them will allow VA to shift resources quickly to where they're needed most—whether that's stopping a cyber threat, keeping a claims system online, or deploying new digital tools for Veterans. Congress will still see how every dollar is spent through execution plans, performance updates, and TBM-aligned reporting. This is about flexibility, not less accountability.

VA is also requesting a three-year funding window for IT. Right now, VA is forced to rush spending decisions at the end of the fiscal year or pause projects during Continuing Resolutions—both of which increase risk and cost. With three-year authority, we can better align IT funding to real project timelines, improve procurement, and reduce technical debt across aging systems. Without this change, critical modernization efforts—like cybersecurity upgrades, electronic health record support, and AI-driven claims processing—face unnecessary delays. Veterans deserve fast, reliable, and secure access to their benefits and care. These updates ensure taxpayer dollars go further and deliver what matters most: better outcomes for Veterans.

Board of Veterans' Appeals

Discretionary and Mandatory Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Board of Veterans' Appeals (Discretionary)	287	287	277
2024 Rescission and 2025 Transfer	(15)	(10)	-
Toxic Exposures Fund (Mandatory)	4	-	-
Total Budget Authority	**276**	**277**	**277**

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Total FTE	**1,368**	**1,405**	**1,320**

The Board requests $277.0 million for 2026 (no change from 2025 enacted with transfers), to support program operations. The majority of the Board's budget (93%) funds personnel costs to support 1,320 FTE, which are a combination of Veterans Law Judges (VLJ), decision writing attorneys, and administrative staff vital to sustaining a goal of adjudicating at least 118,000 appeals in 2026.

Thanks to investments from Congress, the Board recently completed a multiyear capacity building strategy where over 400 staff were hired in 2023 and 2024, the majority of which were decision drafting attorneys to address pending inventories and workload surges. The Board's staffing levels are sufficient to make meaningful improvements to the number of appeals pending and length of time Veterans await a decision. This is further evidenced by the number of appeals pending at the Board cresting at 216,224 in February of 2023, and since declining to 194,945 as of the end of April 2025, of which only 171,633 are Veteran, dependent, or Legacy appeals pending, and the remaining 23,312 are third-party (non-Veteran) appeals, mostly from attorneys and sub-contracted health care providers seeking higher reimbursement fees.

During 2024, the Board transitioned from adjudicating predominately older Legacy appeal system cases to adjudicating predominately Appeals Modernization Act (AMA) appeals filed since the new law went into effect in February 2019. While the persistently large inventory of pending Legacy appeals kept displacing newer AMA appeals, the Board was able to change that dynamic substantially during 2024 and 2025. Currently, more than 87% of all Board decisions are dedicated to AMA appeals and both Direct Docket and Evidence Docket appeal wait times are declining at a rapid pace. Also, grant rates are higher, and remand rates are much lower on AMA appeals than with the older Legacy Appeal system cases that dominated the Board's workload until recently.

When Congress passed the AMA, Legacy appeals still took over 8 years to fully resolve while fully resolved AMA appeals (meaning no remands) took less than 2 years. That gap will likely widen as pending AMA appeals continue to be adjudicated at such a high rate.

Veterans Benefits Administration

Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request	2027 Advance Request
General Operating Expenses (Discretionary)	3,899	3,899	3,879	NA
Rescission	(30)	-	-	NA
Toxic Exposures Fund (Mandatory)	1,769	1,426	1,401	NA
Subtotal, GOE and TEF	**5,638**	**5,325**	**5,280**	**NA**
Loan Administration and Subsidy (Discretionary)	320	320	280	NA
Mandatory Benefits				
Compensation and Pensions[1]	164,136	212,553	227,240	241,948
Insurance Benefits[2]	134	135	132	98
Readjustment Benefits[1]	9,424	18,264	20,372	20,058
Credit Reform Upward Reestimates and Subsidy[3]	1,637	5,405	348	NA
Veterans Housing Liquidating Account	(2)	(3)	(2)	NA
Subtotal, Mandatory Benefits[4]	**175,329**	**236,354**	**248,089**	**262,103**
Total, Mandatory and Discretionary	**181,287**	**241,999**	**253,649**	**262,103**

1 and 2. Includes advance and annual appropriations in years where amounts in addition to advance appropriations were requested; includes supplemental funding in 2024.
3. 2024 and 2025 include upward re-estimates. The 2026 request does not include re-estimates, which are calculated at the fiscal year end.
4. Does not include trust funds, proprietary receipts, or intragovernmental transactions.

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request	2027 Advance Request
General Operating Expenses	25,024	25,025	24,494	NA
Toxic Exposures Fund (Mandatory)	8,154	8,418	6,907	NA
Total FTE	**33,178**	**33,443**	**31,401**	**NA**

The VBA 2026 budget requests $5.3 billion in operational funding to provide Veterans, their dependents and survivors a variety of benefits and services. This includes $3.9 billion for discretionary VBA General Operating Expenses (GOE), which is $20 million (0.5%) below 2025; and $1.4 billion in mandatory Toxic Exposures Fund (TEF) funding, which is $25 million (1.7%) below 2025. With the combined GOE and TEF funding, VBA will deliver $248 billion in mandatory benefit payments and services to Veterans and other beneficiaries at an operating cost of about two cents for every dollar of benefits delivered. In addition, VBA requests $280 million for discretionary Loan Administration and subsidy appropriation, which is $40 million (12.5%) below 2025.

Key Discretionary Investments

***Rudisill v. McDonough* Court Decision ($7.1 million):** In addition to mandatory Readjustment Benefits costs, the Supreme Court decision in the Rudisill v. McDonough case that beneficiaries who earn educational benefits under the Montgomery GI Bill (MGIB) and the Post-9/11 GI Bill (PGIB) may access benefits under either program for a maximum of 48 months of benefits resulted in discretionary costs of $7.1 million in 2026. This includes $4.7 million in payroll to support overtime and 13 FTE, and $2.4 million in contracts.

Loan Administration and Subsidy Appropriation ($280.0 million): The 2026 request reflects a decrease of $40.0 million from 2025. Funding will support an increase in the Native American Direct Loan program appropriation for FTE, outreach efforts, and subsidy costs.

Discretionary Loan Administration and Subsidy Appropriation

Accounts ($ in thousands)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Housing Loan Program	316,742	316,742	266,737
Native American Direct Loan Program	2,719	2,719	5,845
Vocational Rehabilitation Loan Program	461	461	507
Loan Administration Subtotal	**319,922**	**319,922**	**273,089**
Native American Direct Loan Subsidy	-	-	6,865
Vocational Rehabilitation Loan Subsidy	78	78	45
Discretionary Subsidy Subtotal	**78**	**78**	**6,911**
Total Discretionary Credit	**320,000**	**320,000**	**280,000**

Key TEF Investments

Toxic Exposures Fund: VBA request includes $1.4 billion in TEF resources in 2026, which will support timely processing of the additional Compensation and Pension workload resulting from the PACT Act and a planned 6,907 FTE in 2026. The $1.4 billion in multi-year funding allocates $1.2 billion to payroll, including $37.6 million for overtime costs; and $193.0 million for non-pay costs.

Payments to Veterans and Beneficiaries

The number of direct benefits payments to Veterans has increased annually because of legislation, expanding Veterans' benefits and VA's successful efforts to adjudicate claims more quickly. 2026 is expected to follow this trend, as shown in the Number of Beneficiaries table below.

Veterans Benefits: Direct Payments

Accounts ($ in millions)	2024 Enacted	2025 Enacted	2026 Request	2027 Request
Compensation	168,529	192,949	220,259	240,966
Pensions	3,482	3,318	3,112	2,909
Education Benefits	12,045	14,318	16,220	17,643
Veteran Readiness and Employment	2,060	2,753	3,499	4,338
Total	**186,116**	**213,338**	**243,090**	**265,857**

Excludes contract exams, OBRA payments to GOE, burial obligations, and other costs.

Overview of VBA Workload

VBA continues to serve millions of Veterans across multiple benefits programs. The following chart shows the historical and projected growth across VBA's primary lines of business.

Number of Beneficiaries

Business Line	2024 Enacted	2025 Enacted	2026 Request	2027 Request
Compensation Beneficiaries	6,339,674	6,682,405	7,012,751	7,322,671
Pensions Beneficiaries	247,863	223,570	200,204	179,278
Education Program Trainees	896,232	1,003,986	1,116,633	1,182,546
Veteran Readiness and Employment Beneficiaries	107,023	154,790	188,766	226,204
New Housing Loans and Refinancings	416,376	590,093	595,292	NA
Insured Persons	5,441,878	5,535,307	5,526,085	5,518,819

Disability Compensation: VBA has increased claims production through process optimization and automation to help keep pace with increases in claims receipts. The following table provides a summary of workload projections:

Projected Compensation Workload and FTE Requirements

	2024 Enacted	2025 Enacted	2026 Request
Compensation Direct Labor FTE	15,966	15,510	15,052
Rating Receipts Compensation Claims	2,284,547	2,408,405	2,361,784
Rating Production Compensation Claims	2,400,085	2,660,726	2,642,679
Year-End Inventory Compensation Claims	923,297	670,976	390,081

Pension, Dependency and Indemnity Compensation (DIC), Burial and Fiduciary Programs: The following table provides a summary of the VBA pension and DIC rating workload and FTE projections. This summary includes data for only pension and DIC claims considered to be part of VBA's overall disability claims inventory, i.e., "rating claims."

Projected Pension, DIC & Burial Workload and FTE Requirements

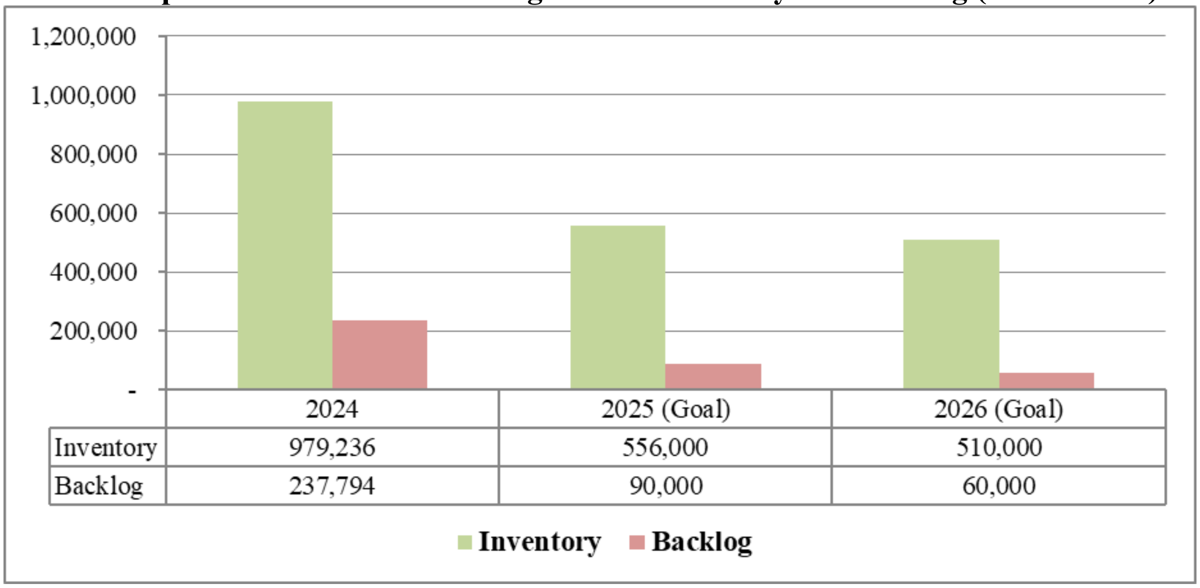
	2024 Enacted	2025 Enacted	2026 Request
Pension, DIC & Burial Direct Labor FTE	1,008	979	973
Total Receipts Pension, DIC & Burial Claims	282,355	305,513	305,020
Rating Production Pension, DIC & Burial Claims	279,242	302,306	306,009
Year-End Inventory Pension, DIC & Burial Claims	74,667	78,775	77,938

Projected Fiduciary Workload and FTE Requirements

All Funding Sources	2024 Enacted	2025 Enacted	2026 Request
Direct Labor FTE	1,335	1,297	1,280
Field Examinations			
Initial Appointment Field Examinations	22,643	23,622	24,845
Follow-up Field/Alternate Examinations	32,732	31,912	31,274
Total Field Examinations	**55,375**	**55,534**	**56,119**
Initial Appointments as a Percentage of Total	*40.89%*	*42.54%*	*44.27%*
Accountings	37,986	39,316	40,888
Fund Usage Reviews	20,361	21,786	23,529

Disability Compensation & Pension Rating Claims Inventory and Backlog: The backlog of claims older than 125 days peaked at over 400,000 in early 2024 as a result of the PACT Act's expansion in eligibility for certain veterans. The inventory of claims and the backlog declined rapidly for the remainder of 2024 and has stayed relatively flat in 2025. VBA will invest in claims processing overtime during the remaining months of 2025 and 2026 to support the Secretary's goal of substantially reducing the claims backlog by the end of calendar year 2025. VA has established a goal to reduce the claims inventory to 556,000 by the end of 2025 and 510,000 by the end of 2026. The goal for a reduced backlog by end of 2025 is 90,000 claims and 60,000 claims by the end of 2026. Achieving these goals is dependent on improved management and accelerated claims processing times.

Compensation & Pension Rating Claims Inventory and Backlog (End of Year)



Disability Compensation & Pension Appeals: The Office of Administrative Review works to reduce VBA's legacy remand inventory, administer VBA's higher-level review (HLR) program, and oversee VBA's Decision Review Operations Centers, which process AMA higher-level reviews, higher-level review returns, and Board remands and grants. VBA and the Board share a total of 29,158 compensation and pension legacy appeals still pending as of April 2025; approximately 9,900 of these belong to VBA. VBA forecasts the FTE required to process legacy appeals will decrease as it eliminates the non-remand inventory. The table below projects the reduction of VBA's C&P legacy appeals inventory through 2027. For the AMA HLR inventory, VBA has experienced exponential growth of HLR receipts since the beginning of 2021 and projected continuation for this workload's receipts through 2027.

Compensation & Pension Appeals Workload

	2024 Enacted	2025 Enacted	2026 Request
Legacy Appeals Inventory	28,366	5,000	5,000
HLR Receipts	222,795	278,488	266,420
HLR Inventory	58,731	54,103	12,804
HLR Average Days to Complete (FYTD)	100.7	84.0	47.0

National Cemetery Administration

Budgetary Resources

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Operations and Maintenance	**480**	**480**	**497**
Grants for Veterans Cemeteries	**60**	**60**	**60**
Major Construction	112	155	213
Minor Construction	183	276	86
Facilities Operations and National Cemetery Gift Funds	1	1	1
Compensation and Pension (Headstones & Markers, Graveliners, Burial Receptacles, Caskets & Urns, Urns & Plaques)	109	136	133
Total, Budgetary Resources	**945**	**1,108**	**990**

Discretionary Funding includes non-emergency appropriations provided in annual Appropriations Acts. The Disaster Relief Supplemental Appropriations Act, 2025, P.L. 118-158, is not included.

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Total FTE	**2,306**	**2,317**	**2,355**

VA honors Veterans and their family members with final resting places in national shrines with lasting tributes that commemorate their service and sacrifice to our Nation. The 2026 budget positions the NCA to meet Veterans' emerging burial and memorial needs in the decades to come through the continued implementation of the following policies in support of five overarching goals:

1. Veterans and eligible family members will have increased access to burial benefits.
2. More Veterans and eligible family members will use VA burial and memorial benefits.
3. Veterans will be memorialized through enhanced tributes befitting their service and sacrifice to the Nation.
4. Stakeholders will place greater trust in NCA based on enhanced accountability.
5. Stakeholders will be served more efficiently and effectively by NCA's internal capacity.

NCA's 2026 request supports VA's Strategic Theme to "Put Veterans First" by aligning NCA long range goals under the following strategic drivers.

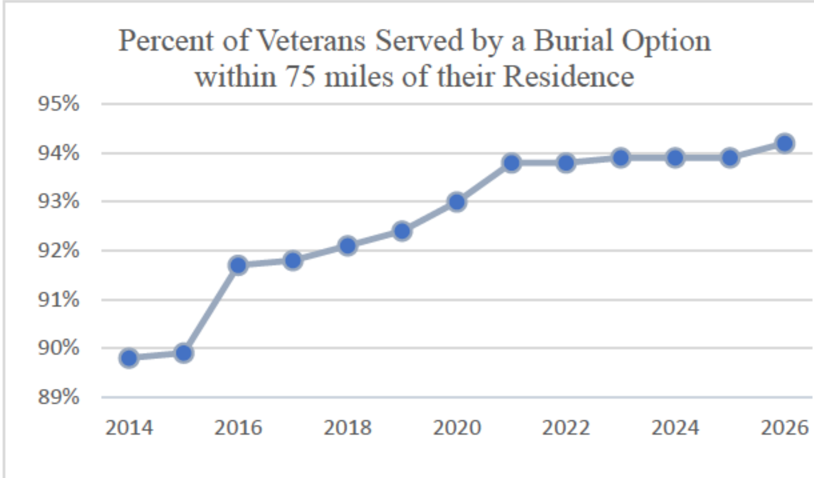
- Timely Access: provide 95% of Veterans with access to a burial option within 75 miles of their home;
- Well-Being of the Veterans at the Center of the Enterprise: meet or exceed “NCA Operational Standards and Measures” at all VA national cemeteries and deliver world class customer service to all NCA’s customers; and
- Final Salute: Use innovation to memorialize Veterans through enhanced tributes befitting their service and sacrifice to the Nation.

VA requests $497 million for the NCA Operations and Maintenance account. The Operations and Maintenance appropriation will fund the operation of 158 national cemeteries and 35 soldiers' lots and monument sites and their maintenance as national shrines. It also funds the costs of administering seven related programs: Veterans’ Cemetery Grants (VCGP), Headstones and Markers, Presidential Memorial Certificates (PMC), Outer Burial Receptacles (OBR), Casket and Urn reimbursements, First Notice of Death (FNOD), and Commemorative Urns and Plaques. The purchase and transportation costs of the headstones and markers, medallions, pre-placed crypts and OBRs, casket and urn reimbursements, and commemorative urns and plaques are financed from the Compensation and Pension appropriation.

VA’s 2026 request includes funding to support 2,355 FTE, which reflects an additional 41 FTE for workload increases and a loss of 3 reimbursable FTE compared to the FY 2025 level. Approximately 64% of NCA staff are Veterans and nearly 87% are in the field providing direct support to Veterans and their families ensuring they receive dignified, respectful, and courteous service.

In 2026, VA requests $11.7 million and 41 FTE for existing cemeteries facing workload increases and project expansions in 2026. Annual Veteran deaths are projected to be 524,569 in 2025 and are then projected to slowly decline. The number of interments at VA national cemeteries is expected to be approximately 130,000 in 2026. While the number of interments is expected to slowly decline, NCA must maintain its inventory of gravesites in perpetuity. The number of gravesites will continue to increase. NCA estimates the number of gravesites to exceed 4.4 million in 2026. In addition, NCA maintains over 24,000 acres with the total developed acreage projected to surpass 10,000 in 2026, an increase over the 9,938 developed acreage in 2025. As NCA’s workload increases, this request is essential for NCA to continue to provide world-class customer service to Veterans and their families and to maintain cemeteries as national shrines.

VA is nearing its goal to provide 95% of Veterans with access to a burial option in a national, state, or tribal Veterans cemetery within 75 miles of their homes. In 2026, 94.2% of the Veteran population will be served with such access. Increasing and maintaining the availability of state, territory, and tribal Veterans cemeteries is a means to increase existing burial access for all Veterans nationwide and provide a more convenient burial option to those Veterans who may not currently have reasonable access to a national cemetery, particularly in rural locations, or who prefer to be interred on tribal lands.



NCA Construction

Major Construction: Construction projects to develop new national cemeteries will enhance burial services and provide new burial options to Veterans and their families. Construction projects also keep existing national cemeteries open by developing additional gravesites and columbaria or by acquiring and developing additional land. In 2026, NCA requests $213 million in major construction funds, which includes $185 million to complete Phase 6 gravesite development and cemetery improvements project at Riverside National Cemetery, in Riverside, California. These funds will be used specifically to develop approximately 100 acres, providing up to 42,000 new gravesites, as well as provide new administration and warehouse buildings, committal shelters, material storage area, satellite restroom, and an Education and Interpretive Center through the repurposing of an existing building. An additional $8 million is requested for major land acquisition, and $20 million is requested for advanced planning and design activities such as master planning and design for new cemeteries and expansions to maintain access to existing national cemeteries.

Minor Construction: NCA requests $86 million in the 2026 minor construction budget to provide funding for gravesite expansion and columbaria projects to keep existing national cemeteries open and for projects that address infrastructure deficiencies and other requirements necessary to support national cemetery operations. NCA is committed to reducing the number of critical Facility Condition Assessment (FCA) infrastructure deficiencies related to safety and/or compliance and will partially address the growing list of FCA deficiencies rated D and F through the Minor Construction account.

NCA Grants for Construction of Veterans Cemeteries

NCA seeks to maintain and increase the availability of state, territory, and tribal Veterans cemeteries which serve as a complement to VA's system of national cemeteries. In 2026, NCA requests $60 million for Grants for Construction of Veterans Cemeteries to provide expansion, establishment, and improvements grants to state, territory, and tribal organizations. This grant program plays a crucial role in achieving NCA's strategic target of providing 95% of Veterans with reasonable access to a burial option. In addition, it provides a cost-effective alternative to VA construction and recurring operating expenses. With the number of state, territory, and tribal Veterans cemeteries increasing from 80 to 125 over the last 12 years, the need to provide expansion grants for existing cemeteries has also grown, in both number and dollar amounts.

General Administration

Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Office of the Secretary	19.17	18.16	22.10
Office of General Counsel	149.28	142.31	139.00
Office of Management	88.42	80.03	70.80
Office of Human Resources & Administration / Office of Operations, Security & Preparedness	120.90	121.49	118.10
Office of Enterprise Integration	38.94	30.72	30.10
Office of Public and Intergovernmental Affairs	17.99	15.93	16.20
Office of Congressional & Legislative Affairs	9.98	9.90	13.50
Office of Accountability and Whistleblower Protection	30.33	29.56	30.20
Rescission of Prior Year Balances	(5.00)	-	-
Total, Discretionary Budget Appropriations	**470.00**	**448.10**	**440.00**
Toxic Exposures Fund (TEF)	**29.45**	**19.83**	**33.00**
Total, Discretionary Budget Appropriations	**499.45**	**467.93**	**473.00**

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Office of the Secretary	76	76	97
Office of General Counsel	708	692	657
Office of Management	268	267	248
Office of Human Resources & Administration / Office of Operations, Security & Preparedness	333	364	364
Office of Enterprise Integration	80	86	86
Office of Public and Intergovernmental Affairs	72	73	66
Office of Congressional & Legislative Affairs	43	45	63
Office of Accountability and Whistleblower Protection	132	139	135
Total Direct Funded FTE	**1,712**	**1,742**	**1,716**
Reimbursable FTE, all offices	**1,397**	**1,633**	**1,903**
Subtotal Direct and Reimbursable FTE	**3,109**	**3,375**	**3,619**
TEF FTE, all offices	**56**	**84**	**84**
Total General Administration FTE	**3,165**	**3,459**	**3,703**

VA requests $440 million in budget authority and 3,619 FTE for the General Administration (GenAd) account. This FTE request includes 1,716 direct funded FTE and 1,903 reimbursable FTE. The appropriation request is $8.1 million (-2%) below the 2025 enacted budget, which is realized through a net decrease of 26 FTE in various Staff Offices. The 2026 request will continue to provide leadership, program management, budgetary oversight, accountability, and process improvements throughout the Department.

Highlights of the GenAd Staff Office requests for 2026 are:

- $22.1 million in budget authority and 97 FTE (budget authority) to the Office of the Secretary of Veterans Affairs (OSVA) to provide executive direction for all VA programs to transform VA into a premiere customer experience organization delivering Veteran care and benefits. To streamline operations and align critical enterprise functions to be under the Secretary's direct oversight, the Department's Office of Survivors Assistance (5 FTE) and the Regulations Policy and Management activities (12 FTE) will be part of OSVA in 2026. The request includes reimbursable funds to support the Office of Employment Discrimination Complaint Adjudication that report directly to the Secretary.

- $139.0 million in budget authority and 657 FTE (budget authority) for the Office of General Counsel (OGC). The request includes a 35 FTE decrease while continuing efforts to address an expanding legal workload. These include an increasing number of cases before the United States Court of Appeals for Veterans Claims (CAVC), and legal and litigation support for VA Intellectual Property. OGC's Office of Regulations Policy and Management (5 FTE) will move from OGC to OSVA in 2026.

- $70.8 million in budget authority and 248 FTE (budget authority) for the Office of Management (OM). To meet budgetary targets, OM will absorb a net decrease of 19 FTE. OM will continue to support a centralized grant management office, enhance support for audit tasks relating to the new financial system, improve Strategic Capital Investment Planning, expand the Enhanced Use Lease program, and maintain actuarial staff.

- $118.1 million in budget authority and 364 FTE (budget authority) for the Office of Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP). The request includes funding for: 14 FTE previously in VHA's Office of the Senior Security Office; Defensive Counterintelligence services provided to VHA's Office of Research and Development and others; human resource services for the Veterans Experience Office (VEO); Retirement Services for GenAd Staff Offices; Rent in VACO for OGC and Office of Accountability and Whistleblower Protection (OAWP) and other GenAd Staff Offices.

- $30.1 million in budget authority and 86 FTE (budget authority) for Office of Enterprise Integration (OEI) will continue to provide analysis, advice, and recommendations to VA leaders.

- $16.2 million in budget authority and 66 FTE (budget authority) for the Office of Public and Intergovernmental Affairs (OPIA). The budget request decreases OPIA staff by seven FTE and continues to fund outreach activities, Tribal government conferences, and the

Public Affairs Training Academy. Outreach activities enable VA to communicate effectively with Veterans and the public and local governments by positively enforcing its commitment and readiness to serve Veterans of all generations.

- $13.5 million in budget authority and 63 FTE for the Office of Congressional and Legislative Affairs. The budget request increases staff by 18 FTE to meet increased workloads and improve relationships and communications with elected officials.

- $30.2 million in budget authority to support 135 FTE (budget authority) OAWP. The budget request reduces OAWP staff by four FTE. OAWP will continue to implement the requirements of the VA Accountability and Whistleblower Protection Act of 2017.

General Administration TEF Investments

Toxic Exposures Fund (TEF), General Administration Funding by Account

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Cost of War Toxic Exposures Fund (TEF)			
Office of the Secretary	0.25	0.19	-
Office of General Counsel	10.66	2.06	9.08
Office of Human Resources & Administration / Office of Operations, Security & Preparedness	6.35	9.15	11.35
Office of Enterprise Integration	1.69	3.00	5.80
Office of Public and Intergovernmental Affairs	3.50	3.50	6.77
PACT Act Program Management Office	7.00	1.93	-
Total, Mandatory Appropriations	**29.45**	**19.83**	**33.00**

1. This reflects the total allocations for General Administration from amounts appropriated to the TEF from the Consolidated Appropriations Act, 2023, appropriated $5.0 billion to the TEF in 2023; the Fiscal Responsibility Act of 2023 appropriated $20.3 billion to the TEF in 2025 and $24.5 billion to the TEF in 2026.

Toxic Exposures Fund (TEF), General Administration FTEs

TEF FTEs	2024 Enacted	2025 Enacted with Transfers	2026 Request
Office of the Secretary	2	1	-
Office of General Counsel	40	58	73
Office of Human Resources & Administration / Office of Operations, Security & Preparedness	12	22	8
Office of Enterprise Integration	-	-	-
PACT Act Program Management Office	2	3	3
Total Toxic Exposures Fund FTEs	**56**	**84**	**84**

The TEF will provide $33.0 million for GenAd Staff Offices in 2026.

Highlights of the GenAd Staff Office TEF requests for 2026 are:

- $9.1 million in budget authority for the OGC. Funding is to meet growing workload in the Court of Appeals Litigation group as BVA's anticipated increases in PACT Act appeals output drives a corresponding growth in OGC. The increase also funds expanding workload in preventative and personnel law as VA hires additional employees. Benefits Law and Health Care Law are also affected as OGC assists in developing regulations, interpreting novel provisions of the PACT Act, and assessing process changes and policy proposals.

- $11.4 million in budget authority for HRA/OSP. Funding is to support modeling within manpower management office and oversight of VA police in response to increases in security requirements.

- $5.8 million in budget authority for OEI. OEI provides integration, coordination, monitoring, and reporting due to the PACT Act, along with contract support in program management and administration, policy and strategic analysis, enterprise synchronization, data engineering, and qualitative data analysis.

- $6.8 million in budget authority for OPIA. With existing FTE, OPIA will coordinate, plan, implement and assess several complex communication actions, including advertisements to inform Veterans of the specifics of the Act and the benefits they may be entitled to.

Construction

Discretionary and Mandatory Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Major Construction	881	961	1,871
Minor Construction	692	692	232
Subtotal, Construction Appropriation (Discretionary)	**1,573**	**1,653**	**2,103**
Recuring Expenses Transformational Fund (RETF)			
Construction, Major Projects	495	-	900
Construction, Minor Projects	181	320	-
Subtotal, RETF Investments	**676**	**320**	**900**
Total, Discretionary and RETF Appropriations	**2,249**	**1,973**	**3,003**
PACT Act Section 707 (Major Medical Facility Leases)			
Medical Facilities[1]	**100**	**200**	**400**
Total, Discretionary, TF, and Mandatory Appropriations	**2,349**	**2,173**	**3,403**

1. Section 707 of the PACT Act appropriated funds for major medical facility leases for 2023 and subsequent years through 2031.

The appropriations request for construction is $2.1 billion, including $1.9 billion for major construction and $232 million for minor construction. When the major and minor construction funds are combined with $900 million from the RETF, a total of $3.0 billion will be available in 2026.

Major Construction projects include funding for:

- Replace Bed Tower, Clinical Building Expansion, Consolidated Administrative Building and Warehouse, Utility Plant and Parking Garages, St. Louis, Missouri ($727 million in major and $900 million in RETF)
- Support expanding affordable housing for homeless or at-risk Veterans, West Los Angeles, California ($530 million)
- Expanded national cemetery in Riverside, California ($185 million)

VA's capital requirements are primarily driven by Veterans' need for care in modern facilities that are safe, secure, and accessible. VA's Strategic Capital Investment Planning (SCIP) process has served as the basis for prioritizing VA capital investment funding decisions since the 2012 budget. Projects prioritized for funding through the SCIP process will correct critical infrastructure and safety deficiencies and address other service gaps at VA facilities.

Office of Inspector General

Appropriations

Accounts ($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Total, Budget Authority	**296**	**296**	**296**

Base funding only; excludes carryover.

FTE

All Funding Sources	2024 Enacted	2025 Enacted with Transfers	2026 Request
Total FTE	**1,126**	**1,170**	**1,070**

The OIG requests $296 million for 1,070 FTE in 2026 to fulfill statutory oversight requirements for all VA programs, services, and operations, including health care and benefits delivery, procurements and acquisitions, information technology and security, construction, leadership and governance, and financial stewardship. The budget supports a spectrum of audits, inspections, and reviews that identify potential improvements to VA program outcomes, strengthen the integrity of high-risk activities, and deter misconduct. These programs also support and enhance the OIG's capacity to detect criminal activity and conduct timely and thorough investigations when serious instances of fraud, waste, and abuse are discovered.

Recurring Expenses Transformational Fund

Planned Use of RETF

($ in millions)	2024 Enacted	2025 Enacted with Transfers	2026 Request
Construction, Major Projects	495	-	900
Construction, Minor Projects	181	320	-
Total, Recurring Expenses Transformational Fund	**676**	**320**	**900**

The Recurring Expenses Transformation Fund (RETF, or Transformational Fund (TF)) was authorized in Sec. 243 of the Consolidated Appropriations Act, 2016 (P.L.114–113). Unobligated balances of expired non-emergency discretionary funds appropriated in 2016, or any succeeding fiscal year may be transferred to the RETF five years after balances expire. The RETF is available for facilities infrastructure improvements, including nonrecurring maintenance, at existing VHA hospitals and clinics, and for information technology systems improvements and sustainment.

The 2026 budget anticipates transfers totaling $900 million in unobligated balances into the RETF. Those funds will used for major construction projects.

Department of Veterans Affairs
Office of the Assistant Secretary for Management
www.va.gov/budget

Exhibit B

2025 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS

COMMUNICATION

From

THE BOARDS OF TRUSTEES,
FEDERAL HOSPITAL INSURANCE AND
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE
TRUST FUNDS

Transmitting

THE 2025 ANNUAL REPORT OF
THE BOARDS OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE AND
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE
TRUST FUNDS

LETTER OF TRANSMITTAL

BOARDS OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE AND
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS,
Washington, D.C., June 18, 2025

HONORABLE MIKE JOHNSON,
Speaker of the House of Representatives

HONORABLE JD VANCE,
President of the Senate

DEAR MR. SPEAKER AND MR. PRESIDENT:

We have the honor of transmitting to you the 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the 60th such report.

Respectfully,

SCOTT BESSENT,
Secretary of the Treasury,
and Managing Trustee of the Trust Funds.

LORI CHAVEZ-DEREMER,
Secretary of Labor,
and Trustee.

ROBERT F. KENNEDY, JR.,
Secretary of Health and Human Services,
and Trustee.

FRANK J. BISIGNANO,
Commissioner of Social Security,
and Trustee.

VACANT,
Public Trustee.

VACANT,
Public Trustee.

MEHMET C. OZ, MD,
Administrator,
Centers for Medicare & Medicaid Services,
and Secretary, Boards of Trustees.

CONTENTS

I. INTRODUCTION

The Medicare program helps pay for health care services for people aged 65 and older, as well as individuals with a disability, end-stage renal disease (ESRD), or Amyotrophic Lateral Sclerosis (also called ALS or Lou Gehrig's disease). It has two separate trust funds, the Hospital Insurance trust fund (HI) and the Supplementary Medical Insurance trust fund (SMI).

HI, otherwise known as Medicare Part A, helps pay for inpatient hospital services, hospice care, and skilled nursing facility (SNF) and home health services following hospital stays. SMI consists of Medicare Part B and Part D. Part B helps pay for physician, outpatient hospital, home health, and other services for individuals who have voluntarily enrolled. Part D provides subsidized access to drug insurance coverage on a voluntary basis for all beneficiaries. It also provides premium and cost-sharing subsidies for low-income enrollees.

Medicare also has a Part C, which serves as an alternative to traditional Part A and Part B coverage. Under this option, beneficiaries can choose to enroll in and receive care from private Medicare Advantage and certain other health insurance plans. Medicare Advantage and Program of All-Inclusive Care for the Elderly (PACE) plans receive prospective, *capitated payments*[1] for these beneficiaries from the HI and SMI Part B trust fund accounts. The other plans are paid from the accounts on the basis of their costs.

The Social Security Act established the Medicare Board of Trustees to oversee the HI and SMI trust funds' financial operations.[2] The Board has six members. Four members serve by virtue of their positions in the Federal Government:

- The Secretary of the Treasury, who is the Managing Trustee;
- The Secretary of Labor;
- The Secretary of Health and Human Services; and
- The Commissioner of Social Security.

Two other members are public representatives whom the President appoints and the Senate confirms. These positions have been vacant

[1]Any term that appears in the glossary is italicized the first time it is used in the text.
[2]The Social Security Act established separate boards for HI and SMI. Both boards have the same membership, so they are collectively referred to as the Medicare Board of Trustees in this report.

since 2015. The Administrator of the Centers for Medicare & Medicaid Services (CMS) serves as Secretary of the Board.

The Social Security Act requires that the Board report annually to Congress on the financial and actuarial status of the HI and SMI trust funds. The 2025 report is the 60th that the Board has submitted.

Exceptions to Current Law in Projections

With two exceptions, the projections in this report are based on the Social Security Act's current-law provisions.

The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and this report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022, effective date. However, implementation was initially delayed until January 1, 2023. Since then, legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

COVID-19 Pandemic Effects

The COVID-19 pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized and the Trustees rely more on recent experience when developing the cost projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

Uncertainty of Projections and Other Challenges

Projections of Medicare costs are highly uncertain, especially when looking out more than several decades, partially because scientific advances will make new interventions, procedures, and therapies possible. Some conditions that are untreatable today may be handled routinely in the future. Spurred by economic incentives, the institutions through which care is delivered will evolve, possibly becoming more efficient. While most health care technological advances to date have increased expenditures, the health care landscape is shifting. No one knows whether future developments will increase or decrease costs.

Certain features of current law may result in some challenges for the Medicare program. For example, physician payment update amounts are specified for all future years. These amounts do not vary based on underlying economic conditions, and they are not expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Payment rate updates for most non-physician Medicare provider categories are reduced by the growth in economy-wide private nonfarm business total factor productivity.[3] However, these health providers have historically achieved lower levels of productivity growth.

If the health sector cannot transition to more efficient care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries will, under current law, fall over time compared to that received by those with private health insurance.

Additionally, the difference in the rate of growth in health care costs and the rate of growth in the overall economy presents uncertainty. Since 1960, U.S. national health expenditure growth rates have typically outpaced economic growth rates. However, the magnitude of the differences has been declining, particularly over the last 15 years. There is some debate on whether this recent narrowing reflects the impact of factors that are mostly cyclical in nature, such as economic growth, or factors that are more permanent, such as structural changes to the health sector. The Trustees assume that the long-range national health expenditure growth differential will continue to narrow,

[3]The term *economy-wide private nonfarm business total factor productivity* will now be referred to as *economy-wide productivity*. Beginning with the November 18, 2021, release of the productivity data, the Bureau of Labor Statistics (BLS) replaced the term *multifactor productivity* with the term *total factor productivity*, a change in name only, as the underlying methods and data were unchanged.

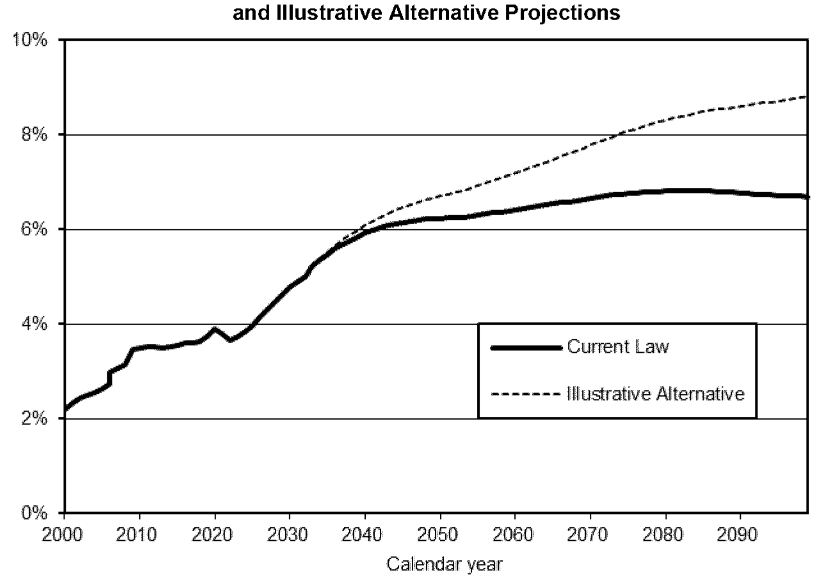
consistent with the trajectory observed over the past half century. They also assume that the cost-reduction provisions required under current law will further decrease this gap.

Summary of Projections

Current-law projections indicate that Medicare still faces a substantial financial shortfall that needs to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers.

Figure I.1 shows Medicare's projected expenditures as a percentage of the Gross Domestic Product (GDP) under two sets of assumptions: current law and an illustrative alternative, described below.[4]

Figure I.1.—Medicare Expenditures as a Percentage of the Gross Domestic Product under Current Law and Illustrative Alternative Projections



Note: Percentages are affected by economic cycles.

[4]A set of illustrative alternative Medicare projections has been prepared under a hypothetical modification to current law. A summary of the projections under the illustrative alternative is contained in section V.C of this report, and a more detailed discussion is available at https://www.cms.gov/files/document/illustrative-alternative-scenario-2025.pdf. Readers should not infer any endorsement of the policies represented by the illustrative alternative by the Trustees, CMS, or the Office of the Actuary. Section V.C also provides additional information on the uncertainties associated with productivity adjustments to specific provider payment updates and the scheduled physician payment updates.

The expenditure projections reflect the cost-reduction provisions required under current law but not the payment reductions and/or delays that would result from the HI trust fund depletion, which is projected in this report to occur in 2033. At that point, HI revenues are projected to cover 89 percent of incurred program costs.

The illustrative alternative shown in the top line of figure I.1 assumes the following:

- There would be a transition from current-law[5] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; and

- The average physician payment updates would transition from current law[6] to payment updates that reflect the *Medicare Economic Index*.

The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the cost-reduction measures prove problematic and new legislation scales them back.

As figure I.1 shows, Medicare's costs under current law rise steadily from their current level of 3.8 percent of GDP in 2024 to 6.2 percent in 2049. Costs then rise more slowly before leveling off at around 6.7 percent in the projection period's final 25 years. Under the illustrative alternative, projected costs would continue rising steadily throughout the projection period, reaching 6.7 percent of GDP in 2049 and 8.8 percent in 2099.

Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting health care cost growth over time. The Board recommends that readers interpret the current-law estimates in the report as the financial outcome under the Trustees' economic and demographic assumptions if the required cost-reduction provisions can be sustained. Readers should review section V.C for more information on this important subject. The key financial outcomes under the illustrative alternative scenario are shown with the current-law projections throughout this report.

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[5]Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth in economy-wide productivity (1.0 percent over the long range).

[6]The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models (advanced APMs) or the merit-based incentive payment system (MIPS), respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.

II. OVERVIEW

A. HIGHLIGHTS

The major findings of this report under the intermediate set of assumptions appear below. The rest of the overview and the following actuarial analysis section describe these findings in more detail.

The non-health-specific intermediate assumptions for this report were set in December 2024. The Trustees will continue to monitor developments, reevaluate the assumptions, and modify the projections in later reports.

In 2024

In 2024, Medicare covered 67.6 million people: 60.3 million aged 65 and older, and 7.3 million disabled. About 50 percent of these beneficiaries have chosen to enroll in Part C private health plans that contract with Medicare to provide Part A and Part B health services.

Total expenditures in 2024 were $1,122.1 billion, and total income was $1,133.3 billion, which consisted of $1,122.3 billion in non-interest income and $11.0 billion in interest earnings.

This $11.2 billion difference means assets held in special issue U.S. Treasury securities increased to $407.9 billion.

Short-Range Results

The estimated depletion date for the HI trust fund is 2033, 3 years earlier than projected last year primarily due to the change in projected expenditures. HI expenditures through the short-range period are projected to be higher than last year's estimates. This increase is mainly a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

In 2024, HI income exceeded expenditures by $28.7 billion. The Trustees project that surpluses will continue through 2027, followed by deficits until the trust fund becomes depleted in 2033. The assets were $237.5 billion at the beginning of 2025, representing about 53 percent of expenditures projected for 2025, which is below the Trustees' minimum recommended level of 100 percent.

The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003. Growth in HI expenditures has averaged 5.2 percent annually over the last 5 years, compared with non-interest income growth of 6.9 percent. Over the next 5 years, projected average annual growth rates for expenditures and non-interest income are 7.4 percent and 5.1 percent, respectively.

The SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and Federal Government contributions for Parts B and D are reset each year to cover expected costs and ensure a reserve for Part B contingencies. The monthly Part B premium for 2025 is $185.00.

Part B and Part D costs have each averaged an annual growth rate of 8.4 percent over the last 5 years, as compared with the Gross Domestic Product (GDP) growth rate of 6.1 percent. The Trustees project that cost growth over the next 5 years will average 8.8 percent for Part B and 7.1 percent for Part D, faster than the projected average annual GDP growth rate of 4.2 percent over the period.

As required by law, the Trustees are issuing a determination of projected *excess general revenue Medicare funding* in this report because the difference between Medicare's total expenditures and its dedicated financing sources[7] is projected to exceed 45 percent of expenditures within 7 years. Since this determination was made last year as well, this year's determination triggers a *Medicare funding warning*, which requires the following:

- The President to submit to Congress proposed legislation to respond to the warning within 15 days after the Fiscal Year 2027 Budget submission; and
- Congress to consider the legislation on an expedited basis.

This is the ninth consecutive year that a determination of excess general revenue Medicare funding has been issued, and the eighth consecutive year that a Medicare funding warning has been issued.

Long-Range Results

For the 75-year projection period, the HI actuarial balance has decreased to −0.42 percent of taxable payroll from −0.35 percent in last year's report. (Under the illustrative alternative projections, the HI actuarial balance would be −1.28 percent of taxable payroll.) Several

[7]Dedicated financing sources consist of HI payroll taxes, the HI share of income taxes on Social Security benefits, Part D State payments, Part B drug fees, and beneficiary premiums.

factors contributed to the change in the actuarial balance, most notably the following:

- Higher-than-estimated 2024 expenditures (−0.09 percent);
- Changes to hospital and hospice growth assumptions (−0.12 percent); and
- Changes to economic and demographic assumptions (+0.15 percent).

Part B expenditures were 1.9 percent of GDP in 2024. The Board projects that they will grow to about 4.2 percent by 2099 under current law. The long-range projections as a percent of GDP are higher than those projected last year because of higher projected spending for outpatient hospital and physician-administered drugs. (Part B costs in 2099 would be 5.3 percent of GDP under the illustrative alternative scenario.)

The Board estimates that Part D expenditures will increase from 0.5 percent of GDP in 2024 to about 0.6 percent by 2099. For Part D, the expenditure share of GDP is lower than the share in last year's report in most years. This is the case because Part D enrollment is lower than projected in last year's report, and it is disproportionately lower for those eligible for low-income subsidies.

The vast majority of SMI income consists of government contributions, which are transfers from the general fund of the Treasury, and premium income.

General fund transfers finance about three-quarters of SMI costs and are central to the automatic financial balance of the fund's two accounts. These transfers represent a large and growing requirement for the Federal budget. SMI government contributions were 1.7 percent of GDP in 2024 and are projected to increase to approximately 3.5 percent in 2099. (SMI government contributions in 2099 would be 4.3 percent under the illustrative alternative scenario.)

Conclusion

Total Medicare expenditures were $1,122.1 billion in 2024. Based on the intermediate set of assumptions, the Trustees project that expenditures will increase at a faster pace in future years than either aggregate workers' earnings or the economy overall. Spending as a percentage of GDP is projected to increase from 3.8 percent in 2024 to 6.7 percent by 2099. Under the relatively higher price increases for physicians and other health services assumed for the illustrative alternative projection, Medicare spending would represent roughly 8.8 percent of GDP in 2099. Growth under either of these scenarios would substantially increase the strain on the nation's workers, the economy, Medicare beneficiaries, and the Federal budget.

The Trustees project that HI tax income and other non-interest income will fall short of HI incurred expenditures beginning in 2027. The HI trust fund does not meet either the Trustees' test of short-range financial adequacy or their test of long-range close actuarial balance.

The Part B and Part D accounts in the SMI trust fund are expected to be adequately financed because income from premiums and government contributions are reset each year to cover expected costs. However, this financing would have to increase faster than the economy to cover expected expenditure growth.

The projections in this report show that change is needed to address Medicare's financial challenges. If elements of current law are not adhered to, even more substantial changes could be needed, as shown in the illustrative alternative scenario. The sooner solutions are enacted, the more flexible and gradual they can be. Introducing reforms early would give affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—more time to adjust their expectations and behavior. The Trustees recommend that Congress and the executive branch work closely together to quickly address these challenges.

B. MEDICARE DATA FOR CALENDAR YEAR 2024

HI (Part A) and SMI (Parts B and D) have separate trust funds, revenue sources, and expenditure categories. Table II.B1 presents Medicare data for calendar year 2024 in total and for each part of the program. For additional information, see section III.B for HI and sections III.C and III.D for SMI.

For fee-for-service Medicare, the largest Part A expenditure category is inpatient hospital services. The largest Part B expenditure categories are outpatient hospital and physician services. Payments to private health plans for providing Part A and Part B services represented roughly 51 percent of total A and B benefit costs in 2024.

Table II.B1.—Medicare Data for Calendar Year 2024

		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2023 (billions)	$208.8	$172.2	$15.7	$396.7
Total income	$451.2	$532.9	$149.3	$1,133.3
Payroll taxes	396.4	—	—	396.4
Interest	7.2	3.5	0.3	11.0
Taxation of benefits	39.8	—	—	39.8
Premiums	5.0	140.1	19.3	164.4
Government contributions	1.2	386.0	111.6	498.7
Payments from States	—	—	18.0	18.0
Other	1.6	3.2	0.2	5.0
Total expenditures	$422.5	$553.4	$146.2	$1,122.1
Benefits	416.3	547.8	145.7	1,109.8
Hospital	144.4	80.5	—	225.0
Skilled nursing facility	28.5	—	—	28.5
Home health care	5.9	10.0	—	15.9
Physician fee schedule services	—	71.4	—	71.4
Private health plans (Part C)	192.5	301.6	—	494.0
Prescription drugs	—	—	145.7	145.7
Other	44.9	84.3	—	129.2
Administrative expenses	6.2	5.6	0.5	12.2
Net change in assets	$28.7	−$20.5	$3.1	$11.2
Assets at end of 2024	$237.5	$151.7	$18.8	$407.9
Enrollment (millions)				
Aged	59.9	55.2	49.0	60.3
Disabled	7.3	6.8	6.2	7.3
Total	67.2	62.0	55.2	67.6
Average benefit per enrollee	$6,193	$8,831	$2,638	$17,663[1]

[1]Calculated as the sum of the Part A, Part B, and Part D amounts.

Note: Totals do not necessarily equal the sums of rounded components.

For HI, the primary financing source is the payroll tax on covered earnings. Employers and employees each pay 1.45 percent of a worker's wages, while self-employed workers pay 2.9 percent of their net earnings. High-income workers pay an additional 0.9-percent tax on their earnings above an unindexed threshold ($200,000 for single taxpayers and $250,000 for married couples).

Other HI revenue sources include a portion of the Federal income taxes that Social Security recipients with incomes above certain unindexed thresholds pay on their benefits, as well as interest earned on the securities held in the HI trust fund.

For SMI, transfers from the general fund of the Treasury represent the largest source of income. The transfers covered about 71 percent of program costs in 2024. Also, beneficiaries pay monthly premiums for Parts B and D. Those premiums financed roughly 23 percent of the total cost in 2024. As with HI, the securities held in the SMI trust fund earn interest.

C. MEDICARE ASSUMPTIONS

Future Medicare expenditures will depend on a number of factors, including the size and composition of the population eligible for benefits, changes in the volume and intensity of services, and increases in the price per service. Future HI trust fund income will depend on the size of the covered workforce and the level of workers' earnings. Future SMI trust fund income will depend on projected program costs. These factors will depend in turn upon future birth rates, death rates, labor force participation rates, wage increases, and many other economic and demographic factors affecting Medicare.

To illustrate the uncertainty and sensitivity inherent in estimates of future Medicare trust fund operations, the Board has prepared current-law projections under a low-cost, high-cost, and intermediate set of economic and demographic assumptions. In addition, the Trustees asked the CMS Office of the Actuary to develop the illustrative alternative projections to demonstrate the potential effect on the Medicare financial status if certain current-law features are not fully implemented in the future.

Table II.C1 summarizes the key assumptions used in this report. Many of the demographic and economic variables that determine Medicare costs and income are common to the Old-Age, Survivors, and Disability Insurance (OASDI) program, and the OASDI annual report explains these variables in detail.[8] These variables include changes in the Consumer Price Index (CPI), wages, real interest rates,[9] fertility rates, mortality rates, and net immigration levels. In most cases, the assumptions vary from year to year during the first 5 to 25 years before reaching their ultimate assumed values[10] for the remainder of the 75-year projection period.

[8]The non-health-specific intermediate assumptions for this report were set in December 2024. The Trustees will continue to monitor developments, reevaluate the assumptions, and modify the projections in later reports.
[9]*Real* indicates that the effects of inflation have been removed.
[10]The assumptions do not include economic cycles beyond the first 10 years.

Table II.C1.—Key Assumptions, 2049–2099

	Intermediate	Low-Cost	High-Cost
Economic:			
Annual percentage change in:			
Gross Domestic Product (GDP) per capita[1]	3.6	4.8	2.4
Average wage in covered employment	3.56	4.78	2.34
Private nonfarm business total factor productivity[2]	1.0	—	—
Consumer Price Index (CPI)	2.4	3.0	1.8
Real-wage growth (percent)	1.13	1.73	0.53
Real interest rate (percent)	2.3	2.8	1.8
Demographic:			
Total fertility rate (children per woman)	1.9	2.1	1.6
Annual percentage reduction in total age-sex adjusted death rates	0.73	0.28	1.21
Net lawful permanent resident (LPR) immigration	788,000	1,000,000	595,000
Net temporary or unlawfully present immigration	465,000	696,000	238,000
Health cost growth:			
Annual percentage change in per beneficiary Medicare expenditures (excluding demographic impacts)[1]			
HI (Part A)	3.5	[3]	[3]
SMI Part B	3.8	[3]	[3]
SMI Part D	4.0	[3]	[3]
Total Medicare	3.7	[3]	[3]

[1]The assumed ultimate increases in per capita GDP and per beneficiary Medicare expenditures can also be expressed in real terms, adjusted to remove the impact of assumed inflation. When adjusted by the chain-weighted GDP price index, assumed real per capita GDP growth under the intermediate assumptions is 1.6 percent, and real per beneficiary Medicare cost growth is 1.4 percent, 1.7 percent, and 1.9 percent for Parts A, B, and D, respectively.
[2]Private nonfarm business total factor productivity is published by the Bureau of Labor Statistics and is used as the economy-wide private nonfarm business total factor productivity to adjust certain provider payment updates.
[3]See section III.B3 for further explanation of the Part A alternative (low-cost and high-cost) assumptions. Long-range alternative projections are not prepared for Parts B and D.

Other assumptions are specific to Medicare. As with all the assumptions underlying the financial projections, the Trustees review the Medicare-specific assumptions annually and update them based on the latest available data and analysis of trends. The assumptions and projection methodology are also subject to periodic review by independent panels of expert actuaries and economists. The most recent review was completed by the 2016–2017 Technical Review Panel on the Medicare Trustees Report.[11]

Section IV.D describes the methodology used to derive the long-range Medicare cost growth assumptions.[12] These assumptions reflect the annual percent change in per beneficiary Medicare expenditures (excluding demographic effects) for the following five categories of provider services:

[11]The Panel's final report is available at https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf.
[12]When Medicare cost growth rates are compared with the per capita increase in GDP, they are characterized as *GDP plus X percent*.

Overview

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis.

Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.6 percent in 2049, or GDP plus 0.0 percent, declining gradually to 3.4 percent in 2099, or GDP minus 0.3 percent.

(ii) *Physician services.*

Payment rate updates are 0.75 percent per year for qualified physicians assumed to be participating in advanced alternative payment models (advanced APMs) and 0.25 percent for those assumed to be participating in the merit-based incentive payment system (MIPS). The year-by-year cost growth rates for physician payments are assumed to decline from 3.1 percent in 2049, or GDP minus 0.5 percent, to 2.8 percent in 2099, or GDP minus 0.9 percent.

(iii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in productivity.*

Such services include durable medical equipment that is not subject to competitive bidding,[13] care at ambulatory surgical centers, ambulance services, and medical supplies.

The Trustees assume the year-by-year cost growth rates for these services to decline from 2.8 percent in 2049, or GDP minus 0.8 percent, to 2.6 percent in 2099, or GDP minus 1.1 percent.

(iv) *The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.*

Payments for these Part B services are established through market processes and are not affected by the productivity adjustments. For physician-administered Part B drugs, the

[13]The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see section IV.B.

Inflation Reduction Act's key inflation provisions are not anticipated to affect such payments over the long range.

The long-range cost growth rates for these services are assumed to equal the growth rates as determined from the "factors contributing to growth" model. The corresponding year-by-year cost growth rates decline from 4.3 percent in 2049, or GDP plus 0.7 percent, to 4.1 percent by 2099, or GDP plus 0.4 percent.

(v) *Prescription drugs provided through Part D.*

Medicare payments to Part D plans are based on a competitive bidding process but are influenced by key Inflation Reduction Act provisions that link drug price growth to the overall inflation rate. As a result, they are assumed to grow slightly more slowly over the long range than would be the case if they were determined strictly through market processes.

The corresponding year-by-year cost growth rates decline from 4.1 percent in 2049, or GDP plus 0.5 percent, to 3.9 percent by 2099, or GDP plus 0.2 percent.

After combining the growth rates from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent in 2049,[14] or GDP plus 0.3 percent, declining to 3.8 percent by 2099, or GDP plus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2049, declining to 3.7 percent, or GDP plus 0.0 percent by 2099.

These cost growth rates must be modified to account for demographic impacts, which reflect the Medicare population's changing distribution by age, sex, and time-to-death.[15] Those who are closer to death have higher health spending, regardless of age. The Trustees assume that as mortality rates for Medicare beneficiaries continue to improve in the future, a smaller portion of the population will be closer to death at a given age, which somewhat offsets the effect of individuals getting older and spending more on health care.

[14]In 2049, the shares of Part B spending are 28 percent for services updated by input price indexes, 16 percent for physician services, 6 percent for services updated by the CPI, and 51 percent for the remaining Part B services.

[15]More information on the time-to-death adjustment is available at https://www.cms.gov/files/document/incorporation-time-death-medicare-demographic-assumptions.pdf.

Overview

This is particularly the case for Part A services—such as inpatient hospital, skilled nursing, and home health services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, incorporating the time-to-death adjustment has a smaller effect.

As in the past, the Trustees establish detailed growth rate assumptions for the initial 10 years (2025 through 2034) by individual type of service (for example, inpatient hospital care and physician services). These assumptions reflect recent trends and the impact of all applicable statutory provisions. For each of Parts A, B, and D, the assumed cost growth rates for years 11 through 25 of the projection period (adjusted to reflect discontinuities in yearly payment policies) are set by interpolating between the rate at the end of the short-range projection period and the rate at the start of the last 50 years of the long-range period.

The 2016–2017 Medicare Technical Review Panel concluded that both the current length of the transition period and the current approach to the transition are reasonable. They recommended that the Trustees continue to use the same approach to transition between short-range and long-range projections for both HI and SMI.[16]

The basis for the Medicare cost growth rate assumptions described above has been chosen primarily to incorporate the productivity adjustments and the physician payment structure in a relatively simple, straightforward manner and with the assumption that these elements of current law will operate as specified in all future years. The Trustees use this approach in part because of the uncertainty associated with these provisions and in part because of the difficulty of modeling the consequences for access to care, health status, and utilization if these provisions of current law do not operate as intended.[17] This approach incorporates the effects of changes in payment mechanisms, delivery systems, and other aspects of health care that have been implemented recently, including modest savings from accountable care organizations.

However, the Trustees have considered neither the possible effects of future changes that could arise in response to the payment limitations or future innovative payment models nor the potential effects of

[16]See Findings 6-2 and 6-3 and Recommendation 6-1.
[17]For a detailed discussion of uncertainty, see section V.C.

sustained slower payment increases on provider participation, beneficiary access to care, quality of services, and other factors.[18]

Consistent with the practice in recent reports, a set of illustrative alternative Medicare projections has been developed. This information is presented in section V.C. An actuarial memorandum on the illustrative alternative is available on the CMS website.[19] The illustrative alternative projection assumes the following:

- There would be a transition from current-law payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; and
- The average physician payment updates would transition from current law to payment updates that reflect the Medicare Economic Index.

The transition from current law to the ultimate illustrative alternative assumptions starts at the same dates that were assumed in last year's report. Under the illustrative alternative projections, the year-by-year cost growth rate assumptions for HI and SMI Part B decline from approximately 4.3 percent in 2049, or GDP plus 0.7 percent, to 4.1 percent by 2099, or GDP plus 0.4 percent. On average over this period, the growth rate of per beneficiary expenditures for these services is equal to the growth rate for per capita national health expenditures, as described previously for other Medicare services for which price updates are based on market processes.

For the HI low-cost and high-cost projections, Medicare expenditures are determined by changing the assumption for the ratio of aggregate costs to taxable payroll (the cost rate). These changes are intended to show how Medicare expenditures could vary in the future as a result of different economic, demographic, and health care trends.[20]

For the HI high-cost assumptions, the assumed annual increase in the cost rate during the initial 25-year period is 2 percentage points greater than under the intermediate assumptions. Under the low-cost assumptions, the assumed annual increase in the cost rate for the

[18]The 2016–2017 Medicare Technical Review Panel considered these issues at some length. Their final report contains a discussion of the delivery system changes to date and the impact on the Medicare projections.

[19]See https://www.cms.gov/files/document/illustrative-alternative-scenario-2025.pdf.

[20]Under the automatic financing provisions for the SMI programs, Parts B and D will be adequately financed. Accordingly, the Trustees have not conducted high-cost and low-cost analyses of the general fund transfers.

initial period is 2 percentage points less than under the intermediate assumptions. The Trustees assume that, after 25 years, the 2-percentage-point differentials will gradually decline to zero in 2074, after which the growth in cost rates is the same under all three sets of assumptions.

While it is possible that actual economic, demographic, and health cost-growth experience will fall within the range defined by the three alternative sets of assumptions, there can be no assurances that it will do so in light of the wide variations in these factors over past decades. In general, readers can place a greater degree of confidence in the assumptions and estimates for the earlier years than for the later years. Nonetheless, the estimates in total are only an indication of the expected trends and the general ranges of future Medicare experience.

Also, because of uncertain long-range adequacy of physician payments and payments affected by the statutory productivity adjustments, actual future Medicare expenditures could exceed the intermediate projections shown in this report, possibly by large amounts. Reference to key results under the illustrative alternative projections demonstrates this potential understatement.

D. FINANCIAL OUTLOOK FOR THE MEDICARE PROGRAM

This report evaluates the HI and SMI trust funds' financial status. For HI, the Trustees apply formal tests of financial status for both the short range and the long range. For SMI, the Trustees assess the trust fund's ability to meet costs incurred over the period for which financing has been set.

HI and SMI are financed in very different ways. Within SMI, current law provides for the annual determination of Part B and Part D beneficiary premiums and government contributions to cover expected costs for the following year. In contrast, HI is subject to substantially greater variation in asset growth, as employee and employer tax rates under current law do not change or adjust to meet expenditures except through new legislation.

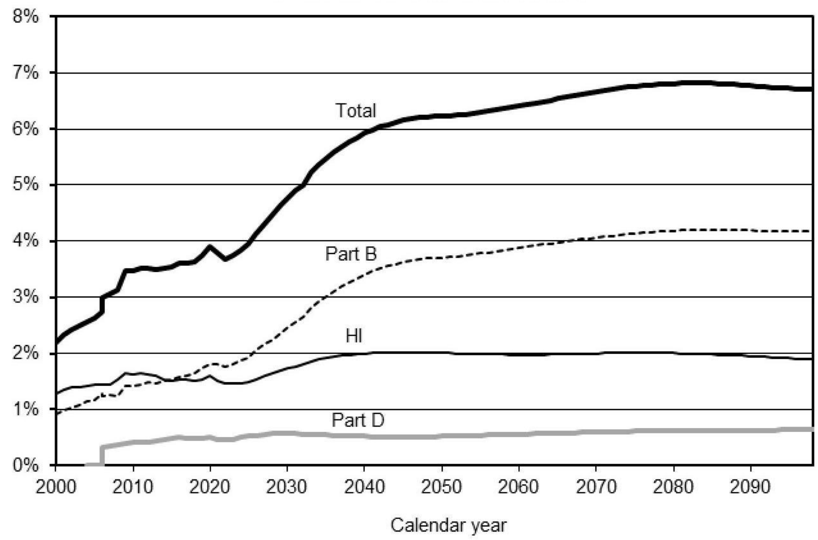
Despite the significant differences in benefit provisions and financing, the two components of Medicare are closely related. HI and SMI operate in an interdependent health care system. Most Medicare beneficiaries are enrolled in HI and SMI Parts B and D, and many receive services from all three.

Accordingly, efforts to improve and reform either component have repercussions for the other component. With the anticipated growth in Medicare expenditures, it is also important to consider the distribution among the various sources of revenues for financing Medicare and the manner in which this distribution will change over time.

This section reviews the projected total expenditures for the Medicare program, along with the primary sources of financing.

Figure II.D1 shows projected costs as a percentage of GDP. Medicare expenditures represented 3.8 percent of GDP in 2024 and will increase to 6.2 percent of GDP by 2049. Costs then increase to 6.7 percent of GDP in 2099, with growth in health care cost per beneficiary becoming the larger factor later in the valuation period, particularly for Part D costs, which are not affected by legislated price reductions. (If the payment update constraints were phased down as in the illustrative alternative projections, then Medicare expenditures would reach an estimated 8.8 percent of GDP in 2099.)

Figure II.D1.—Medicare Expenditures as a Percentage of the Gross Domestic Product



Note: Percentages are affected by economic cycles.

Table II.D1 shows five components of Medicare expenditure growth:

- Growth of overall prices as measured by the CPI;
- Growth of Medicare prices relative to growth in the CPI;
- Growth in the number of beneficiaries;
- Change in the demographic composition of the beneficiaries; and
- Change in the volume and intensity of services.

The table presents these components over three valuation periods. The price growth for Part A is projected to be below CPI growth initially, close to CPI growth in the 2035–2049 period, and below in the long run. For Part B, price growth is projected to be below CPI growth during each valuation period. As discussed in section IV.D, prices for all of Part A and some of Part B are constrained by the provider payment updates specified under current law. Part B prices are further constrained by the current-law physician payment updates.

For all parts of Medicare, growth in the number of beneficiaries is highest over the next 10 years as the baby boom generation continues to enter Medicare. Beneficiary growth slows continually thereafter.

Table II.D1.—Components of Increase in Medicare Incurred Expenditures by Part
[In percent]

	Average annual percentage change						
	Prices						
Valuation period	CPI	Medicare relative to CPI	Overall Medicare	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity	Total increase
Part A:							
2025–2034	3.2%	−0.3%	2.9%	1.8%	0.4%	1.8%	6.9%
2035–2049	2.4	0.0	2.4	0.4	0.2	1.3	4.3
2050–2099	2.4	−0.2	2.2	0.4	−0.1	1.3	3.8
Part B:							
2025–2034	3.2	−1.0	2.2	1.9	0.1	4.5	8.9
2035–2049	2.4	−0.2	2.2	0.5	0.0	2.9	5.6
2050–2099	2.4	−0.1	2.3	0.5	−0.1	1.4	4.2
Part D:							
2025–2034	3.2	−1.3	1.8	2.0	−0.2	1.0	4.8
2035–2049	2.4	−0.3	2.1	0.5	−0.2	1.1	3.6
2050–2099	2.4	0.2	2.6	0.5	−0.1	1.4	4.4

Notes: 1. Price reflects annual updates, total factor productivity reductions, and any other reductions required by law or regulation.
2. Volume and intensity is the residual after the other four factors shown in the table (CPI, excess Medicare price, number of beneficiaries, and beneficiary demographic mix) are removed.
3. Totals do not necessarily equal the sums of rounded components.

Most beneficiaries have the option to enroll in private health insurance plans that contract with Medicare to provide Part A and Part B medical services. The share of Medicare beneficiaries in such plans has risen rapidly in recent years. It reached 50 percent in 2024 from 12.8 percent in 2004. The Trustees project that the overall participation rate for private health plans will continue to increase—from about 51 percent in 2025 to about 58 percent in 2034 and thereafter.[21]

Figure II.D2 shows the past and projected amounts of Medicare revenues under current law excluding interest income, which will not be a significant part of program financing in the long range as trust fund assets decline. The figure compares total Medicare expenditures with Medicare non-interest income from these sources:

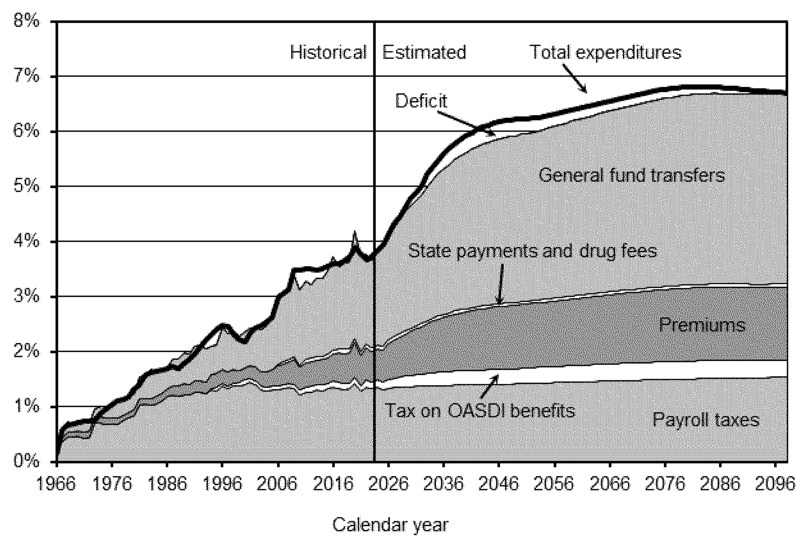
- HI payroll taxes;
- HI income from the taxation of Social Security benefits;
- HI and SMI premiums;
- SMI Part D State payments for certain Medicaid beneficiaries;
- Fees on manufacturers and importers of brand-name prescription drugs (allocated to Part B); and
- HI and SMI general fund transfers.

[21]For more detail on the Medicare Advantage program, see section IV.C.

Overview

The Trustees expect total Medicare expenditures to exceed non-interest revenue for all future years.

Figure II.D2.—Medicare Sources of Non-Interest Income and Expenditures as a Percentage of the Gross Domestic Product



Note: Percentages are affected by economic cycles.

As shown in figure II.D2, for much of the early historical period, payroll tax revenues increased steadily as a percentage of GDP because of increases in the HI payroll tax rate and in the limit on taxable earnings, the latter of which lawmakers eliminated in 1994.

Beginning in 2013, the HI trust fund receives an additional 0.9-percent tax on earnings in excess of a threshold amount.[22] The Trustees project that, as a result of this provision, payroll taxes will grow slightly faster than GDP.[23] Beginning in 2022, HI revenue from income taxes on

[22]Current law also specifies that individuals with incomes greater than $200,000 per year and couples above $250,000 pay an additional Medicare contribution of 3.8 percent on some or all of their non-work income (such as investment earnings). However, the revenues from this tax are not allocated to the Medicare trust funds.

[23]Although the Trustees expect total worker compensation to grow at the same rate as GDP after the first 10 years of the projection, wages and salaries are projected to increase more slowly than fringe benefits (health insurance costs in particular). Thus, projected taxable earnings (wages and salaries) gradually decline as a percentage of GDP. Absent any change to the tax rate scheduled under current law, HI payroll tax revenue would similarly decrease as a percentage of GDP. Over time, however, a growing proportion of workers will have earnings that exceed the fixed earnings thresholds specified in the law ($200,000 for individuals and $250,000 for couples), and an increasing portion of taxable earnings will therefore become subject to the additional 0.9-percent HI payroll tax. The net effect of these factors is an increasing trend in payroll taxes as a percentage of GDP.

Social Security benefits is expected to gradually increase as a share of GDP as the share of benefits subject to such taxes increases.[24]

The Trustees expect growth in SMI Part B and Part D premiums and transfers from the general fund of the Treasury to continue to outpace GDP growth and HI payroll tax growth in the future. This phenomenon occurs primarily because SMI revenue increases at the same rate as expenditures, whereas HI revenue does not. Accordingly, as the HI revenue sources become increasingly inadequate to cover HI costs, SMI revenues will represent a growing share of total Medicare revenues. Government contributions are projected to gradually increase from 45 percent of Medicare financing in 2024 to about 50 percent in 2036, stabilizing thereafter. Growth in these contributions as a share of GDP adds significantly to the Federal budget pressures. SMI premiums will also increase at the same rate as SMI expenditure growth, placing a growing burden on beneficiaries. High-income beneficiaries have paid an income-related premium for Part B since 2007 and for Part D since 2011.

Medicare and the Federal Budget

The interrelationship between the Medicare program and the Federal budget is an important topic—one that will become increasingly critical over time as the general fund requirements for SMI continue to grow.

Transfers from the general fund of the Treasury are the major source of financing for the SMI trust fund. They are central to the automatic financial balance of the fund's two accounts, while representing a large and growing requirement for the Federal budget. SMI government contributions equaled 1.7 percent of GDP in 2024 and will increase to an estimated 3.5 percent in 2099 under current law. Without legislation to address the financial imbalance, interest earnings on trust fund assets and redemption of those assets will cover the difference between HI dedicated revenues and expenditures until 2033.[25] In 2032, this funding shortfall for the HI trust fund represents 0.2 percent of GDP.

Section V.F describes the interrelationship between the Federal budget and the Medicare and Social Security trust funds. It illustrates the

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[24]See section V.C7 of the 2025 OASDI Trustees Report for more detailed information on the projection of income from taxation of Social Security benefits.

[25]After asset depletion in 2033, as described in section II.E, no provision exists to use transfers from the general fund of the Treasury or any other means to cover the HI deficit.

programs' long-range financial outlook from both a trust fund perspective and a budget perspective.

Federal Reporting Requirements on Medicare Funding

Federal law requires that the Trustees make a determination of excess general revenue Medicare funding if they project that under current law the difference between program expenditures and dedicated financing sources[26] will exceed 45 percent of Medicare costs within the first 7 fiscal years of the projection. For this year's report, the difference between program expenditures and dedicated revenues is expected to exceed 45 percent in fiscal year 2025. Therefore, the Trustees are issuing this determination.[27]

Because this determination was made last year as well, this year's determination results in a Medicare funding warning, which requires the following:

- The President to submit to Congress proposed legislation to respond to the warning within 15 days after the Fiscal Year 2027 Budget submission; and

- Congress to consider the legislation on an expedited basis.

Such funding warnings were previously made in each of the 2007 through 2013 reports and in the 2018 through 2024 reports.

While this section has summarized the total financial obligation posed by Medicare and the manner in which it is financed, the HI and SMI components of Medicare have separate and distinct trust funds, each with its own revenue sources and mandated expenditures. Sections II.E and II.F present assessments for the financial status of the HI trust fund and the SMI trust fund, respectively.

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[26]The dedicated financing sources are HI payroll taxes, the HI share of income taxes on Social Security benefits, Part B receipts from the fees on manufacturers and importers of brand-name prescription drugs, Part D State payments, and beneficiary premiums. These sources are the first four layers depicted in figure II.D2.
[27]Section V.B contains additional details on these tests.

E. FINANCIAL STATUS OF THE HI TRUST FUND

1. 10-Year Actuarial Estimates (2025–2034)

Over the past 20 years, the HI trust fund experienced various periods of surpluses and deficits. Expenditures exceeded income each year from 2008 through 2015. However, in 2016 and 2017, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment resulted in a larger surplus in 2022 of $53.9 billion. In 2023 and 2024 there were surpluses of $12.2 billion and $28.7 billion, respectively.

Fund surpluses will continue through 2027. Deficits are projected to return in 2028 and persist for the remainder of the projection period, requiring redemption of trust fund assets until the trust fund's depletion in 2033.

Table II.E1 presents the HI trust fund's projected operations under the intermediate assumptions for the next decade. At the beginning of 2025, HI assets represented 53 percent of annual expenditures. This ratio has declined from 150 percent since 2007. The Board has recommended an asset level at least equal to annual expenditures to serve as an adequate contingency reserve in case of adverse economic or other conditions.

The Trustees apply an explicit test of short-range financial adequacy.[28] Based on the 10-year projection shown in table II.E1, the HI trust fund does not meet this test because estimated assets are below 100 percent of annual expenditures and are not projected to attain this level under the intermediate assumptions. Prompt legislative action is needed to achieve financial adequacy for the HI trust fund throughout the short-range period.

[28]This test is described in section III.B2 of this report.

Table II.E1.—Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2024–2034
[Dollar amounts in billions]

Calendar year	Total income[1]	Total expenditures	Change in fund	Fund at year end	Ratio of assets to expenditures[2]
2024[3]	$451.2	$422.5	$28.7	$237.5	49%
2025	457.3	449.7	7.6	245.1	53
2026	493.2	485.4	7.7	252.8	50
2027	523.4	523.0	0.4	253.2	48
2028	550.8	562.4	−11.7	241.5	45
2029	578.0	604.7	−26.7	214.8	40
2030	605.0	643.5	−38.6	176.2	33
2031	632.9	683.8	−50.9	125.3	26
2032	661.3	725.8	−64.5	60.8	17
2033[4]	692.0	780.4	−88.3	−27.5	8
2034[4]	723.1	827.3	−104.2	−131.7	—[5]

[1]Includes interest income.
[2]Ratio of assets in the fund at the beginning of the year to expenditures during the year.
[3]Figures for 2024 represent actual experience.
[4]Estimates for 2033 and 2034 are hypothetical since the HI trust fund would be depleted in these years.
[5]Trust fund reserves would be depleted at the beginning of this year

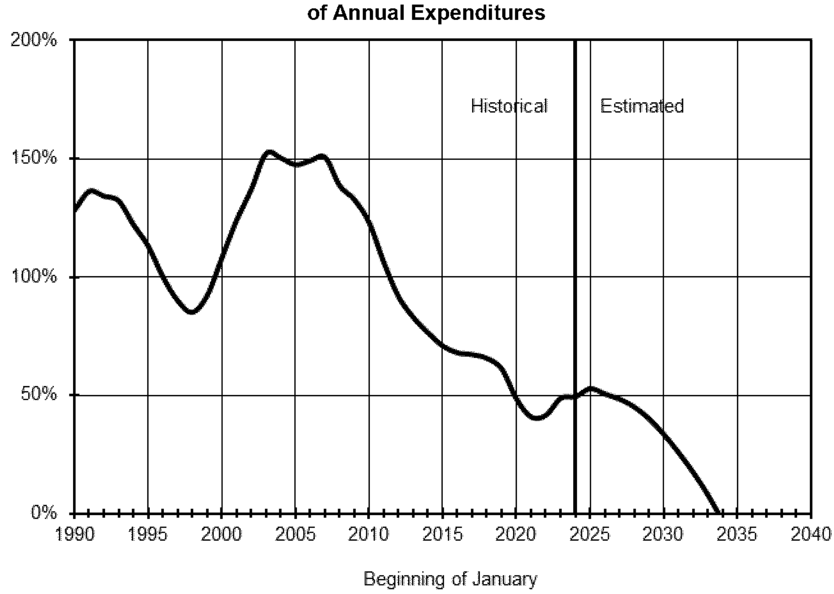
Note: Totals do not necessarily equal the sums of rounded components.

This year's short-range financial outlook for the HI trust fund is less favorable than last year's projections. HI income is projected to be initially higher and then lower throughout the projection period because average wages are initially higher and then lower. HI expenditures are projected to be higher through the short-range period mainly as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

Under the intermediate assumptions, after 2025 the assets of the HI trust fund would steadily decrease as a percentage of annual expenditures throughout the remainder of the short-range projection period, as illustrated in figure II.E1. The ratio declines until the fund is depleted in 2033, 3 years earlier than projected last year.

If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services could be rapidly reduced. To date, Congress has never allowed the HI trust fund to become depleted.

Figure II.E1.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



There is substantial uncertainty in the economic, demographic, and health care projection factors for HI trust fund expenditures and revenues. Accordingly, the date of HI trust fund depletion could differ substantially in either direction from the 2033 intermediate estimate. As shown in greater detail in section III.B, trust fund assets would increase throughout the entire projection period under the low-cost assumptions. However, under the high-cost assumptions, asset depletion would occur in 2029.

2. 75-Year Actuarial Estimates (2025–2099)

Each year, the Board prepares 75-year estimates of the HI trust fund's financial and actuarial status. Although financial outcomes are inherently uncertain, particularly over periods as long as 75 years, such estimates are helpful for assessing the trust fund's long-term financial condition.

Because of the difficulty in comparing dollar values for different periods without some type of relative scale, the Trustees show income and expenditure amounts relative to the earnings in covered employment that are taxable under HI (referred to as *taxable payroll*).

Overview

The ratio of HI income[29] to taxable payroll is called the *income rate*. The ratio of expenditures to taxable payroll is the *cost rate*.[30]

The standard HI payroll tax rate is scheduled to remain constant at 2.9 percent for employees and employers, combined. High-income workers also pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns).

Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers and their earnings will become subject to a higher HI tax rate. (By the end of the long-range projection period, an estimated 80 percent of workers would be subject to this additional tax.) Thus, HI payroll tax revenues will increase steadily as a percentage of taxable payroll.

Similarly, HI income from taxation of Social Security benefits will also increase faster than taxable payroll because the income thresholds determining taxable benefits are not indexed for inflation and the income tax brackets are indexed to the chained CPI, which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the chained CPI as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as taxable payroll.[31]

The cost rate has mostly been declining over the last decade largely because of expenditure growth that was constrained in part by low utilization and low payment updates. The cost rate increased in 2019, as taxable payroll growth slowed, and in 2020 because of the pandemic. The rate then declined again in 2021 and 2022 because of a decrease in expenditures attributable to the pandemic's impact.

After remaining steady in 2023 and 2024, the cost rate is projected to rise in 2025 and beyond primarily as a result of an acceleration of health services cost growth. This cost rate increase is moderated by the productivity adjustments to provider price updates, which are

[29]HI income here includes payroll taxes, income from taxation of Social Security benefits, premiums, general fund transfers for uninsured beneficiaries, and monies from fraud and abuse control activities, but it excludes interest income.
[30]The Trustees estimate these costs on an incurred basis.
[31]See section V.C7 of the 2025 OASDI Trustees Report for more detailed information on the projection of income from taxation of Social Security benefits.

estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2034 and 1.0 percent thereafter. For example, after 25, 50, and 75 years, the prices paid to HI providers under current law would be 20 percent, 38 percent, and 51 percent lower, respectively, than prices without the productivity reductions.

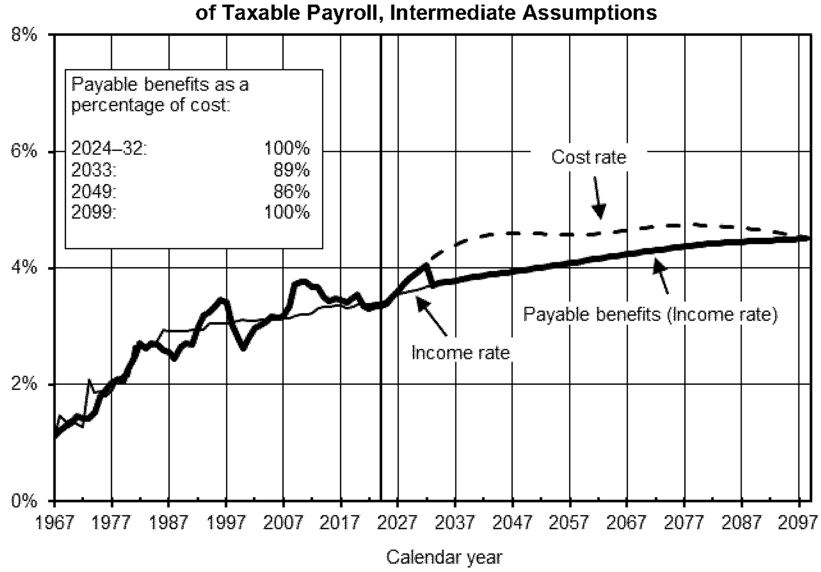
Figure II.E2 shows projected income and cost rates under the intermediate assumptions. As indicated, estimated HI incurred expenditures continue to exceed non-interest income for all projected years. (The projected excess of costs over non-interest income until 2033 is covered by interest earnings and trust fund asset redemption.)

The HI cost rate increases more rapidly than the income rate for most years through about 2043. The projected annual deficits expressed as a share of taxable payroll increase from 0.05 percent in 2027 to a high of 0.69 percent in 2042 and then gradually decrease to 0.00 percent by the end of the projection period. The convergence of growth rates for income and costs reflects the following:

- The continuing effects of slower payment rate updates;
- Assumed decelerating growth in the volume and intensity of services; and
- The increasing portion of earnings that are subjected to the additional 0.9-percent payroll tax.

The percentage of expenditures covered by non-interest income is projected to be 89 percent in 2033 (year of exhaustion), 86 percent in 2049 (25th projection year), and about 100 percent in 2099 (end of the projection period). (Under the illustrative alternative, the expenditures covered by non-interest income are projected to decline from 88 percent in 2033 to 79 percent in 2049 and then to about 66 percent by the end of the projection period.)

Figure II.E2.—Long-Range HI Non-Interest Income and Cost as a Percentage of Taxable Payroll, Intermediate Assumptions



It is possible to summarize the year-by-year cost rates and income rates shown in figure II.E2 into single values[32] representing, in effect, the average value over a given period. Based on the intermediate assumptions, the Trustees project an HI actuarial deficit of 0.42 percent of taxable payroll for the 75-year period under current law. This value represents the difference between the summarized income rate of 4.10 percent and the corresponding cost rate of 4.53 percent.[33]

As a result, the HI trust fund fails the Trustees' test for long-range financial balance, as it has every year since 1991, when this test was first applied. (Under the illustrative alternative projections, the long-range HI deficit would be 1.28 percent of payroll.)

The projected HI cost rates shown in this report are higher than those from the 2024 report for all years because of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

[32]See section III.B3 for details on the summarized income and cost rates.
[33]Totals do not necessarily equal the sums of rounded components.

Addressing the Long-Range Financial Imbalance

Lawmakers have many options to address the long-range financial imbalance and keep the HI trust fund solvent throughout the 75-year projection period. Two potential approaches—with either immediate or gradual implementation—illustrate the magnitude of the changes needed to eliminate the deficit:

- The standard 2.90-percent payroll tax could be immediately increased by the amount of the actuarial deficit to 3.32 percent, or expenditures could be reduced immediately by 9 percent.[34,35]

- The tax and/or benefit changes could occur gradually but would require ultimate adjustments that would be higher than adjustments that were done immediately.

[34]Under the illustrative alternative projection, the corresponding immediate changes would be an increase from 2.90 percent to 4.18 percent in the standard tax rate or a decrease in expenditure levels of 24 percent.

[35]Under the two approaches for addressing the actuarial deficit, tax income would initially be substantially greater than expenditures, and trust fund assets would accumulate rapidly. However, tax income would be inadequate, and assets would subsequently be drawn down to cover the difference. This approach shows that if lawmakers designed legislative solutions to eliminate only the 75-year actuarial deficit, without consideration of such year-by-year patterns, then a substantial financial imbalance could still remain at the end of the period, and the program's long-range sustainability could still be in doubt.

F. FINANCIAL STATUS OF THE SMI TRUST FUND

SMI is composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The Trustees must evaluate the financial status of each account separately to determine the SMI trust fund's financial status because there is no provision in the law for transferring assets or income between the Part B and Part D accounts.

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general fund transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law.

Parts B and D differ fundamentally from HI and OASDI in regard to the nature of their financing and the method by which their financial status is evaluated. Both parts of SMI are voluntary and are mostly financed by premiums from participants and contributions from the general fund of the Treasury. OASDI and HI are generally compulsory and are primarily financed from payroll taxes. The financial assessment of the SMI program therefore differs in important ways.

1. 10-Year Actuarial Estimates (2025–2034)

Table II.F1 shows the estimated operations of the Part B account, the Part D account, and the total SMI trust fund under the intermediate assumptions during calendar years 2024 through 2034.

For Part B, expenditures grew at an average annual rate of 8.4 percent over the past 5 years, exceeding GDP growth by 2.0 percentage points annually, on average. Estimated Part B cost increases average about 8.8 percent over the next 5 years, faster than the GDP growth rate of 4.2 percent. Compared with last year's report, income and expenditures are higher because of higher projected spending for outpatient hospital and physician-administered drugs.

Table II.F1.—Estimated Operations of the SMI Trust Fund under Intermediate Assumptions, Calendar Years 2024–2034
[Dollar amounts in billions]

Calendar year	Total income[1]	Total expenditures	Change in fund	Fund at year end
Part B account:				
2024[2]	$532.9	$553.4	−$20.5	$151.7
2025	585.8	579.1	6.7	158.3
2026	672.2[3]	650.2	21.9	180.3
2027	720.9[3]	714.0	7.0	187.2
2028	787.8	772.9	14.9	202.1
2029	861.0	844.4	16.6	218.7
2030	937.9	921.4	16.5	235.2
2031	1,012.6	995.5	17.1	252.2
2032	1,095.6	1,073.3	22.3	274.5
2033	1,200.8	1,179.6	21.2	295.7
2034	1,295.4	1,273.8	21.5	317.3
Part D account:				
2024[2]	149.3	146.2	3.1	18.8
2025	176.9	178.1	−1.3	17.5
2026	163.7[3]	163.0	0.7	18.2
2027	183.9[3]	183.0	0.8	19.1
2028	197.2	196.7	0.5	19.6
2029	207.3	206.4	0.8	20.4
2030	217.1	216.6	0.5	20.9
2031	221.4	221.2	0.1	21.1
2032	223.5	223.0	0.4	21.5
2033	231.9	231.2	0.7	22.2
2034	239.9	239.2	0.7	22.9
Total SMI:				
2024[2]	682.2	699.6	−17.5	170.4
2025	762.6	757.3	5.4	175.8
2026	835.9[3]	813.2	22.7	198.5
2027	904.8[3]	897.0	7.8	206.3
2028	985.0	969.6	15.4	221.7
2029	1,068.3	1,050.9	17.4	239.1
2030	1,155.0	1,137.9	17.0	256.1
2031	1,233.9	1,216.8	17.2	273.3
2032	1,319.1	1,296.4	22.7	296.1
2033	1,432.6	1,410.8	21.8	317.9
2034	1,535.2	1,513.0	22.2	340.1

[1]Includes interest income.
[2]Figures for 2024 represent actual experience.
[3]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2027, will occur on December 31, 2026. Consequently, the Part B and Part D premiums withheld from these benefits and the associated Part B government contributions will be added to the respective Part B (about $6.3 billion) or Part D (about $0.1 billion) account on December 31, 2026.

Because of the nature of Part B financing, Part B income growth is normally quite close to expenditure growth. The financing for 2025 was set to maintain the Part B account within the customary range during 2025.[36]

For the Part D account, the Trustees project that income and expenditures will grow at an average annual rate of 7.1 percent over the 5-year period 2025–2029. Compared with last year's report, income and expenditures are projected to be lower in most years. This is the case because Part D enrollment is lower than projected in last year's report, and it is disproportionately lower for those eligible for low-income subsidies.

As with Part B, income and expenditures would remain in balance because income from premiums and general fund transfers is adjusted annually to cover costs. The appropriation for Part D government contributions has generally been set so that amounts can be transferred to the Part D account on an as-needed basis. Under this process, there is no need to maintain a contingency reserve. The Part D account reflects a policy to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans.

The primary financial adequacy test for Parts B and D pertains to the financing level established for a given period (normally, through the end of the current calendar year). The financing for each part of SMI is considered satisfactory if it is sufficient to fund all services, including benefits and administrative expenses, provided through a given period. To protect against the possibility that cost increases under either part of SMI will be higher than expected, the trust fund accounts would normally need assets adequate to cover a reasonable degree of variation between actual and projected costs.

For Part B, the Trustees estimate that the financing established through December 2025 will be sufficient to cover benefits and administrative costs incurred through 2025. They estimate that assets will be adequate to cover potential variations in costs if there is new legislation or if cost growth factors exceed expectations. The estimated financing established for Part D, together with the flexible appropriation authority for this trust fund account, would be sufficient to cover benefits and administrative costs incurred through 2025.

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[36]The traditional measure used to evaluate the status of the SMI trust fund's Part B account is defined as the ratio of the excess of Part B assets over Part B liabilities to the next year's Part B incurred expenditures. The customary range for this ratio is 15 to 20 percent, and the minimally financially adequate level is 14 percent; the CMS Office of the Actuary developed these amounts based on private health insurance standards and past studies indicating that this asset reserve level is sufficient to protect against adverse events.

The contingency reserve amount needed in Part B is normally much smaller (both in absolute dollars and as a fraction of annual costs) than in HI or OASDI. A smaller reserve is adequate because the premium rate and corresponding general fund transfers for Part B are determined annually based on estimated future costs, while the HI and OASDI payroll tax rates are fixed under law and are therefore much more difficult to adjust if circumstances change. A statutory competitive bidding process establishes Part D revenues annually to cover estimated costs.[37] Additionally, lawmakers have established a flexible appropriation authority for Part D, which allows additional general fund financing if costs are higher than anticipated.

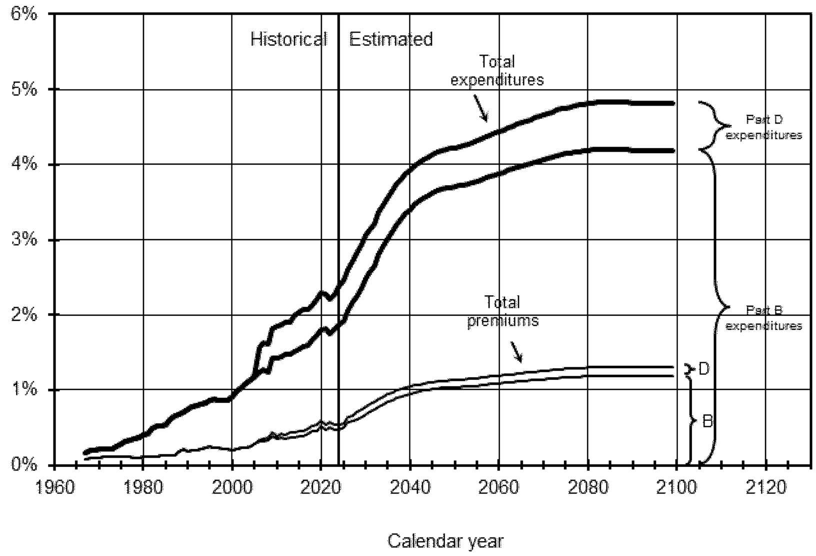
2. 75-Year Actuarial Estimates (2025–2099)

Figure II.F1 shows past and projected total SMI expenditures and premium income as a percentage of GDP. Total SMI expenditures amounted to 2.4 percent of GDP in 2024 and are projected to grow to about 4.5 percent of GDP within 40 years and to 4.8 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2099 would be 5.9 percent of GDP.)

Compared with the projections in the 2024 Trustees Report, the projected Part B expenditures as a share of GDP shown in figure II.F1 are higher. These differences are due to higher projected spending for outpatient hospital and physician-administered drugs. For Part D, the expenditure share of GDP is lower than the share in last year's report in most years. This is the case because Part D enrollment is lower than projected in last year's report, and it is disproportionately lower for those eligible for low-income subsidies.

[37]For more information on the bidding process, see section IV.B.

Figure II.F1.—SMI Expenditures and Premiums as a Percentage of the Gross Domestic Product



Note: Percentages are affected by economic cycles.

3. Implications of SMI Cost Growth

Financing for the SMI trust fund is adequate because beneficiary premiums and government contributions for both Part B and Part D are established annually to cover the expected costs for the upcoming year. If actual costs exceed those anticipated when the financing is determined, future financing rates can include adjustments to recover the shortfall. Likewise, if actual costs are less than those anticipated, the savings will result in lower future financing rates. As long as the future financing rates continue to cover the following year's estimated costs, both parts of the SMI trust fund will remain financially solvent.

A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers. This section compares the past and projected growth in SMI costs with GDP growth. It also assesses the implications of the rapid growth for beneficiaries and the budget of the Federal Government.

Table II.F2 compares the growth in SMI expenditures with that of the economy as a whole. SMI cost growth is expected to continue to outpace growth in GDP throughout the projection period, but at a slower rate compared with the last 10 years or prior periods.

The relatively high growth during 2025–2034 is due to the continuing retirement of the baby boom generation and increases in cost trends. Growth rates are projected to decline during 2035–2049 as beneficiary population growth slows. For the projection period's last 50 years, cost growth moderates further because of the continued deceleration in beneficiary population growth and lower health care cost growth rate assumptions.

On a per capita basis, SMI expenditure growth was only slightly faster than GDP growth for the 2015–2024 period, though it substantially exceeded GDP growth in a number of years that were not affected by the COVID-19 pandemic. Per capita SMI expenditure growth for 2025–2034 is projected to again significantly exceed growth in GDP. Then it is expected to slow and increase only slightly faster than GDP growth after 2050 because of several legislatively specified payment updates, including those for physician prices.

Table II.F2.—Average Annual Rates of Growth in SMI and the Economy
[In percent]

	SMI			U.S. Economy			
Calendar years	Beneficiary population	Per capita expenditures	Total expenditures	Total population	Per capita GDP	Total GDP	Growth differential[1]
Historical data:							
1968–2004	2.1%	10.9%	13.3%	1.0%	6.4%	7.4%	5.4%
2005–2014	2.4	7.0[2]	9.6[2]	0.8	2.9	3.7	5.6[2]
2015–2024	2.3	4.7	7.1	0.6	4.5	5.2	1.8
Intermediate estimates:							
2025–2034	1.9	6.2	8.2	0.6	3.6	4.2	3.8
2035–2049	0.5	4.8	5.3	0.4	3.5	3.9	1.3
2050–2074	0.6	3.8	4.4	0.3	3.6	3.9	0.5
2075–2099	0.3	3.8	4.1	0.3	3.7	4.0	0.1

[1]Excess of total SMI expenditure growth above total GDP growth, calculated as a multiplicative differential.
[2]Includes the addition of the prescription drug benefit to the SMI program in 2006. Excluding 2006, the average annual per capita expenditure increase is 4.2 percent, the total expenditure increase is 6.7 percent, and the growth differential is 3.1 percent.

The availability of SMI Part B and Part D benefits greatly reduces the costs that beneficiaries would otherwise pay for health care services. The introduction of the prescription drug benefit increased beneficiaries' costs for SMI premiums and cost sharing, but it reduced their costs for previously uncovered services by substantially more.

As SMI per capita benefits grow faster than average income or per capita GDP, the premiums and coinsurance amounts paid by beneficiaries represent a growing share of their total income. Figure II.F2 compares past and projected growth in average benefits for SMI versus Social Security. The figure also shows amounts for the standard premium and average cost sharing for Part B, as well as the average basic premium and basic cost sharing for Part D.[38] To facilitate comparison across long time periods, all values are in constant 2024 dollars.

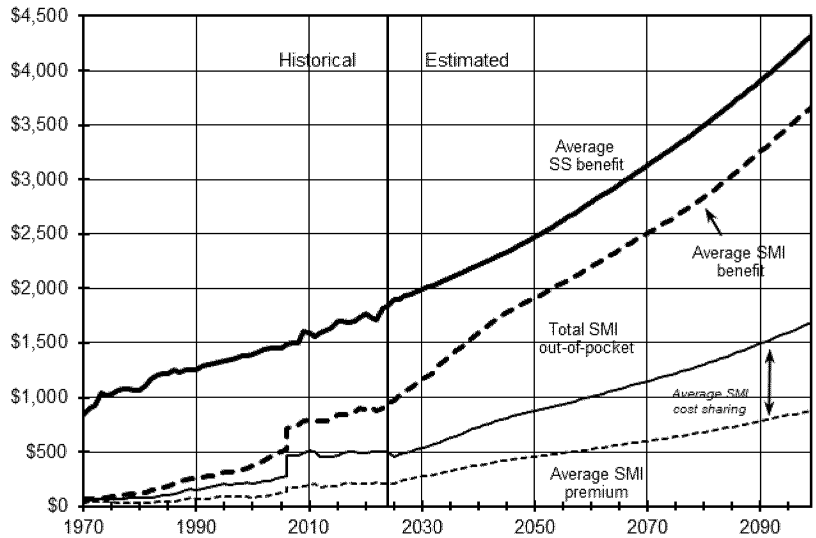
Over time, the average Social Security benefit tends to increase at about the rate of growth in average earnings. Health care costs generally reflect increases in the earnings of health care professionals, growth in the utilization and intensity of services, and other medical cost inflation.

As indicated in figure II.F2, average SMI benefits were only about one-twelfth the level of average Social Security benefits in 1970 but grew to more than one-third by 2005. With the introduction of the Part D prescription drug benefit in 2006, this ratio grew to almost one-half. Under the intermediate projections, SMI benefits would continue increasing at a faster rate and would represent nearly 85 percent of the average Social Security retired-worker benefit in 2099.

Average beneficiary premiums and cost-sharing payments for SMI will increase at about the same rate as average SMI benefits.[39] Therefore, over time, a growing proportion of most beneficiaries' Social Security benefit may be needed to pay their SMI premiums and cost-sharing amounts.

[38]Average cost sharing for Part B is based on its defined benefits, while basic premiums and cost sharing for Part D reflect the defined standard benefit or actuarially equivalent benefits.
[39]As a result, the projected ratio of average SMI out-of-pocket payments to average SMI benefits is nearly constant over time.

Figure II.F2.—Comparison of Average Monthly SMI Benefits, Premiums, and Cost Sharing to the Average Monthly Social Security Benefit
[Amounts in constant 2024 dollars]



Most SMI enrollees have other income in addition to Social Security benefits. Other possible sources include earnings from employment, employer-sponsored pension benefits, and investment earnings. In addition, most draw down their accumulated assets to supplement their income in retirement.

For simplicity, the comparisons in figure II.F2 apply to Social Security benefits only. A comparison of average SMI premiums and cost-sharing amounts to average total beneficiary income would likely lead to similar conclusions.

The Trustees estimate that the average Part B plus Part D premium would equal about 11 percent of the average Social Security benefit in 2025 but would increase to 20 percent in 2099. Similarly, an average cost-sharing amount in 2025 would be equivalent to about 14 percent of the Social Security benefit but would increase to about 19 percent in 2099. The combination of premium and cost-sharing amounts for Parts B and D would equal about 25 percent of the average Social Security benefit in 2025 and would increase to an estimated 39 percent in 2099.

The average OASI benefit amount for all retired workers is the basis for the Social Security benefits shown in figure II.F2. Individual retirees may receive significantly more or less than the average, depending on their past earnings and other factors. For purposes of illustration, the figure shows the average SMI benefit value and cost-sharing liability for all beneficiaries.

The value of SMI benefits and the cost-sharing payments of individual enrollees both vary more substantially than OASI benefits, depending on the enrollees' income, assets, and use of covered health services in a given year.

Medicaid pays Part B premiums and cost-sharing amounts for beneficiaries with very low incomes, and the Medicare low-income drug subsidy pays the corresponding Part D amounts (except for nominal copayments). Moreover, high-income beneficiaries have paid an income-related premium for Part B since 2007 and for Part D since 2011. Further information on this comparison and the variations from the average results is available in a memorandum by the CMS Office of the Actuary at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Beneficiaryoop.html.

Another way to evaluate the implications of rapid SMI cost growth is to compare transfers from the general fund of the Treasury to the SMI trust fund with total Federal income taxes (personal and corporate income taxes). Table II.F3 shows SMI government contributions as a percentage of total Federal income taxes. If these taxes in the future maintain their historical average level of the last 50 years relative to the national economy, then, based on the intermediate assumptions, SMI government contributions in 2099 will represent about 34.3 percent of total income taxes.

Table II.F3.—SMI Government Contributions as a Percentage of Personal and Corporate Federal Income Taxes

Fiscal year	Percentage of income taxes[1]
Historical data:	
1970	0.8%
1980	2.2
1990	5.9
2000	5.4
2010	19.6
2015	14.0
2016	16.2
2017	16.4
2018	16.8
2019	17.0
2020	19.6
2021	18.5
2022	13.3
2023	16.9
2024	16.1
Intermediate Estimates:	
2030	22.0
2040	28.1
2050	30.2
2060	31.7
2070	33.2
2080	34.3
2090	34.4
2099	34.3

[1]Includes the Part D prescription drug benefit beginning in 2006.

These examples illustrate the significant impact of SMI expenditure growth on beneficiaries, taxpayers, and the Federal budget. The projected SMI expenditure increases associated with the cost of providing health care, plus the impact of the baby boom generation reaching eligibility age, would continue to require a growing share of available economic resources to finance these costs. This outlook reinforces the Trustees' recommendation to develop and enact further reforms to address the SMI expenditure growth rate.

G. CONCLUSION

Total Medicare expenditures were $1,122.1 billion in 2024, and the Board projects that they will increase in most future years at a somewhat faster pace than either aggregate workers' earnings or the economy overall. The faster increase is primarily due to the number of beneficiaries increasing more rapidly than the number of workers, coupled with an increase in the volume and intensity of services delivered. Based on the intermediate set of assumptions under current law, Medicare expenditures as a percentage of GDP would increase from the current 3.8 percent to a projected 6.7 percent by 2099.

As it has since 2004, the HI trust fund fails to meet the Board of Trustees' short-range test of financial adequacy. In addition, as in all past reports, the HI trust fund fails to meet the Trustees' long-range test of close actuarial balance.

HI has experienced surpluses since 2021, and they are expected to continue through 2027 and then turn to deficits for the remainder of the 75-year projection period. The projected trust fund depletion date is 2033, 3 years earlier than estimated in last year's report. HI expenditures are projected to be higher than last year's estimates through the short-range period mainly as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

The HI actuarial deficit in this year's report is 0.42 percent of taxable payroll, up from 0.35 percent in last year's report. This result is largely due to the expenditure changes explained above, partially offset by changes in economic and demographic assumptions.

The financial outlook for SMI is fundamentally different than for HI as a result of the statutory differences in the methods of financing for these two components of Medicare.

The Trustees project that both the Part B and Part D accounts of the SMI trust fund will remain in financial balance for all future years because beneficiary premiums and general fund transfers are assumed to be set at a level to meet expected costs each year. However, SMI costs are projected to increase significantly as a share of GDP over the next 75 years, from 2.4 percent to 4.8 percent under current law.

The projected Part B costs as a share of GDP in this report are higher than the projected Part B costs in the 2024 report because of higher projected spending for outpatient hospital and physician-administered drugs.

For Part D, the expenditure share of GDP is lower than the share in last year's report in most years. This is the case because Part D enrollment is lower than projected in last year's report, and it is disproportionately lower for those eligible for low-income subsidies.

The financial projections shown for the Medicare program in this report reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most health care provider categories. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely.

Considering these issues with provider payment rates, the Trustees note that the actual future costs for Medicare could exceed those shown in this report. Projections under an alternative scenario, as provided in section V.C and in a memorandum from the Office of the Actuary,[40] can help illustrate the potential magnitude of the understatement. For example, the total cost of Medicare in 2099 would be 8.8 percent of GDP under the alternative projections (versus 6.7 percent under current law), and the HI actuarial deficit would be 1.28 percent of taxable payroll (versus 0.42 percent). The projected depletion date for the HI trust fund would be unchanged.

Readers should interpret the projections shown in this report as illustrations of the very favorable impact of permanently slower growth in health care costs, if such slower growth is achievable. The illustrative alternative projections show the higher costs if slower growth cannot be achieved under current law.

Policymakers should determine effective solutions to the long-range HI financial imbalance. Even assuming that the provider payment rates will be adequate, HI revenues would cover 89 percent of estimated expenditures in 2033 and 86 percent in 2049. Policymakers should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address the financial imbalance.

The projections in this year's report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the HI trust fund's projected depletion,

[40]See https://www.cms.gov/files/document/illustrative-alternative-scenario-2025.pdf.

this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law.

The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI and reduce the rate of growth in Medicare costs. The sooner solutions are enacted, the more flexible and gradual they can be. The early introduction of reforms also increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior. The Board recommends that Congress and the executive branch work together to quickly address these challenges.

III. ACTUARIAL ANALYSIS

A. INTRODUCTION

The Actuarial Analysis section focuses on the costs and financing of the individual HI and SMI trust fund accounts. The Trustees perform an analysis for each trust fund individually, to determine whether each account's income and expenditures are balanced as necessary to maintain solvency. (It is also valuable to consider Medicare's total expenditures and the sources and relative magnitudes of the program's revenues. Section V.B presents such information for Medicare overall.)

For this report, projections are shown in two different ways. The cash basis reflects the date when payment for the service was made, whereas the incurred basis reflects the date when the service was performed. The projections are first prepared on an incurred basis, and then adjustments are made to account for costs on a cash basis. Generally, trust fund operations show the actual or projected income and expenditures on a cash basis, while analysis and methodology are presented on an incurred basis.

The HI and SMI trust funds are separate and distinct, each with its own sources of financing. There are no provisions for using HI revenues to finance SMI expenditures, or vice versa, or for lending assets between the two trust funds. Moreover, the benefit provisions, financing methods, and, to a lesser degree, eligibility rules are very different between these Medicare components. In particular, both accounts of the SMI trust fund are automatically in financial balance, whereas the HI fund is not.

For these reasons, the Trustees can evaluate the financial status of the Medicare trust funds only by separately assessing the status of each fund. Sections III.B, III.C, and III.D of this report present such assessments for HI (Part A), SMI Part B, and SMI Part D, respectively. The Trustees also provide key results based on an illustrative alternative scenario in section V.C.

B. HI FINANCIAL STATUS

This section presents actual HI trust fund operations in 2024 and HI trust fund projections for the next 75 years. Section III.B1 discusses HI financial results for 2024, and sections III.B2 and III.B3 discuss the short-range HI projections and the long-range projections, respectively. The projections shown in sections III.B2 and III.B3 assume no changes will occur in the statutory provisions and regulations under which HI now operates.[41]

1. Financial Operations in Calendar Year 2024

On July 30, 1965, the Social Security Act established the Federal Hospital Insurance Trust Fund as a separate account in the U.S. Treasury. All the HI financial operations occur within this fund.

Table III.B1 presents a statement of the revenue and expenditures of the fund in calendar year 2024, and of its assets at the beginning and end of the calendar year.

The total assets of the trust fund amounted to $208.8 billion on December 31, 2023. During calendar year 2024, total revenue amounted to $451.2 billion, and total expenditures were $422.5 billion. Total assets thus increased by $28.7 billion during the year to $237.5 billion on December 31, 2024.

[41]The one exception is that the projections disregard payment reductions that would result from the projected depletion of the HI trust fund.

Table III.B1.—Statement of Operations of the HI Trust Fund during Calendar Year 2024
[In thousands]

Total assets of the trust fund, beginning of period	$208,797,298
Revenue:	
Payroll taxes	$396,449,570
Income from taxation of OASDI benefits	39,794,000
Interest on investments	7,196,308
Premiums collected from voluntary participants	4,758,982
Premiums collected from Medicare Advantage participants	206,375
ACA Medicare shared savings program receipts	242,044
Transfer from Railroad Retirement account	645,200
Reimbursement, transitional uninsured coverage	44,000
Reimbursement, program management general fund	574,372
Interfund interest payments to OASDI[1]	−3,499
Interest on reimbursements, Railroad Retirement	25,303
Other	152
Reimbursement, union activity	1,355
Fraud and abuse control receipts:	
Criminal fines	1,932
Civil monetary penalties	46,343
Civil penalties and damages, Department of Justice	425,340
Asset forfeitures, Department of Justice	189,719
3% administrative expense reimbursement, Department of Justice	21,554
General fund appropriation fraud and abuse, FBI	168,347
General fund transfer, Discretionary	367,892
Total revenue	$451,155,289
Expenditures:	
Net benefit payments	$416,288,304
Administrative expenses:	
Treasury administrative expenses	138,494
Salaries and expenses, SSA[2]	1,324,306
Salaries and expenses, CMS[3]	1,654,539
Salaries and expenses, Office of the Secretary, HHS	109,477
Medicare Payment Advisory Commission	8,294
Medicare Access Children's Health Insurance Program (CHIP)	49
Administration for Community Living State Health Insurance Program	49,763
Fraud and abuse control expenses:	
HHS Medicare integrity program	1,104,961
HHS Office of Inspector General	322,299
Department of Justice	101,999
FBI	159,729
HCFAC Discretionary, CMS	872,709
HCFAC Other HHS Discretionary, CMS	526
HCFAC Department of Justice Discretionary, CMS	218,955
HCFAC Office of Inspector General Discretionary, CMS	101,773
Total administrative expenses	6,167,871
Total expenditures	$422,456,175
Net addition to the trust fund	28,699,114
Total assets of the trust fund, end of period	$237,496,412

[1]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds and then are reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the HI trust fund from the other trust funds. A negative figure represents a transfer from the HI trust fund to the other funds.
[2]For facilities, goods, and services provided by the Social Security Administration (SSA).
[3]Includes expenses of the Medicare Administrative Contractors.

Note: Totals do not necessarily equal the sums of rounded components.

a. Revenues

The trust fund's primary source of income consists of amounts appropriated to it, under permanent authority, on the basis of taxes paid by workers, their employers, and individuals with self-employment earnings, in work covered by HI. Included in HI are workers covered under the OASDI program, those covered under the Railroad Retirement program, and certain Federal, State, and local employees not otherwise covered under the OASDI program.

HI taxes are payable without limit on a covered individual's total wages and self-employment earnings. For calendar years prior to 1994, taxes were computed on a person's annual earnings up to a specified maximum annual amount called the *maximum tax base*. Table III.B2 presents the maximum tax bases for 1966–1993. Legislation enacted in 1993 removed the limit on taxable income beginning in calendar year 1994.

Table III.B2 also shows the HI tax rates applicable in each of calendar years 1966 and later. For 2026 and thereafter, the tax rates shown are the rates scheduled in current law. As indicated in the footnote to the table, in 2013 and later employees and self-employed individuals pay an additional HI tax of 0.9 percent on their earnings above certain thresholds.

Table III.B2.—Tax Rates and Maximum Tax Bases

Calendar years	Maximum tax base	Tax rate (Percentage of taxable earnings): Employees and employers, each	Tax rate (Percentage of taxable earnings): Self-employed
Past experience:			
1966	$6,600	0.35%	0.35%
1967	6,600	0.50	0.50
1968–71	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
1990	51,300	1.45	2.90
1991	125,000	1.45	2.90
1992	130,200	1.45	2.90
1993	135,000	1.45	2.90
1994–2012	no limit	1.45	2.90
2013–2025	no limit	1.45[1]	2.90[1]
Scheduled in current law:			
2026 & later	no limit	1.45[1]	2.90[1]

[1]Beginning in 2013, workers pay an additional 0.9 percent of their earnings above $200,000 (for those who file an individual tax return) or $250,000 (for those who file a joint income tax return).

Total HI payroll tax income in calendar year 2024 amounted to $396.4 billion—an increase of 8.0 percent over the amount of $367.2 billion for the preceding 12-month period. This increase occurred primarily because both the number of covered workers and average wages were higher.

Up to 85 percent of an individual's or couple's OASDI benefits may be subject to Federal income taxation if their income exceeds certain thresholds. The income tax revenue attributable to the first 50 percent of OASDI benefits is allocated to the OASI and DI trust funds. The revenue associated with the amount between 50 and 85 percent of benefits is allocated to the HI trust fund. Income from the taxation of OASDI benefits amounted to $39.8 billion in calendar year 2024.

Another substantial source of trust fund income is interest credited from investments in government securities held by the fund. In calendar year 2024, the fund received $7.2 billion in such interest. A description of the trust fund's investment procedures appears later in this section.

Section 1818 of the Social Security Act provides that certain persons not otherwise eligible for HI protection may obtain coverage by enrolling in HI and paying a monthly premium. In 2024, premiums collected from such voluntary participants (or paid on their behalf by Medicaid) amounted to about $4.8 billion.

The Railroad Retirement Act provides for a system of coordination and financial interchange between the Railroad Retirement program and the HI trust fund. This financial interchange requires a transfer that would place the HI trust fund in the same position in which it would have been if the Social Security Act had always covered railroad employment. In accordance with these provisions, a transfer of $645 million in principal and about $14 million in interest from the Railroad Retirement program's Social Security Equivalent Benefit Account to the HI trust fund balanced the two systems as of September 30, 2023. The trust fund received this transfer, together with interest to the date of transfer totaling about $12 million, in June 2024.

Legislation in 1982 added transitional entitlement for those Federal employees who retire before having had a chance to earn sufficient quarters of Medicare-qualified Federal employment. The general fund of the Treasury provides reimbursement for the costs of this coverage, including administrative expenses. In calendar year 2024, such reimbursement amounted to $44 million for estimated benefit payments for these beneficiaries.

Legislation in 1996 established a health care fraud and abuse control account within the HI trust fund. Monies derived from the fraud and abuse control program are transferred from the general fund of the Treasury to the HI trust fund. During calendar year 2024, the trust fund received about $1,221 million from this program.

b. Expenditures

The HI trust fund pays expenditures for HI benefit payments and administrative expenses. All HI administrative expenses incurred by the Department of Health and Human Services, the Social Security Administration, the Department of the Treasury (including the Internal Revenue Service), and the Department of Justice in administering HI are charged to the trust fund. Such administrative duties include payment of benefits, the collection of taxes, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under HI and SMI.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of HI. Although trust fund expenditures include these costs, the statement of trust fund assets presented in this report does not carry the net worth of facilities and other fixed capital assets because the proceeds of sales of such assets revert to the General Services Administration. Since the value of fixed capital assets does not represent funds available for benefit or administrative expenditures, the Trustees do not consider it in assessing the actuarial status of the funds.

Of the $422.5 billion in total HI expenditures, $416.3 billion represented net benefits paid from the trust fund for health services.[42] Net benefit payments increased 4.7 percent in calendar year 2024 over the corresponding amount of $397.5 billion paid during the preceding calendar year. These payments reflect the change in the number of beneficiaries, the price of health services, and the volume and intensity of services. Further information on HI benefits by type of service is available in section IV.A.

The remaining $6.2 billion in expenditures was for net HI administrative expenses, after adjustments to the preliminary allocation of administrative costs among the Social Security and Medicare trust funds and the general fund of the Treasury. The expenditure amount of $6.2 billion also included $2.9 billion for the health care fraud and abuse control program.

c. Actual experience versus prior estimates

Table III.B3 compares the actual experience in calendar year 2024 with the estimates presented in the 2023 and 2024 annual reports. A number of factors can contribute to differences between estimates and subsequent actual experience. In particular, actual values for key economic and other variables can differ from assumed levels, and

[42]Net benefits equal the total gross amounts initially paid from the trust fund during the year, less recoveries of overpayments identified through fraud and abuse control activities.

legislative and regulatory changes may occur after a report's preparation.

As shown in table III.B3, actual HI payroll tax income in 2024 was higher than estimated in the 2023 and 2024 reports because of higher levels of covered wages and covered workers. Actual HI benefit payments in calendar year 2024 were higher than projected in the 2024 report and nearly identical to those projected in the 2023 report.

Table III.B3.—Comparison of Actual and Estimated Operations of the HI Trust Fund, Calendar Year 2024

[Dollar amounts in millions]

		Comparison of actual experience with estimates for calendar year 2024 published in—			
		2024 report		2023 report	
Item	Actual amount	Estimated amount[1]	Actual as a percentage of estimate	Estimated amount[1]	Actual as a percentage of estimate
Payroll taxes	$396,450	$388,919	102%	$373,989	106%
Benefit payments[2]	416,288	411,812	101	416,708	100

[1]Under the intermediate assumptions.

[2]Benefit payments include (i) additional premiums for Medicare Advantage plans that are deducted from beneficiaries' Social Security benefits, (ii) costs of Quality Improvement Organizations, and (iii) health information technology payments.

d. Assets

The Department of the Treasury invests, on a daily basis, the portion of the trust fund not needed to meet current expenditures for benefits and administration in interest-bearing obligations of the U.S. Government. The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that these special public-debt obligations bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue) for all marketable interest-bearing obligations of the United States forming a part of the public debt that are not due or callable until after 4 years from the end of that month. Currently, all invested assets of the HI trust fund are in the form of such special-issue securities.[43] Table V.H9, presented in section V.H, shows the assets of the HI trust fund at the end of fiscal years 2023 and 2024.

2. 10-Year Actuarial Estimates (2025–2034)

This section provides detailed information concerning the short-range financial status of the trust fund, including projected annual income,

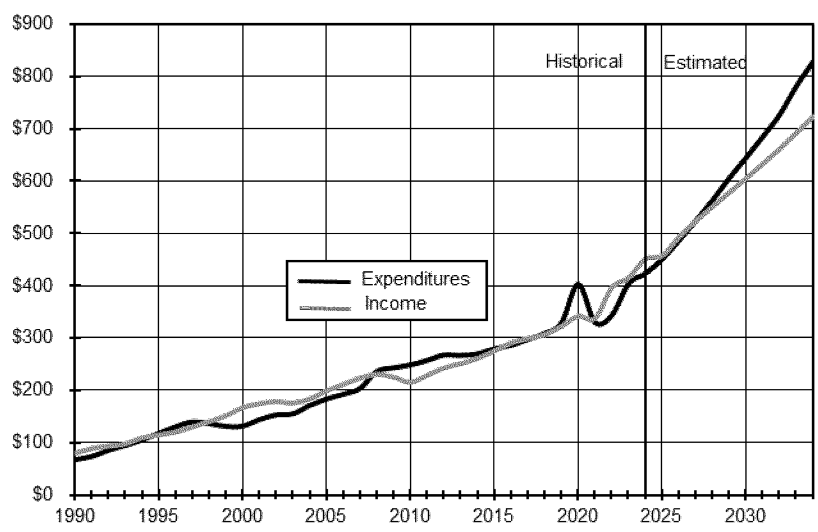
[43]The Department of the Treasury may also make investments in obligations guaranteed as to both principal and interest by the United States, including certain federally sponsored agency obligations.

expenditures, differences between income and expenditures, and trust fund balances. Also discussed is the Trustees' test of short-range financial adequacy.

To illustrate the sensitivity of future costs to different economic and demographic factors and to portray a reasonable range of possible future trends, the Trustees show estimates under three alternative sets of economic and demographic assumptions—intermediate, low-cost, and high-cost assumptions. Because of the uncertainty inherent in such projections, however, the actual operations of the HI trust fund in the future could differ significantly from these estimates.

Figure III.B1 shows past and projected income and expenditures for the HI trust fund under the Trustees' intermediate assumptions. Following the Balanced Budget Act of 1997, the fund experienced annual surpluses through 2007. Beginning in 2008, expenditures exceeded total income, and this situation continued through 2015. In 2016 and 2017, the fund experienced small surpluses. In 2018 through 2019 there were deficits, and in 2020 there was a very large deficit because of the accelerated and advance payments made to providers. There was a small surplus in 2021, and a larger one in 2022, as these payments began to be repaid. Small surpluses occurred again in 2023 and 2024, with small projected surpluses expected in 2025 through 2027. After 2027 annual deficits are expected to return and continue throughout the rest of the projection period.

Figure III.B1.—HI Expenditures and Income
[In billions]



Actuarial Analysis

The impact of the December 2007 through June 2009 recession on HI payroll tax income is apparent in figure III.B1. In 2009 and 2010, payroll taxes decreased substantially as a result of higher unemployment and slow growth in wages along with collection lags; these factors contributed to the $32.3 billion trust fund deficit in 2010. For 2011 through 2015, revenues rebounded somewhat but not enough to reach the level of expenditures, which continued to grow because of increased enrollment and the regular updating of the payment rates. Together these factors resulted in a decline in trust fund deficits from $27.7 billion in 2011 to $3.5 billion in 2015.

In 2016 and 2017, a lower level of growth in expenditures combined with higher growth in payroll taxes led to surpluses of $5.4 billion and $2.8 billion, respectively, in the trust fund. In 2018 and 2019 the trend reversed, with a higher level of growth in expenditures and lower growth in payroll taxes leading to trust fund deficits of $1.6 billion and $5.8 billion, respectively. In 2020, a very large deficit of $60.4 billion was reached because of the accelerated and advance payments to providers, which amounted to $63.5 billion net of repayments and which were paid from the trust fund. The net repayments of about $29.0 billion and $33.8 billion of these payments were completed in 2021 and 2022, resulting in surpluses of $8.5 billion and $53.9 billion, respectively. In 2023 and 2024, there were surpluses of $12.2 billion and $28.7 billion, respectively.

Despite a significant increase in the number of beneficiaries over the last decade, expenditure growth has been slower than observed throughout the history of the program because of a reduction in price updates and low growth in the utilization of services. For example, since 2012, price updates for all HI providers have been reduced by the growth in economy-wide productivity.

HI expenditures are further affected by the *sequestration* required by current law, which reduces benefit payments by the following percentages: 2 percent from April 1, 2013, through April 30, 2020; 1 percent from April 1, 2022, through June 30, 2022; and 2 percent from July 1, 2022, through January 31, 2033.

Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013, through January 31, 2033, excluding May 1, 2020, through March 31, 2022. (See section V.A for recent legislative changes affecting the sequestration of Medicare expenditures.)

As figure III.B1 illustrates, HI income increased at a faster rate during 2011–2016 than HI expenditures, in contrast to the situation that has prevailed during most of the program's history. The recovery from the economic recession that ended in 2009 accelerated income growth during this period. At the same time, the provider payment updates mentioned previously slowed expenditure growth significantly. From 2017 through 2020, expenditures increased more rapidly than income; however, a reversal occurred in 2021 and 2022 that was attributable to repayment of the accelerated and advance payments and the slower rebound in utilization in those years, along with higher payroll tax income in 2022. In 2023, expenditures once again increased more rapidly than income. Although income grew more rapidly than expenditures in 2024, expenditure growth is expected to be faster than income growth for most of the projection period.

Table III.B4 shows the expected operations of the HI trust fund during calendar years 2025–2034 based on the intermediate set of assumptions, together with the past experience. Section IV.A of this report presents the detailed assumptions underlying the intermediate projections.

Table III.B4.—Operations of the HI Trust Fund during Calendar Years 1970–2034

[In billions]

Calendar year	Income								Expenditures			Trust fund	
	Payroll taxes	Income from taxation of benefits	Railroad Retirement account transfers	Reimburse-ment for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other[1,2]	Total	Benefit payments[2,3]	Administrative expenses[4]	Total	Net change	Fund at end of year
Historical data:													
1970	$4.9	—	$0.1	$0.9	—	$0.0	$0.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	—	0.1	0.6	$0.0	0.0	0.7	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	—	0.2	0.7	0.0	0.1	1.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	—	0.4	0.8	0.0	−0.7[5]	3.4	51.4	47.6	0.8	48.4	4.8[6]	20.5
1990	72.0	—	0.4	0.4	0.1	−1.0[7]	8.5	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	$3.9	0.4	0.5	1.0	0.1	10.8	115.0	116.4	1.2	117.6	−2.6	130.3
2000	144.4	8.8	0.5	0.5	1.4	0.0	11.7	167.2	128.5[8]	2.6	131.1	36.1	177.5
2005	171.4	8.8	0.4	0.3	2.4	0.0	16.1	199.4	180.0	2.9	182.9	16.4	285.8
2010	182.0	13.8	0.5	−0.1	3.3	0.0	16.1	215.6	244.5	3.5	247.9	−32.3	271.9
2015	241.1	20.2	0.6	0.2	3.2	0.0	10.1	275.4	273.4	5.5	278.9	−3.5	193.8
2016	253.5	23.0	0.7	0.2	3.3	0.0	10.1	290.8	280.5	4.9	285.4	5.4	199.1
2017	261.5	24.2	0.6	0.1	3.5	0.0	9.4	299.4	293.3	3.2[9]	296.5	2.8	202.0
2018	268.3	24.2	0.6	0.1	3.6	0.0	9.8	306.6	303.0	5.2	308.2	−1.6	200.4
2019	285.1	23.8	0.6	0.1	3.9	0.0	9.0	322.5	322.8	5.4	328.3	−5.8	194.6
2020	303.3	26.9	0.6	0.1	4.0	0.0	6.7	341.7	397.7[10]	4.5	402.2	−60.4	134.1
2021	302.5	25.0	0.6	0.1	4.2	0.0	5.1	337.4	323.6[10]	5.3	328.9	8.5	142.7
2022	352.8	32.8	0.5	0.1	4.5	0.0	5.9	396.6	337.4[10]	5.3	342.7	53.9	196.6
2023	367.2	35.0	0.6	0.1	4.7	0.0	7.9	415.3	397.5[10]	5.6	403.1	12.2	208.8
2024	396.4	39.8	0.7	0.0	4.8	0.0	9.4	451.2	416.3	6.2	422.5	28.7	237.5
Intermediate estimates:													
2025	399.9	40.7	0.7	0.0	5.3	0.0	10.7	457.3	443.2	6.5	449.7	7.6	245.1
2026	423.1	52.2	0.7	0.0	5.9	0.0	11.2	493.2	478.7	6.8	485.4	7.7	252.8
2027	444.1	60.6	0.7	0.0	6.3	0.0	11.7	523.4	516.0	7.0	523.0	0.4	253.2
2028	465.6	65.6	0.7	0.0	6.8	0.0	12.1	550.8	555.1	7.3	562.4	−11.7	241.5
2029	487.4	70.8	0.7	0.0	7.3	0.0	11.8	578.0	597.1	7.6	604.7	−26.7	214.8
2030	509.0	76.6	0.7	0.0	7.7	0.0	10.9	605.0	635.6	7.9	643.5	−38.6	176.2
2031	531.6	83.0	0.7	0.0	8.2	0.0	9.2	632.9	675.6	8.2	683.8	−50.9	125.3
2032	555.1	89.9	0.8	0.0	8.8	0.0	6.8	661.3	717.3	8.5	725.8	−64.5	60.8
2033[11]	580.7	97.0	0.8	0.0	9.5	0.0	4.0	692.0	771.1	9.3	780.4	−88.3	−27.5
2034[11]	605.6	104.5	0.8	0.0	10.1	0.0	2.0	723.1	817.5	9.8	827.3	−104.2	−131.7

[1]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income. These receipts amount to \$2.0–\$3.1 billion each year for the 10-year projection period.
[2]Values after 2005 include additional premiums for Medicare Advantage (MA) plans that are deducted from beneficiaries' Social Security benefits. These additional premiums are beneficiary obligations and occur when a beneficiary chooses an MA plan whose monthly plan payment exceeds the benchmark amount. Beneficiaries subject to such premiums may choose to either reimburse the plans directly or have the premiums deducted from their Social Security benefits. The premiums deducted from the Social Security benefits are transferred to the HI and SMI trust funds and then transferred from the trust funds to the plans.
[3]Includes costs of Peer Review Organizations from 1983 through 2001 (beginning with the implementation of the prospective payment system on October 1, 1983) and costs of Quality Improvement Organizations beginning in 2002.
[4]Includes costs of experiments and demonstration projects. Beginning in 1997, includes fraud and abuse control expenses.
[5]Includes a lump-sum adjustment of −\$0.8 billion transferred from the HI trust fund to the general fund of the Treasury.
[6]Includes repayment of loan principal, from the OASI trust fund, of \$1.8 billion.
[7]Includes a lump-sum adjustment of −\$1.1 billion transferred from the HI trust fund to the general fund of the Treasury.
[8]For 1998 through 2003, includes monies transferred to the SMI trust fund for home health agency costs.
[9]Reflects a larger-than-usual downward adjustment of \$1.8 billion for prior-year allocations among Part A, Part B, and Part D.
[10]Includes net payments of \$63.5 billion made through the Medicare Accelerated and Advance Payments Program in calendar year 2020 and subsequent net repayments of \$29.0 billion, \$33.8 billion, and \$0.5 billion in calendar years 2021 through 2023, respectively.
[11]Estimates for 2033 and later are hypothetical since the HI trust fund would be depleted in those years.

Note: Totals do not necessarily equal the sums of rounded components.

The increases in estimated income shown in table III.B4 primarily reflect increases in payroll tax income to the trust fund since such taxes are the main source of HI financing. As noted, payroll tax revenues increase in 2013 and later as a result of the additional 0.9-percent tax rate on earnings for high-income workers. For all other workers, while the payroll tax rate will remain constant under current law, covered earnings will increase every year under the intermediate assumptions because of projected increases in both the number of HI workers covered and the average earnings of these workers.

The income from taxation of Social Security benefits is affected by 2017 legislation that reduced individual income tax rates beginning in 2018. This income increased in 2022–2024, and larger increases are expected in 2026 and 2027 resulting from the expiration of certain tax rate reductions.

Interest earnings have been a source of income to the trust fund for many years, surpassed only by payroll taxes and income from the taxation of OASDI benefits. As the trust fund balance continues to decrease, interest earnings will follow the same pattern.

The Trustees project that over the next 10 years most of the remaining sources of financing for the HI trust fund will increase along with payroll tax revenues and covered earnings. More detailed descriptions of these sources of income were discussed earlier in this section.

The Trustees have recommended maintenance of HI trust fund assets at a level of at least 100 percent of annual expenditures throughout the projection period. Such a level would provide a cushion of several years in the event that income falls short of expenditures, thereby allowing time for policymakers to implement legislative corrections. The trust fund balance has been below 1 year's expenditures in every year since 2012 and is not projected to reach that level under the intermediate assumptions.

The Trustees have also prepared projections using two alternative sets of assumptions. Table III.B5 summarizes the estimated operations under all three alternatives. Section IV.A presents in substantial detail the assumptions underlying the intermediate assumptions, as well as the assumptions used in preparing estimates under the low-cost and high-cost alternatives.

Table III.B5.—Estimated Operations of the HI Trust Fund during Calendar Years 2024–2034, under Alternative Sets of Assumptions
[Dollar amounts in billions]

Calendar year	Total income	Total expenditures	Net increase in fund	Fund at end of year	Ratio of assets to expenditures[1] (percent)	Expenditures as a percentage of taxable payroll
Intermediate:						
2024[2]	$451.2	$422.5	$28.7	$237.5	49%	3.34%
2025	457.3	449.7	7.6	245.1	53	3.40
2026	493.2	485.4	7.7	252.8	50	3.50
2027	523.4	523.0	0.4	253.2	48	3.61
2028	550.8	562.4	−11.7	241.5	45	3.71
2029	578.0	604.7	−26.7	214.8	40	3.82
2030	605.0	643.5	−38.6	176.2	33	3.90
2031	632.9	683.8	−50.9	125.3	26	3.97
2032	661.3	725.8	−64.5	60.8	17	4.05
2033[3]	692.0	780.4	−88.3	−27.5	8	4.18
2034[3]	723.1	827.3	−104.2	−131.7	—[4]	4.25
Low-cost:						
2024[2]	451.2	422.5	28.7	237.5	49	3.32
2025	463.7	442.7	21.0	258.5	54	3.28
2026	514.5	471.1	43.5	302.0	55	3.26
2027	552.8	505.4	47.5	349.5	60	3.30
2028	591.2	540.1	51.1	400.6	65	3.33
2029	631.0	576.9	54.1	454.7	69	3.36
2030	672.8	610.2	62.6	517.2	75	3.36
2031	717.6	644.2	73.4	590.6	80	3.36
2032	764.8	679.2	85.5	676.1	87	3.35
2033	816.2	726.0	90.2	766.3	93	3.40
2034	868.6	764.6	104.0	870.3	100	3.39
High-cost:						
2024[2]	451.2	422.5	28.7	237.5	49	3.36
2025	444.8	456.3	−11.5	226.0	52	3.59
2026	457.9	493.9	−36.0	190.0	46	3.83
2027	488.6	538.5	−49.8	140.1	35	4.00
2028	511.3	588.8	−77.5	62.6	24	4.19
2029[3]	530.5	641.1	−110.6	−48.0	10	4.40
2030[3]	549.0	688.5	−139.5	−187.5	—[4]	4.58
2031[3]	566.1	736.8	−170.7	−358.2	—[4]	4.76
2032[3]	582.7	787.2	−204.5	−562.7	—[4]	4.94
2033[3]	600.1	851.9	−251.9	−814.5	—[4]	5.21
2034[3]	615.0	909.1	−294.0	−1,108.6	—[4]	5.40

[1]Ratio of assets in the fund at the beginning of the year to expenditures during the year.
[2]Figures for 2024 represent actual experience.
[3]Estimates are hypothetical for 2033 and later under the intermediate assumptions, and for 2029 and later under the high-cost assumptions, since the HI trust fund would be depleted in those years.
[4]Trust fund reserves would be depleted at the beginning of this year.

Note: Totals do not necessarily equal the sums of rounded components.

Because of the price assumptions for these alternative scenarios, the expenditures presented in these scenarios represent a narrow range of outcomes, and actual experience could easily fall outside of this range. For the low-cost scenario, the Trustees assume higher price inflation, which leads to higher spending. Similarly, under the high-cost scenario, the Trustees assume lower price inflation, which leads to lower spending. These price inflation assumptions partially offset the effects of the other assumptions in the high-cost and low-cost scenarios, resulting in a narrow range of expenditures. Given the considerable variation in the factors affecting health care spending, actual Part A experience could easily fall outside of this range. Because the taxable payroll assumptions in these scenarios are similarly affected by the price inflation assumptions, Part A expenditures as a percent of taxable payroll provide better insight into the variability of spending than the nominal dollar amounts, as shown in table III.B5.

The Board of Trustees has established an explicit test of short-range financial adequacy. The requirements of this test are conditional on the initial status of the HI trust fund ratio. If the fund ratio is at least 100 percent at the beginning of the projection period, the test requires that the ratio remain at or above 100 percent throughout the 10-year projection period. Alternatively, if the fund ratio is initially less than 100 percent, the test requires that the ratio reach a level of at least 100 percent within 5 years (with no depletion of the trust fund at any time during this period) and then remain at or above 100 percent throughout the rest of the 10-year period. The Trustees apply this test based on the intermediate projections.

The HI trust fund does not meet this short-range test. Failure of the trust fund to meet this test is an indication that HI solvency over the next 10 years is in question and that action is necessary to improve the short-range financial adequacy of the fund. While the short-range test is stringent, its purpose is to ensure that health care benefits continue to be available without interruption to the millions of aged and disabled Americans who rely on such coverage.

Table III.B6 shows the ratios of assets in the HI trust fund at the beginning of a calendar year to total expenditures during that year. As table III.B6 shows, the Trustees project that the trust fund ratio, which was below the 100-percent level at the beginning of 2024, will increase in 2025 before decreasing for the rest of the projection period until the fund is depleted in 2033. Accordingly, the financing for HI is not considered adequate in the short range (2025–2034).

The projected trust fund depletion date is 2033, 3 years earlier than estimated in last year's report. HI expenditures are projected to be higher than last year's estimates mainly as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

In total, for the period 2025–2034, income is $12 billion (or about 0.2 percent) lower, and expenditures are $250 billion (or about 4 percent) higher than projected in last year's report.

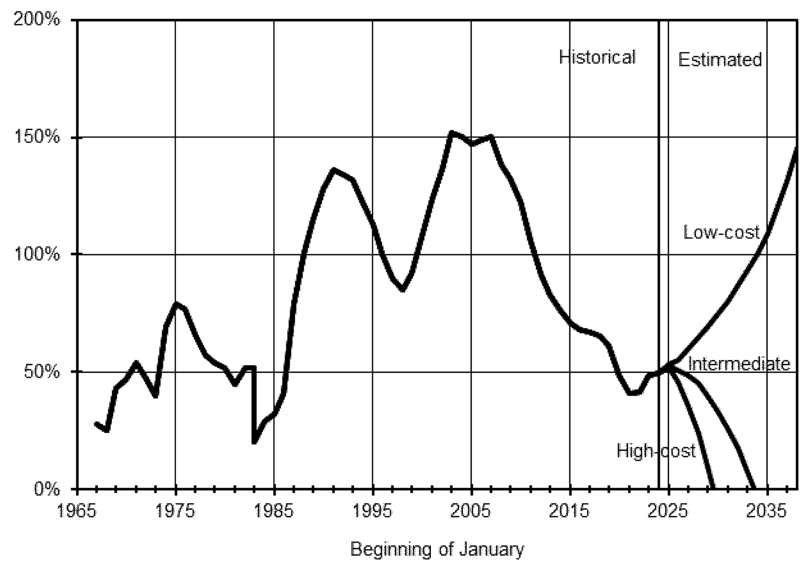
Table III.B6.—Ratio of Assets at the Beginning of the Year to Expenditures during the Year for the HI Trust Fund

Calendar year	Ratio
Historical data:	
1967	28%
1970	47
1975	79
1980	52
1985	32
1990	128
1995	113
2000	108
2005	147
2010	123
2015	71
2016	68
2017	67
2018	66
2019	61
2020	48
2021	41
2022	42
2023	49
2024	49
Intermediate Estimates:	
2025	53
2026	50
2027	48
2028	45
2029	40
2030	33
2031	26
2032	17
2033	8
2034	—[1]

[1]Trust fund reserves would be depleted at the beginning of this year.

Figure III.B2 shows the historical trust fund ratios and the projected ratios under the three sets of assumptions. It also shows the declining level of assets (as a percentage of expenditures) through 2021, after which the level of assets rises in 2022 and 2023. After remaining steady in 2024, the fund ratio would rise in 2025 and decline afterward under the intermediate assumptions. Similarly, the fund ratio would rise until 2025 and subsequently decline under the high-cost assumptions. Only under conditions of robust economic growth and extremely low health care cost increases, as assumed in the low-cost alternative, would HI assets grow significantly relative to expenditures under current law.

Figure III.B2.—HI Trust Fund Balance at the Beginning of the Year as a Percentage of Annual Expenditures



The HI trust fund is projected to be depleted in 2033 under the intermediate assumptions. Under the low-cost assumptions, trust fund assets are projected to increase throughout the entire projection period, while asset depletion would occur in 2029 under the high-cost assumptions.

3. Long-Range Estimates

This section examines the long-range actuarial status of the trust fund under the three alternative sets of economic and demographic assumptions, while section IV.A summarizes the assumptions used in preparing projections.

The Trustees measure the long-range actuarial status of the HI trust fund by comparing, on a year-by-year basis, the non-interest income (from payroll taxes, taxation of OASDI benefits, premiums, general fund transfers for uninsured persons, and monies derived from the fraud and abuse control program) with the corresponding incurred costs, expressed as percentages of taxable payroll.[44] These percentages are referred to as *income rates* and *cost rates*, respectively.

[44]Taxable payroll is the total amount of wages, salaries, tips, self-employment income, and other earnings subject to the HI payroll tax.

Table III.B7 shows historical and projected HI costs and income under the intermediate assumptions, expressed as percentages of taxable payroll. The ratio of expenditures to taxable payroll has generally increased over time; it rose from 1.11 percent in 1967 to 3.46 percent in 1996—an increase that reflected rapid growth in HI expenditures, which more than offset growth in average earnings per worker, and increases in (and eventual elimination of) the maximum taxable wage base for HI.

Cost rates declined significantly during 1997–2000 to 2.63 percent because of favorable economic performance, the impact of legislation, and efforts to curb fraud and abuse in the Medicare program. The cost rate increased to 3.17 percent by 2005 as a result of legislation and, after remaining about level through 2007, increased rapidly to 3.75 percent in 2010, reflecting the impact of the recession, which lowered taxable payroll. The resulting deficit in 2010 as a percentage of taxable payroll was the largest since the program began (0.55 percent). Cost rates generally decreased from 2011 through 2015 as the economy recovered, while health care cost growth rates were low. Cost rates remained fairly level until 2020, when there was a slight increase that was attributable to very low growth in taxable payroll as a result of the pandemic. In 2021 and 2022, cost rates declined as utilization remained low during the pandemic. There was a very small rebound in 2023 as expenditures grew slightly faster than taxable payroll. The cost rate remained stable in 2024 as expenditures and taxable payroll grew at a nearly identical rate.

Table III.B7.—HI Cost and Income Rates[1]

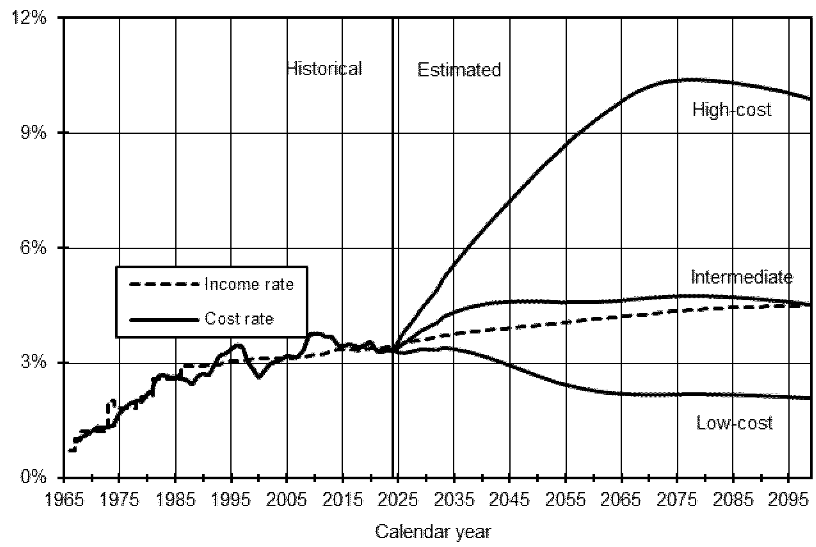
Calendar year	Cost rates	Income rates	Difference[2]
Historical data:			
1967	1.11%	1.09%	−0.01%
1970	1.35	1.41	+0.07
1975	1.79	1.90	+0.11
1980	2.26	2.16	−0.10
1985	2.68	2.74	+0.06
1990	2.72	2.92	+0.21
1995	3.36	3.05	−0.30
2000	2.63	3.11	+0.49
2005	3.17	3.12	−0.05
2010	3.75	3.20	−0.55
2015	3.43	3.35	−0.09
2016	3.48	3.35	−0.12
2017	3.45	3.36	−0.09
2018	3.41	3.33	−0.09
2019	3.47	3.35	−0.13
2020	3.54	3.37	−0.17
2021	3.34	3.39	+0.05
2022	3.31	3.38	+0.07
2023	3.34	3.41	+0.07
2024	3.34	3.41	+0.07
Intermediate estimates:			
2025	3.40	3.45	+0.05
2026	3.50	3.53	+0.03
2027	3.61	3.56	−0.05
2028	3.71	3.58	−0.14
2029	3.82	3.60	−0.22
2030	3.90	3.63	−0.27
2031	3.97	3.65	−0.32
2032	4.05	3.68	−0.37
2033	4.18	3.71	−0.47
2034	4.25	3.73	−0.52
2035	4.31	3.76	−0.56
2040	4.51	3.84	−0.67
2045	4.59	3.91	−0.68
2050	4.60	3.98	−0.62
2055	4.58	4.06	−0.52
2060	4.58	4.14	−0.45
2065	4.62	4.21	−0.41
2070	4.69	4.28	−0.41
2075	4.73	4.35	−0.39
2080	4.74	4.41	−0.33
2085	4.71	4.44	−0.26
2090	4.65	4.47	−0.19
2095	4.59	4.49	−0.10
2099	4.52	4.51	−0.00

[1]Based on the Trustees' intermediate assumptions and expressed as a percentage of taxable payroll. Taxable payroll includes statutory wage credits for military service for 1957−2001.
[2]Difference between the income rates and cost rates. Negative values represent deficits.

The Trustees expect growing deficits through about 2045, as cost rates grow faster than income rates. The increase in cost rates during this period is mostly attributable to rising per beneficiary spending and the impact of demographic shifts—notably, the aging of the baby boom population. After 2045, the size of the projected deficits decreases as subsequent demographic shifts reduce the growth in cost rates, resulting in cost-rate growth that is lower than income-rate growth. Projected HI expenditures are 4.60 and 4.52 percent of taxable payroll in 2050 and 2099, respectively. (Under the illustrative alternative projections, the HI cost rates for 2050 and 2099 would equal 5.04 and 6.91 percent, respectively.)

Figure III.B3 shows the year-by-year costs as a percentage of taxable payroll for each of the three sets of assumptions. It also shows the income rates, but only for the intermediate assumptions in order to simplify the presentation.

Figure III.B3.—Estimated HI Cost and Income Rates as a Percentage of Taxable Payroll



Based on the intermediate assumptions, the Trustees project that cost rates will continue to exceed income rates in all years starting in 2027. By the end of the 75 years, the income rates and cost rates would be roughly equal. Throughout the period, cost rate growth is constrained by the productivity reductions in provider payments, and income rates continue to increase as a larger share of earnings becomes subject to the additional 0.9-percent payroll tax and a larger share of Social Security benefits becomes subject to income tax that is credited to the HI trust fund.

Under the more favorable economic and demographic conditions assumed in the low-cost assumptions, HI costs would be lower than scheduled income and surpluses would steadily grow throughout the entire 75-year projection period. This very favorable result is due in large part to HI expenditure growth rates that would average only about 5 percent per year, reflecting the combined effects of (i) slower growth in utilization and intensity of services and (ii) lower Medicare enrollment.

The high-cost projections illustrate the large financial imbalance that could occur if future economic conditions resemble those of the 1973–1995 period, if HI expenditure growth accelerates toward pre-1997 levels, and if fertility rates decline.[45]

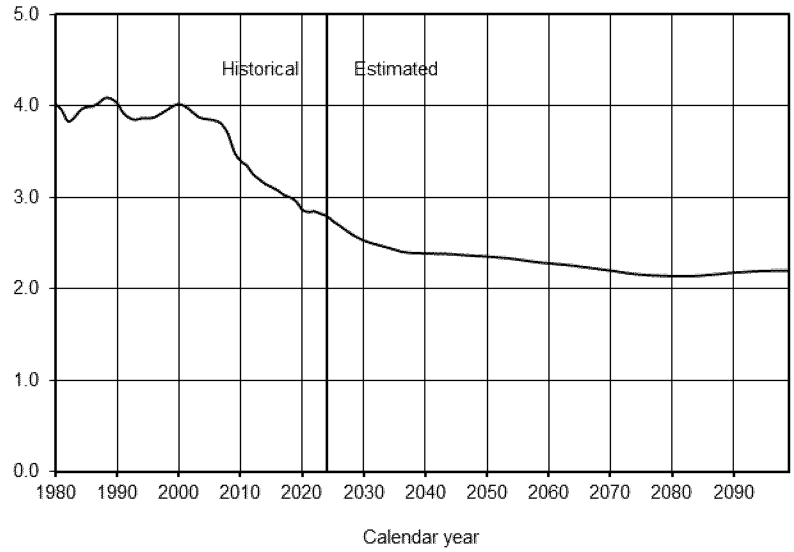
The Trustees project costs beyond the initial 25-year period for the intermediate estimate based on the assumption that average HI expenditures per beneficiary will increase at a rate determined by the economic model described in sections II.C and IV.D, less the price update adjustments based on economy-wide productivity gains. This net rate is roughly the same as the increase in Gross Domestic Product (GDP) per capita in 2049 and declines to about 0.3 percentage point *slower* than the growth in GDP by 2099. Beyond the initial 25-year projection period, the low-cost and high-cost alternatives assume that HI cost increases, relative to taxable payroll increases, are initially 2 percentage points less rapid and 2 percentage points more rapid, respectively, than the results under the intermediate assumptions. The assumed initial 2-percentage-point differentials decrease gradually until the year 2074, when HI cost increases (relative to taxable payroll) are assumed to be the same as under the intermediate assumptions.

Figure III.B3 shows the cost rates over a 75-year valuation period in order to present fully the future economic and demographic developments that one may reasonably expect to occur, such as the impact of the large increase in the number of people over age 65 that began to take place in 2011. Growth occurs in part because the ratio of workers to beneficiaries will decrease as persons born during the period between the end of World War II and the mid-1960s (known as the baby boom generation) reach eligibility age and begin to receive benefits.

Figure III.B4 shows the projected ratio of workers per HI beneficiary from 1980 to 2099. As figure III.B4 indicates, the ratio was about 4 workers per beneficiary from 1980 through 2008. It began to decline initially because of the recession but then declined further because of the retirement of the baby boom generation.

[45]Actual experience during these periods was similar on average to the high-cost economic and programmatic assumptions for the future.

Figure III.B4.—Workers per HI Beneficiary
[Based on intermediate assumptions]



While every beneficiary in 2024 had about 2.8 workers to pay for his or her HI benefit, in 2030 under the intermediate demographic assumptions there would be only about 2.5 workers for each beneficiary. This ratio would then continue to decline until there were only 2.2 workers per beneficiary in 2099. This reduction implies an increase in the HI cost rate of about 30 percent by 2099, relative to its current level, solely because of this demographic factor.[46]

While year-by-year comparisons of revenues and costs are necessary to measure the adequacy of HI financing, the financial status of the trust fund is often summarized, over a specific valuation period, by a single measure known as the *actuarial balance*. The actuarial balance of the HI trust fund is defined as the difference between the summarized income rate for the valuation period and the summarized cost rate for the same period.

The summarized income rates, cost rates, and actuarial balance are based upon the present values of future income, costs, and taxable payroll. The Trustees calculate the present values, as of the beginning of the valuation period, by discounting the future annual amounts of

[46]In addition to this factor, the projected increase in the HI cost rate reflects greater use of health care services as the beneficiary population ages and higher average costs per service because of medical price inflation and technological advances in care. The slower growth in Medicare payment rates to HI providers substantially offsets these increases.

income and expenditures using the projected effective rates of interest credited to the HI trust fund for the first 10 years and transition to the ultimate interest rate assumption by year 15. They then determine the summarized income and cost rates over the projection period by dividing the present value of income and cost, respectively, by the present value of taxable payroll. The difference between the summarized income rate and cost rate over the long-range projection period (after an adjustment to take into account the fund balance at the valuation date and a target trust fund balance at the end of the valuation period) is the actuarial balance.

The summarized cost rate includes the cost of maintaining a trust fund balance at the end of the period equal to the following year's estimated costs. While a zero or positive actuarial balance implies that the end-of-period trust fund balance is at least as large as the target trust fund balance, there is no such implication for the trust fund balance at other times during the projection period.

Table III.B8 shows the actuarial balances based on the Trustees' three sets of economic and demographic assumptions, for the next 25, 50, and 75 years. Based on the intermediate set of assumptions, the summarized income rate for the entire 75-year period is 4.10 percent of taxable payroll and the summarized cost rate is 4.53 percent. As a result, the actuarial balance is −0.42 percent, and the HI trust fund fails to meet the Trustees' long-range test of close actuarial balance.[47]

One can interpret the actuarial balance as the percentage that could be added to the income rates and/or subtracted from the cost rates immediately and throughout the entire valuation period in order for the financing to support HI costs and provide for the targeted trust fund balance at the end of the projection period. The income rate increase according to this method is 0.42 percent of taxable payroll. However, if no such changes occurred until 2033, when the trust fund would be depleted, then the required increase would be 0.55 percent of taxable payroll under the intermediate assumptions.[48]

[47]This test is defined in section V.I.

[48]Actuarial balance could also be reached by reducing benefits by 9 percent every year immediately, or by making no change until 2033 and then reducing benefits by 12 percent.

Table III.B8.—HI Actuarial Balances under Three Sets of Assumptions

	Intermediate assumptions	Alternative	
		Low-Cost	High-Cost
Valuation periods:[1]			
25 years, 2025–2049:			
Summarized income rate	3.83	3.79	3.91
Summarized cost rate	4.41	3.29	6.07
Actuarial balance	−0.57	0.50	−2.16
50 years, 2025–2074:			
Summarized income rate	3.98	3.94	4.07
Summarized cost rate	4.49	2.80	7.46
Actuarial balance	−0.51	1.13	−3.39
75 years, 2025–2099:			
Summarized income rate	4.10	4.05	4.21
Summarized cost rate	4.53	2.60	8.07
Actuarial balance	−0.42	1.45	−3.86

[1]Income rates include beginning trust fund balances, and cost rates include the cost of attaining a trust fund balance at the end of the period equal to 100 percent of the following year's estimated expenditures.

Note: Totals do not necessarily equal the sums of rounded components.

The divergence in outcomes among the three sets of assumptions is apparent both in the estimated operations of the trust fund on a cash basis (as discussed in section III.B2) and in the 75-year summarized costs. Under the low-cost economic and demographic assumptions, the summarized cost rate for the 75-year valuation period is 2.60 percent of taxable payroll, the summarized income rate is 4.05 percent of taxable payroll, and the actuarial balance is 1.45 percent of taxable payroll; therefore, HI income rates would be adequate under the highly favorable conditions assumed in the low-cost alternative. Under the high-cost assumptions, the summarized cost rate for the 75-year projection period is 8.07 percent of taxable payroll, which is nearly twice the summarized income rate of 4.21 percent of taxable payroll, resulting in an actuarial balance of −3.86 percent of taxable payroll.

As suggested earlier, past experience has indicated that economic and demographic conditions that are as financially adverse as those assumed under the high-cost alternative can, in fact, occur over many years. Readers should view all of the alternative sets of economic and demographic assumptions as plausible. The wide range of results under the three sets of assumptions is indicative of the uncertainty of HI's future cost and its sensitivity to future economic and demographic conditions. Accordingly, it is important to maintain an adequate balance in the HI trust fund as a reserve for contingencies and to promptly address financial imbalances through corrective legislation.

Table III.B9 shows the long-range actuarial balance under the intermediate projections with its component parts—the present values of tax income, expenditures, and asset requirement of the HI program over the next 75 years.

Table III.B9.—Components of 75-Year HI Actuarial Balance under Intermediate Assumptions (2025–2099)

Present value as of January 1, 2025 (in billions):	
a. Payroll tax income	$27,203
b. Taxation of benefits income	5,355
c. Fraud and abuse control receipts	123
d. Other Income	453
e. Total income (a + b + c + d)	33,133
f. Expenditures	36,435
g. Expenditures minus income (f − e)	3,301
h. Trust fund assets at start of period	237
i. Open-group unfunded obligation (g − h)	3,064
j. Ending target trust fund[1]	365
k. Present value of actuarial balance (e − f + h − j)	−3,429
l. Taxable payroll	812,997
Percent of taxable payroll:	
Actuarial balance (k ÷ l)	−0.42%

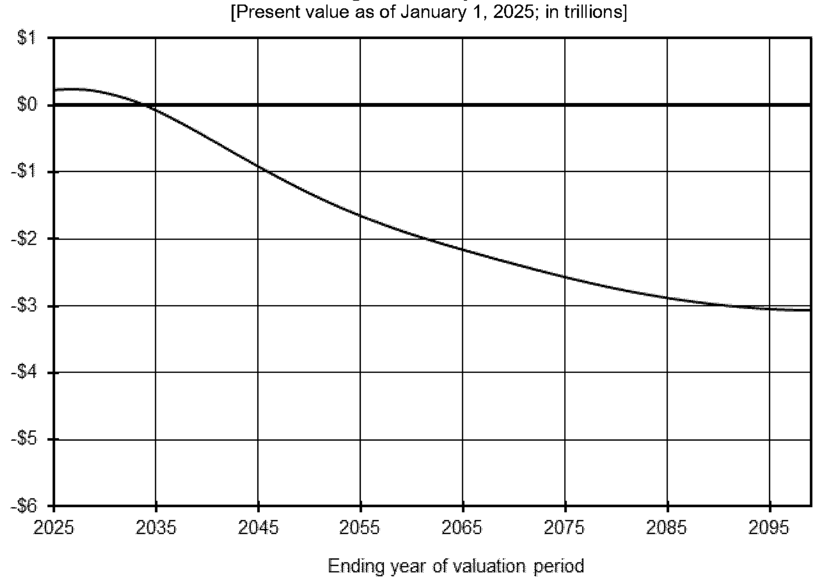
[1]The calculation of the actuarial balance includes the cost of accumulating a target trust fund balance equal to 100 percent of annual expenditures by the end of the period.

Note: Totals do not necessarily equal the sums of rounded components.

The present value of future expenditures less future tax income, decreased by the amount of HI trust fund assets on hand at the beginning of the projection, amounts to $3.1 trillion. This value is referred to as the 75-year *unfunded obligation* for the HI trust fund, and it is higher than last year's value of $2.4 trillion because of higher expenditures and lower income, as explained in more detail later in this section. The actuarial balance is like the unfunded obligation but with three differences. The first is that it is a measure of the degree to which the program is funded rather than unfunded and so is opposite in sign. The second is that it includes the target trust fund balance at the end of 75 years as a cost. The third difference is that it is expressed as a percentage of taxable payroll. Specifically, the actuarial balance is −0.42 percent of taxable payroll and is calculated as the trust fund balance plus the present value of revenues less the present value of costs (−$3.1 trillion), less the present value of the target trust fund balance ($365 billion), all divided by the present value of future taxable payroll ($813 trillion).

Figure III.B5 shows the present values, as of January 1, 2025, of cumulative HI taxes less expenditures (plus the 2025 trust fund) through each of the next 75 years. The Trustees estimate these values under current-law expenditures and tax rates.

Figure III.B5.—Present Value of Cumulative HI Taxes Less Expenditures through Year Shown, Evaluated under Current-Law Tax Rates and Legislated Expenditures
[Present value as of January 1, 2025; in trillions]



The cumulative annual balance of the trust fund at the beginning of 2025 is about $0.2 trillion. The cumulative present value steadily declines after 2027 because of the anticipated shortfall of tax revenues, relative to expenditures. The projected depletion date of the trust fund is 2033, at which time cumulative expenditures would have exceeded cumulative tax revenues by enough to equal the initial fund assets accumulated with interest. The downward slope over the next 50 years further illustrates the difference between the HI expenditures projected under current law and the financing currently scheduled to support these expenditures. The slope flattens at the end of the projection period because of the continuing effects of the slower payment rate updates that are required under current law.

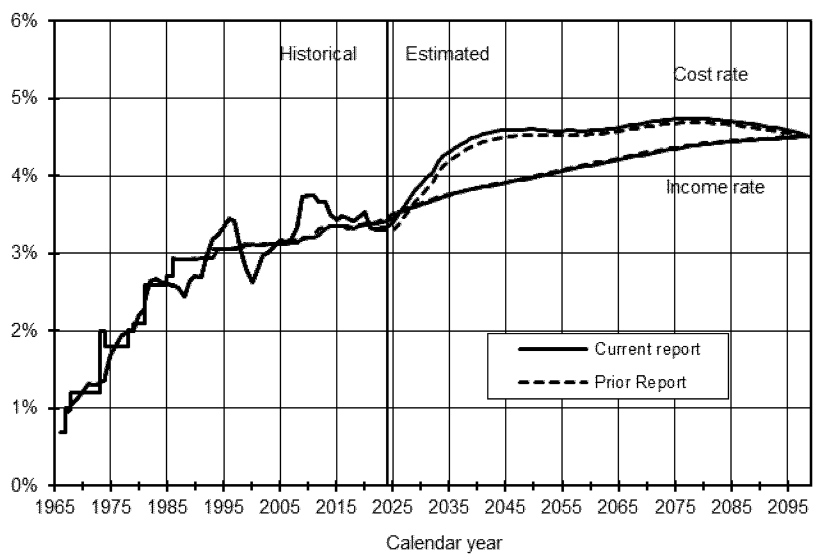
As noted previously, over the full 75-year period, the fund has a projected present value unfunded obligation of $3.1 trillion. This unfunded obligation indicates that if $3.1 trillion were added to the trust fund at the beginning of 2025, the program would meet the projected cost of expenditures over the next 75 years. More realistically, additional annual revenues and/or reductions in expenditures, with a present value totaling $3.1 trillion, would be necessary to reach financial balance (but with zero trust fund assets at the end of 2099).

Actuarial Analysis

The estimated unfunded obligation of $3.1 trillion and the closely associated present value of the actuarial deficit ($3.4 trillion) are useful indicators of the sizable financial burden facing the American public. In other words, increases in revenues and/or reductions in benefit expenditures—equivalent to a lump-sum amount today of $3.4 trillion—would be necessary to bring the HI trust fund into long-range financial balance. At the same time, long-range measures expressed in dollar amounts can be difficult to interpret, even when calculated as present values, which are sensitive to the underlying discount rate assumptions. For this reason, the Board of Trustees has customarily emphasized relative measures, such as the income rate and cost rate comparisons shown earlier in this section, and comparisons with the present value of future taxable payroll or GDP.

Figure III.B6 compares the year-by-year HI cost and income rates for the current annual report with the corresponding projections from the 2024 report.

Figure III.B6.—Comparison of HI Cost and Income Rate Projections: Current versus Prior Year's Reports



As figure III.B6 indicates, the intermediate HI cost rate projections in this year's report are higher than in the 2024 report, and the projected income rates in this year's report are fairly similar to those in the 2024 report. The higher cost rate projections are primarily a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

The Trustees' estimate of the 75-year HI actuarial balance under the intermediate assumptions, −0.42 percent of taxable payroll, is 0.07 percentage point less favorable than estimated in the 2024 annual report. The reasons for this change, which are listed in table III.B10, are explained below:

(1) Change in valuation period: Updating the valuation period from 2024–2098 to 2025–2099 results in no change in the actuarial balance.
(2) Updating the projection base: Actual 2024 incurred HI expenditures were higher than previously estimated, resulting in a 0.08-percent decrease in the actuarial balance.
(3) Private health plan assumptions: Per capita expenditures for private health care were similar to those estimated in last year's report. Updated star ratings, which resulted in lower quality bonuses and a lower rebate share, were largely offset by higher payment risk scores. The net effect of these modifications is a 0.01-percent increase in the actuarial balance.
(4) Hospital utilization assumptions: The primary change in hospital assumptions in this year's report is higher utilization than assumed in last year's report. The impact of this and other small changes is a 0.10-percent decrease in the actuarial balance.
(5) Other provider utilization assumptions: Higher assumed utilization for hospice services and other small changes result in a 0.01-percent decrease in the actuarial balance.
(6) Other economic and demographic assumptions: The net effect of several adjustments to the economic and demographic assumptions is a 0.11-percent increase in the actuarial balance. These adjustments lead to lower taxable payroll (decreasing the actuarial balance by 0.05 percent) and lower payment rate update assumptions (increasing the actuarial balance by 0.13 percent). In addition, adjustments for enrollment, demographic factors, updated expectations for health care spending following the end of the public health emergency, and other small changes lead to a 0.03-percent increase in the actuarial balance.

Table III.B10.—Change in the 75-Year Actuarial Balance since the 2024 Report

1. Actuarial balance, intermediate assumptions, 2024 report	−0.35%
2. Changes:	
a. Valuation period	0.00
b. Base estimate	−0.08
c. Private health plan assumptions	0.01
d. Hospital utilization assumptions	−0.10
e. Other provider utilization assumptions	−0.01
f. Other economic and demographic assumptions	0.11
Net effect, above changes	−0.07
3. Actuarial balance, intermediate assumptions, 2025 report	−0.42

4. Long-Range Sensitivity Analysis

The low-cost and high-cost estimates discussed in previous sections demonstrate the effects of varying all the principal assumptions simultaneously in order to portray a generally more optimistic or pessimistic future for the projected financial status of the HI trust fund. In contrast, this section presents estimates that illustrate the sensitivity of the long-range HI cost rate, income rate, and actuarial balance to changes in selected individual assumptions. In this sensitivity analysis, the intermediate set of assumptions is the reference point, and only one assumption at a time varies within that alternative. In each case, the Trustees assume that the provisions of current law remain unchanged throughout the 75-year projection period.

Each table that follows shows the effects of changing a particular assumption on the HI summarized income rates, summarized cost rates, and actuarial balances for 25-year, 50-year, and 75-year valuation periods. The discussion of the tables generally does not include the income rate, since it varies only slightly with changes in assumptions. The change in each of the actuarial balances is approximately equal to the change in the corresponding cost rate, but in the opposite direction. For example, a lower projected cost rate would result in an improvement or increase in the corresponding projected actuarial balance.

a. Real-Wage Growth

Table III.B11 shows the sensitivity of projected HI income rates, cost rates, and actuarial balances to the real-wage growth. The ultimate real-wage growth will be 0.53 percentage point (high-cost alternative), 1.13 percentage points (intermediate projections), and 1.73 percentage points (low-cost alternative). In each case, the assumed ultimate annual increase in the CPI is 2.4 percent (as assumed for the intermediate projections).

Projected HI cost rates are fairly sensitive to the assumed growth rates in real wages. For the 75-year period 2025–2099, the summarized cost rate decreases from 4.95 percent (for real-wage growth of 0.53 percentage point) to 4.14 percent (for growth of 1.73 percentage points). The HI actuarial balance over this period shows an improvement for faster rates of growth in real wages.

Table III.B11—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various Real-Wage Growth Assumptions
[As a percentage of taxable payroll]

	Average annual real-wage growth		
Valuation period	0.53	1.13	1.73
Summarized income rate:			
25-year: 2025–2049	3.85	3.83	3.83
50-year: 2025–2074	3.95	3.98	4.03
75-year: 2025–2099	4.03	4.10	4.17
Summarized cost rate:			
25-year: 2025–2049	4.61	4.41	4.25
50-year: 2025–2074	4.80	4.49	4.21
75-year: 2025–2099	4.95	4.53	4.14
Actuarial balance:			
25-year: 2025–2049	−0.76	−0.57	−0.42
50-year: 2025–2074	−0.85	−0.51	−0.19
75-year: 2025–2099	−0.92	−0.42	0.04

The sensitivity of the HI actuarial balance to different real-wage growth assumptions is significant, but not as substantial as one might intuitively expect. Higher real-wage growth immediately increases both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage related. The HI cost rate decreases with increasing real-wage growth because the higher real-wage levels increase the taxable payroll to a greater extent than they increase HI benefits. In particular, each 0.5-percentage-point increase in the assumed real-wage growth increases the long-range HI actuarial balance, on average, by about 0.40 percent of taxable payroll.

b. Consumer Price Index

Table III.B12 shows the sensitivity of projected HI income rates, cost rates, and actuarial balances to the rate of increase for the CPI. The ultimate annual increase in the CPI will be 3.0 percent (low-cost alternative), 2.4 percent (intermediate projections), and 1.8 percent (high-cost alternative).[49] In each case, the assumed ultimate real-wage growth is 1.13 percent (as assumed for the intermediate projections).

[49]Prior to the 2015 report, the Trustees used the lower CPI growth rate for the low-cost alternative and the higher CPI growth rate for the high-cost alternative.

Table III.B12.—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various CPI-Increase Assumptions
[As a percentage of taxable payroll]

	Ultimate percentage increase in the CPI		
Valuation period	3.00	2.40	1.80
Summarized income rate:			
25-year: 2025–2049	3.90	3.83	3.79
50-year: 2025–2074	4.13	3.98	3.83
75-year: 2025–2099	4.26	4.10	3.89
Summarized cost rate:			
25-year: 2025–2049	4.40	4.41	4.42
50-year: 2025–2074	4.48	4.49	4.50
75-year: 2025–2099	4.52	4.53	4.54
Actuarial balance:			
25-year: 2025–2049	−0.50	−0.57	−0.63
50-year: 2025–2074	−0.35	−0.51	−0.67
75-year: 2025–2099	−0.26	−0.42	−0.65

The variation in the rate of change assumed for the CPI has only a small impact on the actuarial balance, as the summarized income rates are slightly affected while the summarized cost rates are virtually unchanged.

Faster assumed growth in the CPI results in a somewhat larger HI income rate because the income thresholds for the taxation of Social Security benefits and for the additional 0.9-percent payroll tax rate are not indexed. Therefore, the share of Social Security benefits subject to income tax, as well as the share of earnings subject to the additional tax, increases over time. This impact accelerates under conditions of faster CPI growth.

After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income for the taxation of Social Security benefits increases at a similar rate as taxable payroll. In contrast, the cost rate remains about the same with greater assumed rates of increase in the CPI. HI cost rates are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on taxable payroll of workers as it does on medical care costs.

In practice, differing rates of inflation could occur between the economy in general and the medical-care sector. Readers can judge the effect of such a difference from the sensitivity analysis shown in section III.B4d on health care cost factors.

c. Real-Interest Rate

Table III.B13 shows the sensitivity of projected HI income rates, cost rates, and actuarial balances to the annual real-interest rate for special public-debt obligations issuable to the trust fund. The ultimate annual real-interest rate will be 1.8 percent (high-cost alternative), 2.3 percent (intermediate projections), and 2.8 percent (low-cost alternative). In each case, the assumed ultimate annual increase in the CPI is 2.4 percent (as assumed for the intermediate projections), which results in ultimate annual yields of 4.2, 4.8, and 5.2 percent under the three illustrations.

Table III.B13.—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various Real-Interest Assumptions
[As a percentage of taxable payroll]

	Ultimate annual real-interest rate		
Valuation period	1.8 percent	2.3 percent	2.8 percent
Summarized income rate:			
25-year: 2025–2049	3.84	3.83	3.83
50-year: 2025–2074	3.99	3.98	3.97
75-year: 2025–2099	4.13	4.10	4.08
Summarized cost rate:			
25-year: 2025–2049	4.43	4.41	4.38
50-year: 2025–2074	4.52	4.49	4.46
75-year: 2025–2099	4.56	4.53	4.49
Actuarial balance:			
25-year: 2025–2049	−0.59	−0.57	−0.55
50-year: 2025–2074	−0.52	−0.51	−0.49
75-year: 2025–2099	−0.43	−0.42	−0.42

For all periods, the cost rate decreases slightly with increasing real-interest rates. Over 2025–2099, for example, the summarized HI cost rate would decline from 4.56 percent (for an ultimate real-interest rate of 1.8 percent) to 4.49 percent (for an ultimate real-interest rate of 2.8 percent). Accordingly, each 1.0-percentage-point increase in the assumed real-interest rate increases the long-range actuarial balance, on average, by about 0.01 percent of taxable payroll.

d. Health Care Cost Factors

Table III.B14 shows the sensitivity of projected HI income rates, cost rates, and actuarial balances to two variations on the relative annual growth rate in the aggregate cost of providing covered health care services to HI beneficiaries. For this sensitivity analysis, the ratio of costs to taxable payroll will grow 1 percentage point more slowly than the intermediate projections, the same as the intermediate projections, and 1 percentage point faster than the intermediate projections. In each case, the taxable payroll will be the same as assumed for the intermediate projections.[50]

[50]These variations in HI cost growth rates are not equivalent to the high- and low-cost alternative assumptions, which use a different level and pattern of growth differentials and vary other assumptions in addition to the cost growth factors.

Actuarial Analysis

As noted previously, factors such as wage and price increases may simultaneously affect HI tax income and the costs incurred by hospitals and other providers of medical care to HI beneficiaries. (Sections III.B4a and III.B4b evaluate the sensitivity of the trust fund's financial status to these factors.) Other factors, such as the utilization of services by beneficiaries or the relative complexity of the services provided, can have an impact on provider costs without affecting HI tax income. The sensitivity analysis shown in table III.B14 illustrates the financial effect of any combination of these factors that results in the ratio of cost to payroll taxes increasing by 1 percentage point faster or slower than the intermediate assumptions.

Table III.B14.—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various Health Care Cost Growth Rate Assumptions

[As a percentage of taxable payroll]

	Annual cost/payroll relative growth rate		
Valuation period	−1 percentage point	0 percentage point	+1 percentage point
Summarized income rate:			
25-year: 2025–2049	3.83	3.83	3.83
50-year: 2025–2074	3.98	3.98	3.98
75-year: 2025–2099	4.10	4.10	4.11
Summarized cost rate:			
25-year: 2025–2049	3.85	4.41	5.06
50-year: 2025–2074	3.53	4.49	5.82
75-year: 2025–2099	3.24	4.53	6.59
Actuarial balance:			
25-year: 2025–2049	−0.02	−0.57	−1.22
50-year: 2025–2074	0.45	−0.51	−1.83
75-year: 2025–2099	0.86	−0.42	−2.48

As illustrated in table III.B14, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll. For the 75-year period, the cost rate increases from 3.24 percent (for an annual cost/payroll growth rate of 1 percentage point less than the intermediate assumptions) to 6.59 percent (for an annual cost/payroll growth rate of 1 percentage point more than the intermediate assumptions). Each 1.0-percentage-point increase in the assumed cost/payroll relative growth rate decreases the long-range actuarial balance, on average, by about 1.67 percent of taxable payroll.

C. PART B FINANCIAL STATUS

This section presents actual operations of the Part B account in the SMI trust fund in 2024 and Part B projections for the next 75 years. Section III.C1 discusses Part B financial results for 2024, and sections III.C2 and III.C3 discuss the short-range Part B projections and the long-range projections, respectively. The projections shown in sections III.C2 and III.C3 assume no changes will occur in the statutory provisions and regulations under which Part B now operates.

1. Financial Operations in Calendar Year 2024

Table III.C1 presents a statement of the revenue and expenditures of the Part B account of the SMI trust fund in calendar year 2024, and of its assets at the beginning and end of the year.

Table III.C1.—Statement of Operations of the Part B Account in the SMI Trust Fund during Calendar Year 2024
[In thousands]

Total assets of the Part B account in the trust fund, beginning of period		$172,209,745
Revenue:		
Premiums from enrollees:		
Enrollees aged 65 and over	$125,426,580	
Disabled enrollees under age 65	14,409,949	
Total premiums		139,836,529
Premiums collected from Medicare Advantage participants		307,502
Government contributions:		
Enrollees aged 65 and over	335,103,814	
Disabled enrollees under age 65	57,749,192	
Repayment amount[1]	−1,664,577	
Adjustment for exempted amounts[2]	−5,174,153	
Repayment of the Medicare Accelerated and Advance Payments (AAP) Program transfer[3]	−36,174	
Union activity	1,898	
Total government contributions		385,980,000
Other		132
Interest on investments		3,541,998
Interfund interest receipts & payments[4]		−4,177
Annual fees—branded Rx manufacturers and importers		2,788,862
ACA Medicare shared savings program receipts		439,644
Total revenue		$532,890,491
Expenditures:		
Net Part B benefit payments		$547,849,094
Administrative expenses:		
Transfer to Medicaid[5]	1,319,549	
Treasury administrative expenses	431	
Salaries and expenses, CMS[6]	2,271,738	
Salaries and expenses, Office of the Secretary, HHS	109,477	
Salaries and expenses, SSA	1,801,005	
Medicare Payment Advisory Commission	5,530	
Railroad Retirement administrative expenses	11,033	
Railroad Retirement administrative expenses, OIG	2,172	
Railroad Retirement administrative expenses, SMAC	17,288	
ACL State Health Ins Program, OBRA	49,763	
MACRA[7]	-465	
Total administrative expenses		5,587,521
Total expenditures		$553,436,615
Net addition to the trust fund		−20,546,124
Total assets of the Part B account in the trust fund, end of period		$151,663,621

[1]Represents transfers from Part B to the general fund of the Treasury of amounts collected from beneficiaries for repayment of (i) the 2016 and 2021 transfers for the premium income lost and (ii) the forgone income-related premium income in those years as a result of the specification of the aged actuarial rate. The repayment amounts reflect the $3.00 that is added to the Part B premium otherwise determined. This addition will continue until the total amount of the forgone income-related premium income plus transfers is fully repaid.
[2]The additional premium repayment amounts (footnote 1 repayment amounts) are not to be matched by government contributions; however, since CMS is not able to separate the additional repayment premium amounts from the standard premium amounts, the additional repayment premium amounts are matched. An adjustment for exempted amounts is therefore necessary to transfer these erroneous Federal matching amounts back to the general fund.
[3]Represents transfers from Part B to the general fund of the Treasury of amounts recovered from providers for repayment of AAP program payments, as required by the Continuing Appropriations Act, 2021 and Other Extensions Act.
[4]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds and then are reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the Part B account in the SMI trust fund from the other trust funds. A negative figure represents a transfer from the Part B account of the SMI trust fund to the other funds.

[5]Represents amount transferred from the Part B account in the SMI trust fund to Medicaid to pay the Part B premium for certain qualified individuals.
[6]Includes expenses of the Medicare Administrative Contractors.
[7]Represents amounts transferred from the Part B account of the SMI trust fund for administration of provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Note: Totals do not necessarily equal the sums of rounded components.

The total assets of the account amounted to $172.2 billion on December 31, 2023. During calendar year 2024, total revenue amounted to $532.9 billion, and total expenditures were $553.4 billion. Total assets were $151.7 billion as of December 31, 2024. The asset level decreased during 2024 by approximately $20.5 billion.

a. Revenues

The major sources of revenue for the Part B account are (i) contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury and (ii) premiums paid by (or on behalf of) eligible persons who voluntarily enroll.

Of the total Part B revenue in calendar year 2024, $139.8 billion represented premium payments by (or on behalf of) enrollees—an increase of 6.6 percent over the amount of $131.2 billion for the preceding year.

Government contributions matched the premiums paid for fiscal years 1967 through 1973 dollar for dollar. Beginning July 1973, disabled persons who are under age 65 and who have met certain other conditions became eligible to enroll in Medicare, and the calculation of the premium-matching government contributions was changed. The amount of government contributions corresponding to premiums paid is determined by applying a matching rate to the amount of premiums received.[51] By law, a matching rate is determined for each of two groups of Part B enrollees—one for those aged 65 and older and one for the disabled. The matching rate is equal to twice the monthly actuarial rate applicable to the particular group of enrollees, minus the standard monthly premium rate, divided by the standard monthly premium rate.

[51]For 2016 through 2025, under the intermediate assumptions, the standard premium includes an additional amount ($3.00 through 2024 and $0.90 in 2025) to repay the balance due resulting from general fund transfers in 2016 and 2021 to the Part B account of the SMI trust fund, in accordance with the Bipartisan Budget Act of 2015 and the Continuing Appropriations Act, 2021 and Other Extensions Act. This additional amount is not included in the determination of the matching rates and is not to be matched by government contributions.

Actuarial Analysis

The Secretary of Health and Human Services (HHS) promulgates standard monthly premium rates and actuarial rates each year. Table III.C2 shows past monthly premium rates and actuarial rates together with the corresponding percentages of Part B costs covered by the premium rate. Estimated future premium amounts under the intermediate set of assumptions appear in tables V.E2 and V.E3.

Table III.C2.—Standard Part B Monthly Premium Rates, Actuarial Rates, and Premium Rates as a Percentage of Part B Cost

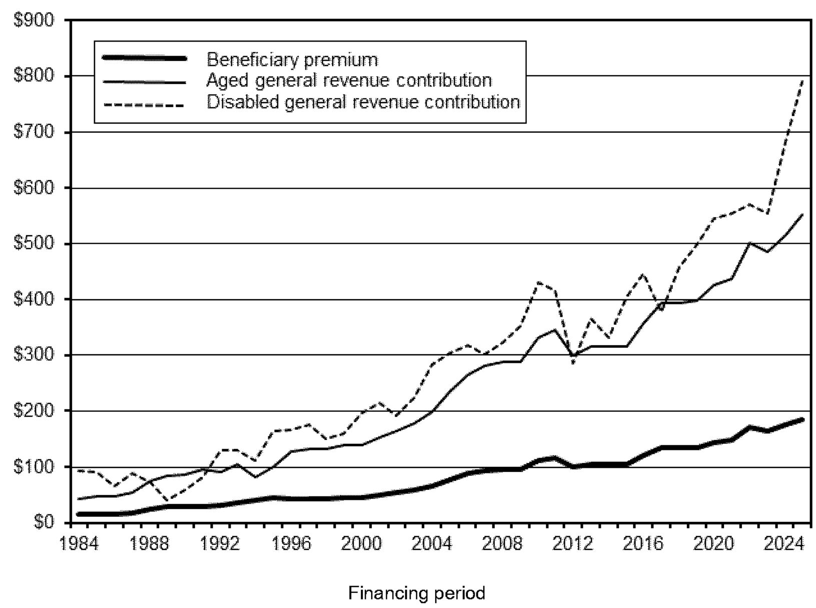
		Monthly actuarial rate		Premium rates as a percentage of Part B cost	
	Standard monthly premium rate[1]	Enrollees aged 65 and over	Disabled enrollees under age 65	Enrollees aged 65 and over	Disabled enrollees under age 65
July 1966–March 1968	$3.00	—	—	50.0%	—
April 1968–June 1970	4.00	—	—	50.0	—
12-month period ending June 30 of					
1975	6.70	$6.70	$18.00	50.0	18.6%
1980	8.70	13.40	25.00	32.5	17.4
Calendar year					
1985	15.50	31.00	52.70	25.0	14.7
1990	28.60	57.20	44.10	25.0	32.4
1991	29.90	62.60	56.00	23.9	26.7
1992	31.80	60.80	80.80	26.2	19.7
1993	36.60	70.50	82.90	26.0	22.1
1994	41.10	61.80	76.10	33.3	27.0
1995	46.10	73.10	105.80	31.5	21.8
1996	42.50	84.90	105.10	25.0	20.2
1997	43.80	87.60	110.40	25.0	19.8
1998	43.80	87.90	97.10	24.9	22.6
1999	45.50	92.30	103.00	24.6	22.1
2000	45.50	91.90	121.10	24.8	18.8
2001	50.00	101.00	132.20	24.8	18.9
2002	54.00	109.30	123.10	24.7	21.9
2003	58.70	118.70	141.00	24.7	20.8
2004	66.60	133.20	175.50	25.0	19.0
2005	78.20	156.40	191.80	25.0	20.4
2006	88.50	176.90	203.70	25.0	21.7
2007	93.50	187.00	197.30	25.0	23.7
2008	96.40	192.70	209.70	25.0	23.0
2009	96.40	192.70	224.20	25.0	21.5
2010	110.50	221.00	270.40	25.0	20.4
2011	115.40	230.70	266.30	25.0	21.7
2012	99.90	199.80	192.50	25.0	25.9
2013	104.90	209.80	235.50	25.0	22.3
2014	104.90	209.80	218.90	25.0	24.0
2015	104.90	209.80	254.80	25.0	20.6
2016	121.80	237.60	282.60	25.6	21.5
2017	134.00	261.90	254.20	25.6	26.4
2018	134.00	261.90	295.00	25.6	22.7
2019	135.50	264.90	315.40	25.6	21.5
2020	144.60	283.20	343.60	25.5	21.0
2021	148.50	291.00	349.90	25.5	21.2
2022	170.10	334.20	368.90	25.4	23.1
2023	164.90	323.70	357.90	25.4	22.9
2024	174.70	343.40	427.20	25.1	20.1
2025	185.00	368.10	487.80	25.0	18.9

[1]The amount shown for each year represents the standard Part B premium paid by, or on behalf of, most Part B enrollees. It does not reflect other amounts that certain beneficiaries must pay, such as the income-related monthly adjustment amount for beneficiaries with high incomes and the premium surcharge for beneficiaries who enroll late. In addition, it does not reflect a reduction in premium for beneficiaries covered

by the hold-harmless provision. As a result of this provision, most Part B beneficiaries had their 2010 and 2011 monthly premium held to the 2009 rate of $96.40, had their 2016 monthly premium held to the 2015 rate of $104.90, and had the increase in their 2017 monthly premium limited to about $4.00, on average. Section V.E describes these amounts in more detail.

Figure III.C1 is a graph of the monthly per capita financing rates in all financing periods after 1983 for enrollees aged 65 and over and for disabled individuals under age 65. The graph shows the portion of the financing contributed by the beneficiaries and by government contributions. As indicated, government contributions are the largest income source for Part B.

Figure III.C1.—Part B Aged and Disabled Monthly Per Capita Trust Fund Income



Note: The amounts shown do not include the catastrophic coverage monthly premium rate for 1989.

In calendar year 2024, contributions received from the general fund of the Treasury amounted to $386.0 billion, which accounted for 72.4 percent of total revenue. The Bipartisan Budget Act of 2015 and the Continuing Appropriations Act, 2021 and Other Extensions Act require that payments be made from the Part B account of the SMI trust fund to the general fund of the Treasury, and these amounts totaled $1.7 billion in 2024. Transfers amounting to $5.2 billion were made from the Part B account to the general fund in order to adjust for certain transfers made for exempted amounts.[52] In accordance with the Continuing Appropriations Act, 2021 and Other Extensions Act,

[52]See footnote 4 of table III.C1.

$36 million of the government contributions represent a transfer from the Part B account to the general fund to partially repay the outstanding balance of the Accelerated and Advance Payments (AAP) Program. The balance of the general fund transfers consisted almost entirely of premium-matching contributions.

Another source of Part B revenue is interest received on investments held by the Part B account. A description of the investment procedures of the Part B account appears later in this section. In calendar year 2024, $3.5 billion of revenue was from interest on the investments of the account. One more source of Part B revenue is the annual fees assessed on manufacturers and importers of brand-name prescription drugs, which amounted to $2.8 billion in 2024.

b. Expenditures

The account pays expenditures for Part B benefit payments and administrative expenses. All expenses incurred by the Department of Health and Human Services, the Social Security Administration, and the Department of the Treasury in administering Part B are charged to the account. Such administrative duties include payment of benefits, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services while maintaining the quality of these services.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part B. The account expenditures include such costs. The net worth of facilities and other fixed capital assets, however, does not appear in the statement of Part B assets presented in this report, since the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and is not, therefore, pertinent in assessing the actuarial status of the funds.

Of total Part B expenditures, $547.8 billion represented net benefits paid from the account for health services.[53] Net benefits increased 10.1 percent compared with the corresponding amount of $497.4 billion paid during the preceding calendar year. The change in net benefits paid reflects the net change in both the number of beneficiaries and the

[53]Net benefits equal the total gross amounts initially paid from the trust fund during the year less recoveries of overpayments identified through fraud and abuse control activities.

price, volume, and intensity of services. Additional information on Part B benefits by type of service is available in section IV.B1.

The remaining $5.6 billion of expenditures was for administrative expenses and represented 1.0 percent of total Part B expenditures in 2024. Administrative expenses are shown on a net basis, after adjustments to the preliminary allocation of such costs among the Social Security and Medicare trust funds and the general fund of the Treasury.

c. Actual experience versus prior estimates

Table III.C3 compares the actual experience in calendar year 2024 with the estimates presented in the 2023 and 2024 annual reports. A number of factors can contribute to differences between estimates and subsequent actual experience. In particular, actual values for key economic and other variables can differ from assumed levels, and lawmakers may adopt legislative and regulatory changes after a report's preparation.

As shown in table III.C3, actual Part B benefit payments were somewhat higher than the estimates in the 2023 and 2024 reports. For both of these reports, actual government contributions were slightly higher than the estimates, but premiums from enrollees were lower.

Table III.C3.—Comparison of Actual and Estimated Operations of the Part B Account in the SMI Trust Fund, Calendar Year 2024

[Dollar amounts in millions]

		Comparison of actual experience with estimates for calendar year 2024 published in:			
		2024 report		2023 report	
Item	Actual amount	Estimated amount[1]	Actual as a percentage of estimate	Estimated amount[1]	Actual as a percentage of estimate
Premiums from enrollees	$139,837	$143,153	98%	$144,015	97%
Government contributions	385,980[2]	381,826	101	382,306	101
Benefit payments[3]	544,590	529,878	103	530,473	103

[1]Under the intermediate assumptions.
[2]See footnotes 1–3 of table III.C1.
[3]Benefit payments include (i) additional premiums for Medicare Advantage plans that are deducted from beneficiaries' Social Security benefits and (ii) costs of Quality Improvement Organizations.

d. Assets

The Department of the Treasury invests the portion of the Part B account not needed to meet current expenditures for benefits and administration in interest-bearing obligations of the U.S. Government.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the account. The law requires that these special public-debt obligations shall bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue) for all marketable interest-bearing obligations of the United States forming a part of the public debt that are not due or callable until after 4 years from the end of that month. Since the inception of the SMI trust fund, the Department of the Treasury has always invested the assets in special public-debt obligations.[54] Table V.H10, presented in section V.H, shows the assets of the SMI trust fund (Parts B and D) at the end of fiscal years 2023 and 2024.

2. 10-Year Actuarial Estimates (2025–2034)

This section provides detailed information concerning the short-range financial status of the Part B account, including projected annual income, expenditures, differences between income and expenditures, and trust fund balances. Section IV.B1 presents an explanation of the effects of these assumptions on the estimates in this report. The Trustees also assume that financing for future periods will be determined according to the statutory provisions described in section III.C1a, although Part B financing rates have been set only through December 31, 2025.

In 2025 the monthly Part B premium rate is \$185.00, which is higher than the 2024 monthly premium of \$174.70. The estimated monthly premium for 2026 is \$206.20. This premium, paid by affected enrollees and Medicaid and matched by general fund transfers, would maintain a contingency reserve at the level necessary to accommodate typical financial variation, plus the possibility of legislative action that would raise costs after the establishment of financing rates.

For determining an individual's monthly premium rate, there is a hold-harmless provision in the law that limits the dollar increase in the premium to the dollar increase in an individual's Social Security benefit. This provision applies to most beneficiaries who have their premiums deducted from their Social Security benefits, or roughly 70 percent of Part B enrollees.[55]

[54] The Department of the Treasury may also make investments in obligations guaranteed as to both principal and interest by the United States, including certain federally sponsored agency obligations.

[55] About 30 percent of Part B enrollees are not eligible for the hold-harmless provision. This group consists of new enrollees during the year, enrollees who do not receive Social Security benefit checks, enrollees with high incomes who are subject to the income-related premium adjustment, and dual Medicare-Medicaid beneficiaries (whose premiums are paid by State Medicaid programs).

In 2016, the cost-of-living adjustment (COLA) for Social Security benefits was 0 percent, and premiums did not increase from the 2015 level for beneficiaries to whom the hold-harmless provision applies. Without the Bipartisan Budget Act of 2015 (BBA 2015), Part B premiums for other beneficiaries would have been raised substantially to offset premiums forgone as a result of the hold-harmless provision. However, BBA 2015 specified that the Part B premium for 2016 be determined as if the hold-harmless provision did not apply and that a transfer be made from the general fund of the Treasury to the Part B account of the SMI trust fund in the amount of the estimated forgone premiums (and that the transfer be treated as premiums for matching purposes).

BBA 2015 further requires that, starting in 2016, the Part B premium otherwise determined be increased by $3.00, which is to be collected and repaid to the general fund of the Treasury.

Similarly, the Continuing Appropriations Act, 2021 and Other Extensions Act specified that the 2021 actuarial rate for enrollees aged 65 and older be determined as the sum of the 2020 actuarial rate for enrollees aged 65 and older and one-fourth of the difference between the 2020 actuarial rate and the preliminary 2021 actuarial rate (as determined by the Secretary of HHS) for such enrollees. The premium revenue lost by using the resulting lower premium (excluding the forgone income-related premium revenue) was replaced by a transfer from the general fund of the Treasury, which will be repaid over time by increasing the balance due and continuing the additional repayment premium amounts.

The additional repayment premium amounts will continue until the balance due (defined in BBA 2015 and the Continuing Appropriations Act, 2021 and Other Extensions Act as the sum of the two transfers to the Part B account from the general fund plus forgone income-related premiums) has been repaid.[56] The 2025 premium of $185.00 includes $0.90 for this purpose.

The initial balance due, which includes the amount transferred to the Part B account in 2016 and the estimated forgone income-related premiums, was $9.1 billion. The balance due on January 1, 2020, was $3.7 billion. In 2021, the balance due was increased by $8.8 billion, which consists of the amount transferred to the Part B account in 2021 plus the estimated forgone income-related premiums. The balance due

[56]In the final repayment year, the additional amount may be less than $3.00 in order to avoid overpayments.

on January 1, 2025, was $1.4 billion. The Trustees estimate that the last repayment will be made by the end of 2025.

Projected Part B expenditures are affected by the sequestration required by current law, which reduces benefit payments by the following percentages: 2 percent from April 1, 2013, through April 30, 2020; 1 percent from April 1, 2022, through June 30, 2022; and 2 percent from July 1, 2022, through January 31, 2033.

Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013, through January 31, 2033, excluding May 1, 2020, through March 31, 2022. (See section V.A for recent legislative changes affecting the sequestration of Medicare expenditures.)

Table III.C4 shows the estimated operations of the Part B account under the intermediate assumptions on a calendar-year basis through 2034.

Table III.C4.—Operations of the Part B Account in the SMI Trust Fund (Cash Basis) during Calendar Years 1970–2034

[In billions]

	Income				Expenditures			Account	
Calendar year	Premium income	Government contribution[1]	Interest and other[2,3]	Total	Benefit payments[3,4]	Adminis-trative expenses	Total	Net change	Balance at end of year[5]
Historical data:									
1970	$1.1	$1.1	$0.0	$2.2	$2.0	$0.2	$2.2	−$0.0	$0.2
1975	1.9	2.6	0.1	4.7	4.3	0.5	4.7	−0.1	1.4
1980	3.0	7.5	0.4	10.9	10.6	0.6	11.2	−0.4	4.5
1985	5.6	18.3	1.2	25.1	22.9	0.9	23.9	1.2	10.9
1990	11.3	33.0	1.6	45.9	42.5	1.5	44.0	1.9	15.5
1995	19.7	39.0	1.6	60.3	65.0	1.6	66.6	−6.3	13.1
2000	20.6	65.9	3.4	89.9	88.9[6]	1.8	90.7	−0.8	44.0
2005	37.5	118.1	1.4	157.0	149.2	3.2	152.4	4.6	24.0
2010	52.0[7]	153.5[7]	3.3	208.8	209.7	3.2	212.9	−4.1	71.4
2015	69.4[7]	203.9[7]	5.7	279.0	275.8	3.1	279.0	0.1	68.2
2016	72.1[7]	235.6[7]	5.5	313.2	289.5	3.9	293.4	19.8	88.0
2017	81.5	217.3	6.8	305.6	308.6	5.0[8]	313.7	−8.1	79.9
2018	93.3	253.2	7.1	353.7	333.0	4.2	337.2	16.5	96.3
2019	99.4	268.2	5.9	373.6	365.7	4.6	370.3	3.3	99.6
2020	111.2[7]	336.0[7,9]	5.1	452.3	414.1[10]	4.5	418.6	33.7	133.3
2021	111.0[7]	318.6[7,9]	6.0	435.5	400.5[10]	5.0	405.5	30.1	163.3
2022	130.9	329.7[9]	6.9	467.6	431.6[10]	5.1	436.7	30.9	194.2
2023	131.2	342.1[9]	7.6	480.9	497.4[10]	5.4	502.9	−22.0	172.2
2024	139.8	386.0	7.1	532.9	547.8	5.6	553.4	−20.5	151.7
Intermediate estimates:									
2025	154.8	423.5	7.5	585.8	573.0	6.1	579.1	6.7	158.3
2026	180.0[7]	483.9[7]	8.3	672.2	643.7	6.5	650.2	21.9	180.3
2027	193.0[7]	519.0[7]	8.9	720.9	707.0	6.9	714.0	7.0	187.2
2028	211.7	566.4	9.6	787.8	765.6	7.3	772.9	14.9	202.1
2029	232.3	618.2	10.5	861.0	836.7	7.8	844.4	16.6	218.7
2030	254.0	672.2	11.6	937.9	913.2	8.2	921.4	16.5	235.2
2031	275.2	724.6	12.7	1,012.6	986.9	8.6	995.5	17.1	252.2
2032	299.0	782.6	14.0	1,095.6	1,064.2	9.1	1,073.3	22.3	274.5
2033	329.0	856.5	15.3	1,200.8	1,169.8	9.7	1,179.6	21.2	295.7
2034	356.3	922.4	16.6	1,295.4	1,263.4	10.4	1,273.8	21.5	317.3

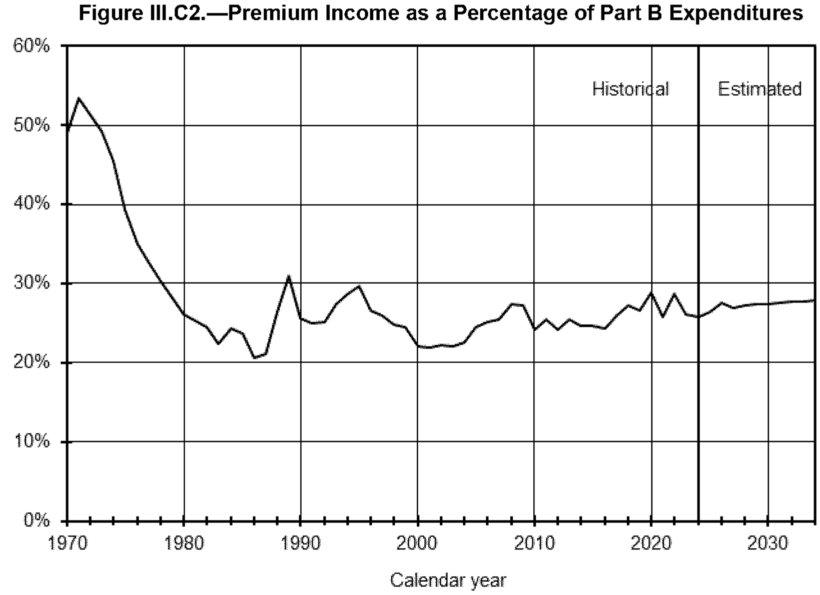
[1]General fund matching payments, plus certain interest-adjustment items.
[2]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income. In 2008, includes an adjustment of $0.8 billion for interest earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.
[3]See footnote 2 of table III.B4.
[4]Includes costs of Peer Review Organizations from 1983 through 2001 and costs of Quality Improvement Organizations beginning in 2002.
[5]The financial status of Part B depends on both the assets and the liabilities of the trust fund (see table III.C8).
[6]Benefit payments less monies transferred from the HI trust fund for home health agency costs.
[7]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2010, actually occurred on December 31, 2009, payment of benefits normally due January 3, 2016, occurred on December 31, 2015, and payment of benefits normally due January 3, 2021, occurred on December 31, 2020. Consequently, the Part B premiums withheld from these benefits and the associated government contributions were added to the Part B account on December 31, 2009 (about $13.8 billion), December 31, 2015 (about $7.9 billion), and December 31, 2020 (about $10.0 billion), respectively. Similarly, the payment date for those benefits normally due on January 3, 2027, will be December 31, 2026. Accordingly, an estimated $6.3 billion will be added to the Part B account on December 31, 2026.
[8]Reflects a larger-than-usual upward adjustment of $1.7 billion for prior-year allocations among Part A, Part B, and Part D.
[9]Includes (i) a transfer of $37.8 billion in calendar year 2020 from the general fund of the Treasury to Part B, which occurred in November of 2020 for the outstanding balance of the Medicare Accelerated and Advance Payments (AAP) Program, as required by the Continuing Appropriations Act, 2021 and Other Extensions Act, and (ii) subsequent recoveries from providers that were transferred from Part B to the

general fund of the Treasury in the amounts of $14.3 billion, $21.7 billion, and $1.7 billion in calendar years 2021 through 2023, respectively.
[10]Includes net payments of $37.0 billion made through the AAP program in calendar year 2020 and subsequent net repayments of $18.9 billion, $17.6 billion, and $0.3 billion in calendar years 2021 through 2023, respectively.
Note: Totals do not necessarily equal the sums of rounded components.

As shown in table III.C4, the Part B account would increase by the end of 2025 to an estimated $158.3 billion. The financing for 2025 was set to maintain Part B assets at a fully sufficient level.

The statutory provisions governing Part B financing have changed over time. Under current law, the standard Part B premium is set at the level of about 25 percent of average expenditures for beneficiaries aged 65 and over. As discussed previously, the Bipartisan Budget Act of 2015 and the Continuing Appropriations Act, 2021 and Other Extensions Act specify that the Part B premium otherwise estimated be increased by $3.00, starting with 2016, until the balance due (which is the sum of the government contributions transferred in 2016 and 2021 plus the forgone income-related premium income) is repaid. In addition, Part B beneficiaries with high incomes pay a higher income-related premium. Figure III.C2 shows historical and projected ratios of premium income to Part B expenditures.

Figure III.C2.—Premium Income as a Percentage of Part B Expenditures



Beneficiary premiums are also affected by fees on the manufacturers and importers of brand-name prescription drugs that are allocated to the Part B account of the SMI trust fund. Because of these fees there is a reduction in the premium margin such that total revenues from premiums, matching government contributions, and the earmarked fees relating to brand-name prescription drugs will equal the appropriate level needed for program financing.

The amount and rate of growth of benefit payments have caused concern for many years. Table III.C5 shows payment amounts in the aggregate, on a per capita basis, and relative to the Gross Domestic Product (GDP). Rates of growth appear historically and for the next 10 years based on the intermediate assumptions.

Aggregate Part B benefit growth has averaged 8.4 percent annually over the past 5 years. During 2024, Part B benefits increased 10.1 percent and constituted 1.88 percent of GDP.

The Part B expenditures are affected by the sequestration of Medicare benefits required under current law. Projected Part B costs continue to increase faster than GDP, as indicated in table III.C5.

Table III.C5.—Growth in Part B Benefits (Cash Basis) through December 31, 2034

Calendar year	Aggregate benefits [billions]	Percent change	Per capita benefits	Percent change	Part B benefits as a percentage of GDP
Historical data:					
1970	$2.0	5.9%	$101	3.5%	0.18%
1975	4.3	28.8	180	24.6	0.25
1980	10.6	22.1	390	19.3	0.37
1985	22.9	16.7	768	14.5	0.53
1990	42.5	10.9	1,304	9.1	0.71
1995	65.0	10.8	1,823	9.2	0.85
2000	90.6[1]	11.4	2,425	10.5	0.88
2005	148.0	9.7	3,723	8.0	1.14
2010	209.5	3.5	4,773	1.2	1.39
2015	274.4	5.9	5,406	3.1	1.50
2016	288.8	5.2	5,543	2.5	1.54
2017	308.5	6.8	5,772	4.1	1.57
2018	333.2	8.0	6,095	5.6	1.61
2019	365.7	9.7	6,528	7.1	1.70
2020	414.1[2]	13.2	7,224	10.7	1.94
2021	400.5[2]	−3.3	6,858	−5.1	1.69
2022	431.6[2]	7.8	7,253	5.8	1.66
2023	497.4[2]	15.3	8,182	12.8	1.79
2024	547.8	10.1	8,831	7.9	1.88
Intermediate estimates:					
2025	573.0	4.6	9,027	2.2	1.88
2026	643.7	12.3	9,901	9.7	2.03
2027	707.0	9.8	10,600	7.1	2.14
2028	765.6	8.3	11,207	5.7	2.22
2029	836.7	9.3	11,988	7.0	2.33
2030	913.2	9.1	12,850	7.2	2.44
2031	986.9	8.1	13,688	6.5	2.54
2032	1,064.2	7.8	14,575	6.5	2.63
2033	1,169.8	9.9	15,839	8.7	2.78
2034	1,263.4	8.0	16,908	6.7	2.88

[1]See footnote 6 of table III.C4.
[2]See footnote 10 of table III.C4.

Note: Percentages are affected by economic cycles.

Actuarial Analysis

The Trustees have prepared the estimates shown throughout the report using the intermediate set of assumptions. They have also prepared estimates using two alternative sets of assumptions. Table III.C6 summarizes the estimated operations of the Part B account for all three alternatives. Section IV.B1 presents in substantial detail the assumptions underlying the intermediate estimates, as well as the assumptions used in preparing estimates under the low-cost and high-cost alternatives.

Table III.C6.—Estimated Operations of the Part B Account in the SMI Trust Fund during Calendar Years 2024–2034, under Alternative Sets of Assumptions

[Dollar amounts in billions]

Calendar year	Premiums from enrollees	Other income[1]	Total income	Total expenditures	Balance in fund at end of year	Expenditures as a percentage of GDP
Intermediate:						
2024[2]	$139.8	$393.1	$532.9	$553.4	$151.7	1.90%
2025	154.8	430.9	585.8	579.1	158.3	1.90
2026	180.0[3]	492.2[3]	672.2	650.2	180.3	2.05
2027	193.0[3]	527.9[3]	720.9	714.0	187.2	2.16
2028	211.7	576.1	787.8	772.9	202.1	2.24
2029	232.3	628.7	861.0	844.4	218.7	2.35
2030	254.0	683.8	937.9	921.4	235.2	2.47
2031	275.2	737.4	1,012.6	995.5	252.2	2.56
2032	299.0	796.6	1,095.6	1,073.3	274.5	2.65
2033	329.0	871.8	1,200.8	1,179.6	295.7	2.80
2034	356.3	939.0	1,295.4	1,273.8	317.3	2.91
Low-cost:						
2024[2]	139.8	393.1	532.9	553.4	151.7	1.90
2025	154.8	431.1	586.0	576.5	161.2	1.86
2026	177.5[3]	485.8[3]	663.2	645.7	178.7	1.97
2027	190.1[3]	520.7[3]	710.8	704.7	184.8	2.03
2028	206.6	563.3	769.9	756.6	198.1	2.07
2029	225.1	610.2	835.3	820.0	213.4	2.13
2030	244.0	658.6	902.7	888.2	227.9	2.19
2031	262.3	704.9	967.2	952.5	242.5	2.22
2032	282.8	755.9	1,038.7	1,019.3	262.0	2.26
2033	309.0	821.6	1,130.6	1,111.7	280.9	2.34
2034	331.9	877.9	1,209.8	1,191.4	299.3	2.38
High-cost:						
2024[2]	139.8	393.1	532.9	553.4	151.7	1.90
2025	154.8	431.0	585.8	574.0	163.5	1.94
2026	176.8[3]	483.6[3]	660.4	642.5	181.4	2.13
2027	194.6[3]	531.6[3]	726.2	717.7	189.9	2.29
2028	216.3	587.7	804.0	787.4	206.5	2.43
2029	239.9	647.9	887.8	869.4	225.0	2.59
2030	264.5	710.4	974.9	956.5	243.4	2.77
2031	288.8	771.6	1,060.4	1,041.3	262.5	2.94
2032	316.1	839.5	1,155.6	1,131.0	287.1	3.10
2033	350.7	926.2	1,276.9	1,252.1	311.9	3.34
2034	382.7	1,004.7	1,387.4	1,362.3	337.0	3.54

[1]Other income contains government contributions, fees on manufacturers and importers of brand-name prescription drugs, and interest.
[2]Figures for 2024 represent actual experience.
[3]See footnote 7 of table III.C4.

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. Percentages are affected by economic cycles.

Because of the price assumptions for these alternative scenarios, the expenditures presented in these scenarios represent a narrow range of outcomes, and actual experience could easily fall outside of this range. For the low-cost scenario, the Trustees assume higher price inflation, which leads to higher spending. Similarly, under the high-cost scenario, the Trustees assume lower price inflation, which leads to lower spending. These price inflation assumptions partially offset the effects of the other assumptions in the high-cost and low-cost scenarios, resulting in a narrow range of expenditures. Given the considerable variation in the factors affecting health care spending, actual Part B experience could easily fall outside of this range. Because the GDP assumptions in these scenarios are similarly affected by the price inflation assumptions, Part B expenditures as a percent of GDP provide better insight into the variability of spending than the nominal dollar amounts, as shown in table III.C6.

The alternative projections shown in table III.C6 illustrate two important aspects of the financial operations of the Part B account:

- Despite the differing assumptions underlying the three alternatives, the balance between Part B income and expenditures remains relatively stable. This result occurs because the Secretary of HHS annually reestablishes the premiums and government contributions underlying Part B financing to cover each year's anticipated incurred benefit costs and other expenditures and then increases these amounts by a margin that reflects the uncertainty of the projection. Thus, Part B income automatically tracks Part B expenditures fairly closely, regardless of the specific economic and other conditions.

- As a result of the close matching of income and expenditures described above, projected account assets show similar, stable patterns of change under all three sets of assumptions.

Adequacy of Part B Financing Established for Calendar Year 2024

The traditional concept of financial adequacy, as it applies to Part B, is closely related to the concept as it applies to many private group insurance plans. Part B is somewhat similar to private yearly renewable term insurance, with financing established each year based on estimated costs for the year. For Part B, premium income paid by the enrollees and contributions from the Federal Government provide financing. As with private plans, the income during a 12-month period for which financing is being established should be sufficient to cover the costs of services expected to be rendered during that period (including associated administrative costs), even though payment for some of these services will not occur until after the period closes. The portion of income required to cover those benefits not paid until after the end of the year is added to the account; thus assets in the account at any time should not be less than the costs of the benefits and the administrative expenses incurred but not yet paid.

Because the Secretary of HHS establishes the income per enrollee (premium plus government contribution) prospectively each year, it is subject to projection error. Additionally, legislation enacted after the financing has been established, but effective for the period for which financing has been set, may affect costs. Account assets, therefore, need to be maintained at a level that is adequate to cover not only the value of incurred-but-unpaid expenses but also a reasonable degree of variation between actual and projected costs (in case actual costs exceed projected).

The Trustees traditionally evaluate the actuarial status or financial adequacy of the Part B account over the period for which the enrollee premium rates and level of government contribution have been established. There are two primary tests that are used for this evaluation. The first is that the assets and income for years for which financing has been established should be sufficient to meet the projected benefits and associated administrative expenses incurred for that period. The second primary test is that the assets should be sufficient to cover projected liabilities for benefits that have not yet been paid as of the end of the period.

If Part B does not meet these adequacy tests, it can still continue to operate if the account remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that costs will be higher than assumed, assets should be sufficient to include contingency levels that cover a reasonable degree of variation between actual and projected costs.

As noted above, the tests of financial adequacy for Part B rely on the incurred experience of the account, including a liability for the costs of services performed in a particular year but not yet paid in that year. Table III.C7 shows the estimated transactions of the account on an incurred basis. Readers should view the incurred experience as an estimate, even for historical years.[57]

Table III.C7.—Estimated Part B Income and Expenditures (Incurred Basis) for Financing Periods through December 31, 2025
[In millions]

	Income				Expenditures			
Financing period	Premium income	Government contribution	Interest and other	Total	Benefit payments	Adminis-trative expenses	Total	Net operations in year
Historical data:								
12-month period ending June 30,								
1970	$936	$936	$12	$1,884	$1,928	$213	$2,141	−$257
1975	1,887	2,396	105	4,388	3,957	438	4,395	−7
1980	2,823	6,627	421	9,871	9,840	645	10,485	−614
Calendar year								
1985	5,613	18,243	1,248	25,104	22,750	986	23,736	1,368
1990	11,320	33,035	1,558	45,913	42,577	1,541	44,118	1,795
1995	19,717	45,743	1,739	67,199	64,923	1,607	66,531	668
2000	20,555	65,898	3,450	89,903	91,059[1]	1,770	92,828	−2,925
2005	37,535	118,091	1,365	156,992	151,430	3,185	154,615	2,376
2010	55,580	163,660	3,281	222,520	212,093	3,153	215,245	7,275
2015	67,515	197,931	5,727	271,172	278,987	3,145	282,133	−10,961
2016	73,986	241,582	5,496	321,064	292,122	3,909	296,031	25,033
2017	81,522	217,253	6,796	305,571	309,751	5,014	314,765	−9,194
2018	93,312	253,237	7,147	353,697	336,983	4,203	341,186	12,511
2019	99,413	268,241	5,919	373,573	366,882	4,628	371,510	2,062
2020	108,746	328,446	5,148	442,340	378,863	4,541	383,404	58,935
2021	113,411	326,125	5,975	445,511	422,242	5,018	427,260	18,252
2022	130,941	329,712	6,913	467,567	451,425	5,098	456,523	11,043
2023	131,166	342,127	7,563	480,855	498,451	5,422	503,873	−23,018
2024	139,837	385,980	7,074	532,890	539,438	5,588	545,026	−12,135
Intermediate estimates:								
2025	154,844	423,491	7,454	585,789	580,390	6,082	586,472	−683

[1]See footnote 6 of table III.C4.

Estimates of the liability amounts for benefits incurred but unpaid as of the end of each financing period, and of the administrative expenses related to processing these benefits, appear in table III.C8. In some years, account assets have not been as large as liabilities. Nonetheless, the fund has remained positive, which has allowed payment of all claims.

[57]Part B experience is more difficult to determine on an incurred basis than on a cash basis. For some services, reporting of payment occurs only on a cash basis, and it is necessary to infer the incurred experience from the cash payment information. Moreover, for recent time periods the tabulations of bills are incomplete because of normal processing time lags.

Table III.C8.—Summary of Estimated Part B Assets and Liabilities as of the End of the Financing Period, for Periods through December 31, 2025
[Dollar amounts in millions]

	Balance in trust fund	Government contribution due but unpaid	Total assets	Benefits incurred but unpaid	Administrative costs incurred but unpaid	Liabilities[1]	Excess of assets over liabilities	Ratio[2]
Historical data:								
As of June 30,								
1970	$57	$15	$72	$567	—	$567	−$495	−0.21
1975	1,424	67	1,491	1,257	$14	1,271	—	0.04
1980	4,657	—	4,657	2,621	188	2,809	1,848	0.15
As of December 31,								
1985	10,924	—	10,924	3,142	−38	3,104	7,820	0.28
1990	15,482	—	15,482	4,060	20	4,080	11,402	0.24
1995	13,130	6,893[3]	20,023	4,298	−214	4,084	15,939	0.23
2000	44,027	—	44,027	8,715	−285	8,430	35,597	0.35
2005	24,008	—	24,008	13,556	—	13,556	10,452	0.06
2010	71,435	—	71,435	18,394	—	18,394	53,042	0.23
2015	68,157	—	68,157	24,919	—	24,919	43,238	0.15
2016	87,964	—	87,964	27,592	—	27,592	60,372	0.19
2017	79,882	—	79,882	28,622	—	28,622	51,260	0.15
2018	96,343	—	96,343	32,571	—	32,571	63,772	0.17
2019	99,602	—	99,602	33,744	—	33,744	65,858	0.17
2020	133,283	—	133,283	35,518	—	35,518	97,766	0.23
2021	163,333	—	163,333	38,379	—	38,379	124,954	0.27
2022	194,215	—	194,215	40,583	—	40,583	153,633	0.30
2023	172,210	—	172,210	41,271	—	41,271	130,939	0.24
2024	151,664	—	151,664	41,795	—	41,795	109,868	0.19
Intermediate estimates:								
2025	158,320	—	158,320	49,136	—	49,136	109,185	0.17

[1]These amounts include only items incurred but not paid. They do not include the amounts that are to be paid back to the general fund of the Treasury over time or the AAP amounts paid to providers that are to be paid back to the trust fund over time.
[2]Ratio of the excess of assets over liabilities to the following year's total incurred expenditures.
[3]This amount includes both the principal of $6,736 million and the accumulated interest through December 31, 1995, for the shortfall in the fiscal year 1995 appropriation for government contributions. Normally, this transfer would have occurred on December 31, 1995, and the trust fund balance would have reflected it. However, because of absence of funding, there was a delay in the transfer of the principal and the appropriate interest until March 1, 1996.

The amount of assets minus liabilities, compared with the estimated incurred expenditures for the following calendar year, forms a relative measure of the Part B account's financial status. The last column in table III.C8 shows such ratios for past years and the estimated ratio at the end of 2025. Actuarial analysis has indicated that a ratio of roughly 15 to 20 percent is sufficient to protect against unforeseen contingencies, such as unusually large increases in Part B expenditures.

The Secretary of HHS established Part B financing through December 31, 2025. Estimated incurred expenditures exceed estimated income in 2025, as shown in table III.C7. The excess of assets over liabilities decreases by an estimated $0.7 billion by the end of December 2025, as indicated in table III.C8. This very slight decrease occurs because the 2025 Part B financing was set to keep nearly the same amount of excess assets and to maintain the contingency reserve at a fully adequate level.

Since the financing rates are set prospectively, variations between assumed cost increases and subsequent actual experience could affect the actuarial status of the Part B account. To test the status of the account under varying assumptions, the Trustees prepared a lower-growth-range projection and an upper-growth-range projection by varying the key assumptions for 2024 and 2025. These two alternative sets of assumptions provide a range of financial outcomes within which one might reasonably expect the actual experience of Part B to fall. The Trustees determined the values for the lower- and upper-growth-range assumptions from a statistical analysis of the historical variation in the respective increase factors.

The methods underlying this sensitivity analysis are fundamentally different from the methods underlying the low-cost and high-cost projections discussed previously in this section. This sensitivity analysis is based on stochastic modeling and is shown for the period for which the financing has been established (through 2025 for this report), whereas the low-cost and high-cost projections illustrate the financial impact of slower or faster growth trends throughout the entire short-range (10-year) projection period.

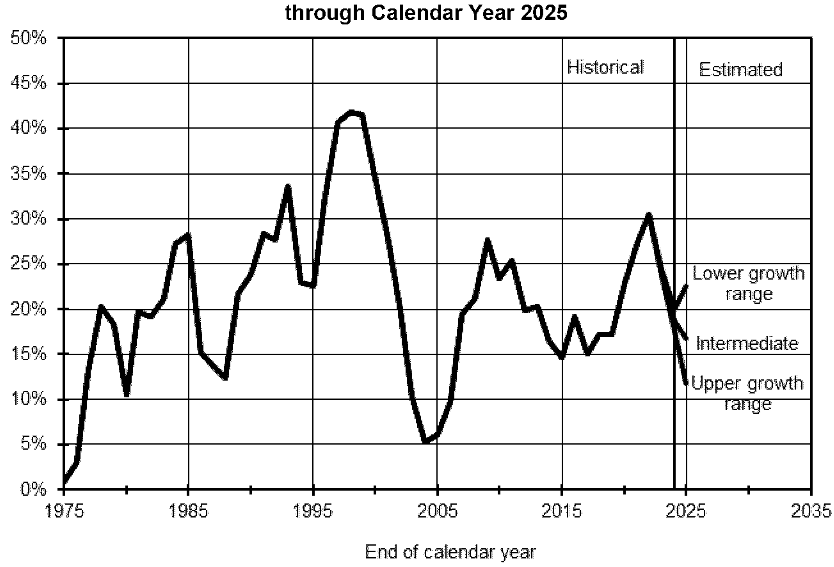
Table III.C9 indicates that, under the lower-growth-range scenario, account assets would exceed liabilities at the end of December 2025 by a margin equivalent to 22.5 percent of the following year's incurred expenditures. Under the upper-growth-range scenario, account assets would still exceed liabilities, but by a margin of 11.8 percent of incurred expenditures in 2025. Figure III.C3 shows the reserve ratio for historical years and for 2025 under the three cost-growth scenarios.

Table III.C9.—Actuarial Status of the Part B Account in the SMI Trust Fund under Three Cost Sensitivity Scenarios for Financing Periods through December 31, 2025

As of December 31,	2023	2024	2025
Intermediate scenario:			
Actuarial status (in millions)			
Assets	$172,210	$151,664	$158,320
Liabilities	41,271	41,795	49,136
Assets less liabilities	130,939	109,868	109,185
Ratio[1]	24.0%	18.7%	16.7%
Lower-range scenario:			
Actuarial status (in millions)			
Assets	$172,210	$151,664	$179,129
Liabilities	41,271	40,936	46,851
Assets less liabilities	130,939	110,727	132,278
Ratio[1]	24.4%	19.9%	22.5%
Upper-range scenario:			
Actuarial status (in millions)			
Assets	$172,210	$151,664	$136,579
Liabilities	41,271	42,583	51,526
Assets less liabilities	130,939	109,080	85,053
Ratio[1]	23.7%	17.6%	11.8%

[1]Ratio of assets less liabilities at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

Figure III.C3.—Actuarial Status of the Part B Account in the SMI Trust Fund through Calendar Year 2025



Note: The Trustees measure the actuarial status of the Part B account in the SMI trust fund by the ratio of (i) assets minus liabilities at the end of the year to (ii) the following year's incurred expenditures.

Based on the test described above, the Trustees conclude that the financing established for the Part B account for calendar year 2025 is adequate to cover 2025 expected expenditures.

3. Long-Range Estimates

Section III.C2 presented the expected operations of the Part B account over the next 10 years. This section examines the long-range expenditures of the account under the intermediate assumptions. Because of its automatic financing provisions, the Trustees expect the Part B account to be adequately financed into the indefinite future and so have not conducted a long-range analysis using high-cost and low-cost assumptions.

Table III.C10 shows the estimated Part B incurred expenditures under the intermediate assumptions expressed as a percentage of GDP for selected years over the calendar-year period 2024–2099.[58] (The intermediate assumptions are discussed in sections II.C and IV.D.)

Table III.C10.—Part B Expenditures (Incurred Basis) as a Percentage of the Gross Domestic Product[1]

Calendar year	Part B expenditures as a percentage of GDP
2024	1.86%
2025	1.92
2026	2.06
2027	2.17
2028	2.25
2029	2.36
2030	2.48
2031	2.57
2032	2.66
2033	2.81
2034	2.92
2035	3.02
2040	3.41
2045	3.63
2050	3.71
2055	3.78
2060	3.88
2065	3.98
2070	4.06
2075	4.14
2080	4.19
2085	4.21
2090	4.19
2095	4.18
2099	4.18

[1]Expenditures are the sum of benefit payments and administrative expenses.

Note: Percentages are affected by economic cycles.

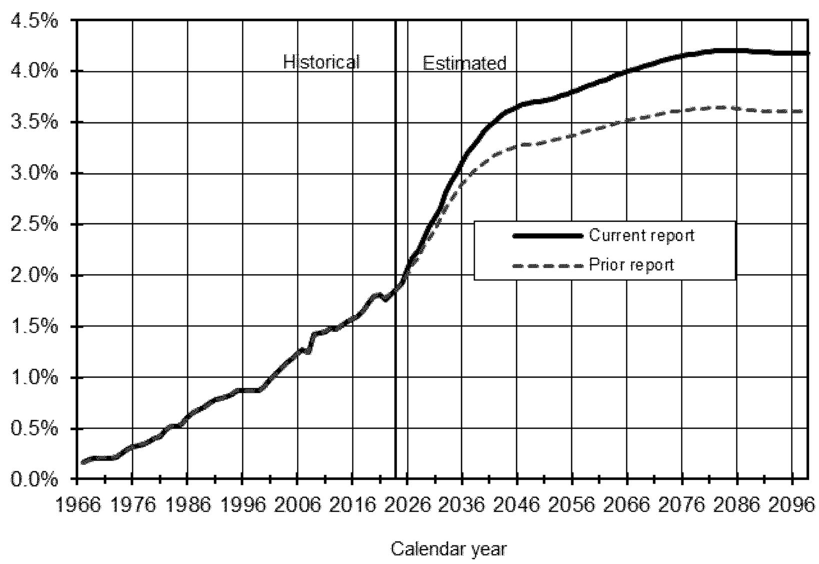
Under the intermediate assumptions, incurred Part B expenditures as a percentage of GDP increase from 1.86 percent in 2024 to 4.21 percent in 2085 before declining to 4.18 percent in 2099. (Part B expenditures

[58]These estimated incurred expenditures are for benefit payments and administrative expenses combined, unlike the values in table III.C5, which express only benefit payments on a cash basis as a percentage of GDP.

instead increase to 5.3 percent in 2099 under the illustrative alternative scenario.)

Figure III.C4 compares the year-by-year Part B expenditures as a percentage of GDP for the 2025 report with the projections from the 2024 report. Both reports show a projected leveling off of the share of Part B spending as a percentage of GDP because of legislated updates, including those for physician payments. The expenditures as a percentage of GDP in this year's report are higher because of higher projected spending for outpatient hospital and physician-administered drugs.

Figure III.C4.—Comparison of Part B Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



Note: Percentages are affected by economic cycles.

D. PART D FINANCIAL STATUS

This section presents actual operations of the Part D account in the SMI trust fund in 2024 and Part D projections for the next 75 years. Section III.D1 discusses Part D financial results for 2024, and sections III.D2 and III.D3 discuss the short-range Part D projections and the long-range projections, respectively. The projections shown in sections III.D2 and III.D3 assume no changes will occur in the statutory provisions and regulations under which Part D currently operates.

1. Financial Operations in Calendar Year 2024

The total assets of the account amounted to approximately $15.7 billion on December 31, 2023. During calendar year 2024, total Part D expenditures were approximately $146.2 billion. Government contributions were provided on an as-needed basis to cover the portion of expenditures that Medicare subsidies support. Total Part D receipts were $149.3 billion. As a result, total assets in the Part D account increased to $18.8 billion as of December 31, 2024.

Table III.D1 presents a statement of the revenue and expenditures of the Part D account of the SMI trust fund in calendar year 2024, and of its assets at the beginning and end of the calendar year.

Table III.D1—Statement of Operations of the Part D Account in the SMI Trust Fund during Calendar Year 2024
[In thousands]

Total assets of the Part D account in the trust fund, beginning of period		$15,687,603
Revenue:		
Premiums from enrollees:		
Premiums deducted from Social Security benefits	$5,801,152	
Premiums paid directly to plans[1]	13,475,413	
Total premiums		19,276,566
Government contributions:		
Prescription drug benefits	111,154,722	
Prescription drug administrative expenses	404,154	
Total government contributions		111,558,876
Payments from States		17,995,273
Interest on investments		265,348
DOJ/OIG/MA settlements[2]		166,034
Total revenue		$149,262,096
Expenditures:		
Part D benefit payments[1]		$145,679,713
Part D administrative expenses		487,806
Total expenditures		$146,167,519
Net addition to the trust fund		3,094,576
Total assets of the Part D account in the trust fund, end of period		$18,782,179

[1]Premiums paid directly to plans are not displayed on the Treasury statement and are estimated. These premiums have been added to the benefit payments reported on the Treasury statement to obtain an estimate of total Part D benefits. Direct data on such benefit amounts are not yet available.
[2]Reflects amounts transferred to the Part D account for settlements related to Department of Justice (DOJ) civil and criminal court cases, Office of the Inspector General (OIG) civil monetary penalties, and Medicare Advantage (MA) civil monetary penalties.

Note: Totals do not necessarily equal the sums of rounded components.

a. Revenues

The major sources of revenue for the Part D account are contributions of the Federal Government authorized to be apportioned and transferred from the general fund of the Treasury, premiums paid by eligible persons who voluntarily enroll, and payments from States.

Of the total Part D revenue in 2024, $5.8 billion represented premium amounts withheld from Social Security benefits or other Federal benefit payments. Total premium payments, including those paid directly to Part D plans, amounted to an estimated $19.3 billion or 12.9 percent of total revenue.

In calendar year 2024, contributions received from the general fund of the Treasury amounted to $111.6 billion, which accounted for 74.7 percent of total revenue. The payments from States were $18.0 billion.

Another source of Part D revenue is interest received on investments held by the Part D account. Because this account holds a very low amount of assets, and only for brief periods of time, the interest on the investments of the account in calendar year 2024 was $0.3 billion. Finally, law enforcement and other settlements were negligible.

b. Expenditures

Part D expenditures include both the costs of prescription drug benefits provided by Part D plans to enrollees and Medicare payments to retiree drug subsidy (RDS) plans on behalf of beneficiaries who obtain their primary drug coverage through such plans. Unlike Parts A and B of Medicare, the Part D account in the SMI trust fund does not directly support all Part D expenditures. In particular, enrollee premiums that are paid directly to Part D plans, and thus do not flow through the Part D account, finance a portion of these expenditures. However, these premium amounts are included in the Part D account operations (both income and expenditures) presented in this report. Total expenditures are characterized as either benefits (representing the gross cost of enrollees' prescription drug coverage plus RDS amounts) or Federal administrative expenses.

All expenses incurred by the Department of Health and Human Services, the Social Security Administration (SSA), and the Department of the Treasury in administering Part D are charged to the account. These administrative duties include making payments to Part D plans, fraud and abuse control activities, and experiments and demonstration projects designed to improve the quality, efficiency, and economy of health care services.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part D. The account expenditures include such costs. However, the statement of Part D assets presented in this report does not carry the net worth of facilities and other fixed capital assets because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and is not, therefore, pertinent in assessing the actuarial status of the funds.

Of the $146.2 billion in total Part D expenditures in 2024, $145.7 billion represented benefits, as defined above, and the remaining $0.5 billion reflected Federal administrative expenses. The Medicare direct premium subsidy payments and enrollee premiums implicitly cover administrative expenses incurred by Part D plans.

The total assets of the Part D account as of December 31, 2024, were higher than in 2023 primarily because of the increased advanced payments to Part D plans required in 2025 as a result of the benefit redesign under the Inflation Reduction Act of 2022.

c. Actual experience versus prior estimates

Table III.D2 compares the actual experience in calendar year 2024 with the estimates presented in the 2023 and 2024 annual reports. A number of factors can contribute to differences between estimates and subsequent actual experience. In particular, actual values for key economic variables can differ from assumed levels, lawmakers may adopt legislative and regulatory changes after a report's preparation, and new, high-impact drugs can enter the market.

As shown in table III.D2, compared with the 2024 report, actual premiums from enrollees were lower because of higher-than-estimated average low-income premium subsidy amounts. Payments from States were substantially lower, and government contributions were higher, because of a decrease in the number of full-benefit dual-eligible beneficiaries. Previous estimates did not account for this decrease, which occurred as a result of the reversal of the Medicaid continuous enrollment condition after the COVID-19 public health emergency ended. (This reversal is known as Medicaid unwinding.) Benefit payments were slightly lower because a temporary retrospective subsidy payment to reduce cost sharing for vaccines and covered insulins for the 2023 plan year, as provided for by the Inflation Reduction Act, was made in 2025 rather than in 2024.

Compared with the 2023 report, the larger benefit payments for calendar year 2024 were mainly due to an unexpected surge in the use of antidiabetic drugs beginning in 2023, which resulted in higher reinsurance costs and low-income cost-sharing subsidies. The aforementioned Medicaid unwinding reduced the payments from States. Both the surge of anti-diabetic drugs and Medicaid unwinding were major reasons that the government contributions were substantially higher than projected.

Table III.D2.—Comparison of Actual and Estimated Operations of the Part D Account in the SMI Trust Fund, Calendar Year 2024
[Dollar amounts in millions]

		Comparison of actual experience with estimates for calendar year 2024 published in:			
		2024 report		2023 report	
Item	Actual amount	Estimated amount[1]	Actual as a percentage of estimate	Estimated amount[1]	Actual as a percentage of estimate
Premiums from enrollees	$19,277	$19,760	98%	$19,540	99%
Payments from States	17,995	20,184	89	19,110	94
Government contributions	111,559	107,435	104	101,652	110
Benefit payments	145,680	146,878	99	138,732	105

[1]Under the intermediate assumptions.

d. Assets

The Department of the Treasury invests the portion of the Part D account not needed to meet current expenditures for benefits and administration in interest-bearing obligations of the U.S. Government.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the account. The law requires that these special public-debt obligations shall bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue) for all marketable interest-bearing obligations of the United States forming a part of the public debt that are not due or callable until after 4 years from the end of that month. Since the inception of the SMI trust fund, the Department of the Treasury has always invested the assets in special public-debt obligations.[59] Table V.H10, presented in section V.H, shows the assets of the SMI trust fund (Parts B and D) at the end of fiscal years 2023 and 2024.

As explained in section III.D2, the flexible apportionment of government contributions for Part D eliminates the need to maintain a contingency reserve. As a general rule, Part D assets are very low and are held only briefly in anticipation of immediate expenditures. However, in recent years, a reserve has accumulated in the Part D account for the future settlement of the portion of administrative expenses incurred by SSA on behalf of Medicare.

2. 10-Year Actuarial Estimates (2025–2034)

This section provides detailed information concerning the short-range financial status of the Part D account, including projected annual

[59]The Department of the Treasury may also make investments in obligations guaranteed for both principal and interest by the United States, including certain federally sponsored agency obligations.

income, expenditures, differences between income and expenditures, and trust fund balances. Section IV.B2 presents an explanation of the effects of the Trustees' intermediate assumptions and other assumptions unique to Part D on the estimates in this report.

Generally, the income to the Part D account includes the beneficiary premiums described previously and transfers from the general fund of the Treasury to cover each year's incurred benefit costs and other expenditures. The language that has been included in the Part D appropriation provides, without further Congressional action, resources for benefit payments under the Part D drug benefit program on an as-needed basis. The transfers from the Treasury reflect the direct premium subsidy payments, government subsidies,[60] amounts of reinsurance payments, RDS amounts, low-income subsidies, net risk-sharing payments, administrative expenses, advanced discount payments, and inflation rebates.[61] This income requirement is reduced by State payments for the full-benefit dually eligible beneficiaries who were covered under Medicaid prior to the implementation of Part D.

Until 2015, actual cash transfers from the Treasury were made on the day the benefit payments to plans were due, typically the first business day of a month, causing the Part D account balance at the end of a month to include only a modest amount from State payments to the account after the benefit payments were made. Then in 2015 a policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans, and therefore the Part D account now includes a more substantial balance at the end of most months. In addition, the account balance carries an accumulated reserve for the future settlement of the portion of administrative expenses incurred by SSA on behalf of Medicare.

The beneficiary premiums and direct subsidy rate are calculated based on the national average monthly bid amounts and defined prior to each year's operations. Starting in 2024, the base beneficiary premium constitutes the lesser of 25.5 percent[62] of the expected total plan costs

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[60]Under the Inflation Reduction Act of 2022, the drug manufacturers' discount for costs below the catastrophic threshold will be replaced by government subsidies if the drugs are selected for price negotiation. In addition, there will be a one-time temporary retrospective subsidy to reduce cost sharing for vaccines and covered insulins for the 2023 plan year.

[61]The Inflation Reduction Act provided for the assessment of inflation rebates for those drugs for which prices are increasing more rapidly than the Consumer Price Index (CPI-U). However, the Trustees project that the inflation rebates will be modest while other price growth constraints will be more effective.

[62]Beginning in 2030, the base beneficiary premium percentage will be reset according to the specifications of the Inflation Reduction Act of 2022.

for basic Part D coverage or the prior year's base beneficiary premium increased by 6 percent. The actual premium a beneficiary pays is calculated as the difference between the plan bid and the national average monthly bid amount, which is then applied to the base beneficiary premium. Beginning in 2011, beneficiaries with modified adjusted gross incomes exceeding a specified threshold pay income-related premiums in addition to the premiums charged by the plans in which the individuals have enrolled. The extra premiums are credited to the Part D trust fund account and reduce the financing amounts from the general fund.

Starting in 2011, the drug manufacturers provide a 50-percent ingredient cost discount for brand-name drugs in the coverage gap that reduces beneficiary out-of-pocket expenses. In 2019, the Bipartisan Budget Act of 2018 increased the brand-name drug discount in the coverage gap to 70 percent, with a corresponding decrease in plan benefits. As of January 1, 2025, as a result of the altered Part D benefit structure under the Inflation Reduction Act, the brand-name discount from manufacturers has been revised to instead provide a 10-percent discount[63] in the initial coverage phase and a 20-percent discount in the catastrophic phase. Medicare Part D pays advanced discount payments prospectively to the non-employer Part D plans and will be reimbursed for these amounts once the plans receive the discounts from the drug manufacturers. Although the net cashflow for this arrangement is zero, the timing of the cashflow has an impact on the yearly financing amounts.

Expenditures from the account include the premiums withheld from beneficiaries' Social Security benefits and transferred to the private drug plans, the direct premium subsidy payments, reinsurance payments, RDS amounts, low-income subsidy payments, net risk-sharing payments, government subsidies, administrative expenses, and advanced discount payments. As noted previously, the Trustees supplement these expenditures to include the amount of enrollee premiums paid directly to Part D plans, thereby providing an estimate of total Part D benefit payments and other expenditures.

Part D expenditures on direct premium subsidy payments, RDS amounts, advanced discount payments, government subsidies, and administrative expenses are affected by the sequestration required by current law, which reduces benefit payments by the following percentages: 2 percent from April 1, 2013, through April 30, 2020;

[63]The 10-percent discount will be replaced by a government subsidy following the negotiation of a selected drug.

1 percent from April 1, 2022, through June 30, 2022; and 2 percent from July 1, 2022, through January 31, 2033.

Reinsurance, the low-income cost-sharing subsidy, and net risk-sharing payments are not affected by sequestration. (See section V.A for recent legislative changes affecting the sequestration of Medicare expenditures.)

Premiums for stand-alone prescription drug plans would have increased substantially in 2025 because of certain factors, including the new Part D benefit structure under the Inflation Reduction Act. However, to limit the increase in premiums and stabilize the year-by-year changes for these plans, a 3-year voluntary demonstration was implemented beginning with contract year 2025. These premium reductions result in a corresponding increase in the direct premium subsidies paid by Medicare.

Table III.D3 shows the estimated operations of the Part D account under the intermediate assumptions on a calendar-year basis through 2034.

Table III.D3.—Operations of the Part D Account in the SMI Trust Fund (Cash Basis) during Calendar Years 2004–2034

[In billions]

	Income					Expenditures			Account	
Calendar year	Premium income[1]	Government contribution[2]	Payments from States[3]	Interest and other	Total	Benefit payments[4]	Administrative expense	Total	Net change	Balance at end of year[5]
Historical data:										
2004	—	$0.4	—	—	$0.4	$0.4	—	$0.4	—	—
2005	—	1.1	—	—	1.1	1.1	—	1.1	—	—
2006	$3.5	39.2	$5.5	$0.0	48.2	47.1	$0.3	47.4	$0.8	$0.8
2007	4.1	38.8	6.9	0.0	49.7	48.8	0.9	49.7	0.0	0.8
2008	5.0	37.3	7.1	0.0	49.4	49.0	0.3	49.3	0.1	0.9
2009	6.3[6]	47.1	7.6	0.0	61.0	60.5	0.3	60.8	0.1	1.1
2010	6.5[6]	51.1	4.0	0.0	61.7	61.7	0.4	62.1	−0.4	0.7
2011	7.7	52.6	7.1	0.0	67.4	66.7	0.4	67.1	0.3	1.0
2012	8.3	50.1	8.4	0.0	66.9	66.5	0.4	66.9	0.0	1.0
2013	9.9	51.0	8.8	0.0	69.7	69.3	0.4	69.7	−0.0	1.0
2014	11.4	58.1	8.7	0.0	78.2	77.7	0.4	78.1	0.1	1.1
2015	12.7[6]	68.4	8.9	0.0	90.0	89.4	0.3	89.8	0.3	1.3
2016	13.8[6]	82.4	10.0	0.0	106.2	99.5	0.5	99.9	6.3	7.6
2017	15.5	73.2	11.4	0.1	100.2	100.1	−0.1[7]	100.0	0.2	7.8
2018	15.9	67.8	11.7	0.1	95.4	94.7	0.5	95.2	0.2	8.0
2019	15.7	70.2	12.3	0.5	98.7	97.0	0.5	97.5	1.2	9.2
2020	15.8[6]	77.7	11.6	0.7	105.8	104.6	0.4	105.0	0.8	10.0
2021	17.0[6]	85.3	12.1	0.3	114.7	104.5	0.5	105.0	9.7	19.7
2022	17.6	92.4	13.7	0.7	124.3	125.2	0.5	125.7	−1.4	18.3
2023	18.3	93.7	15.8	0.2	128.1	130.2	0.5	130.7	−2.6	15.7
2024	19.3	111.6	18.0	0.4	149.3	145.7	0.5	146.2	3.1	18.8
Intermediate estimates:										
2025	15.0	143.0	18.4	0.5	176.9	177.5	0.6	178.1	−1.3	17.5
2026	21.9[6]	122.2	19.1	0.5	163.7	162.4	0.6	163.0	0.7	18.2
2027	27.0[6]	137.1	19.2	0.5	183.9	182.4	0.7	183.0	0.8	19.1
2028	31.3	146.4	19.0	0.5	197.2	196.0	0.7	196.7	0.5	19.6
2029	34.1	153.2	19.3	0.5	207.3	205.7	0.7	206.4	0.8	20.4
2030	39.3	157.4	19.8	0.6	217.1	215.8	0.7	216.6	0.5	20.9
2031	40.6	159.7	20.6	0.6	221.4	220.5	0.8	221.2	0.1	21.1
2032	41.2	160.3	21.4	0.6	223.5	222.2	0.8	223.0	0.4	21.5
2033	42.5	167.1	21.7	0.6	231.9	230.4	0.8	231.2	0.7	22.2
2034	44.2	173.1	22.0	0.6	239.9	238.4	0.9	239.2	0.7	22.9

[1]Premiums include both amounts withheld from Social Security benefits or other Federal payments and those paid directly to Part D plans.

[2]Includes, net of payments from States, all government transfers required to fund benefit payments, inflation rebates as specified under the Inflation Reduction Act of 2022, administrative expenses, and State expenses for making low-income eligibility determinations.

[3]Payments from States with respect to the Federal assumption of Medicaid responsibility for drug expenditures for full-benefit dually eligible individuals.

[4]Includes payments to Part D plans, government subsidies under the Inflation Reduction Act, payments to retiree drug subsidy plans, payments to States for making low-income eligibility determinations, Part D drug premiums collected from beneficiaries, and transfers to Medicare Advantage plans and private drug plans. Includes amounts for the Transitional Assistance program of $0.4 billion, $1.0 billion, and $0.1 billion in 2004–2006, respectively.

[5]As noted in section III.D2, a new policy was developed in 2015 under which amounts from the Treasury are transferred into the Part D account 5 business days before the benefit payments to the plans, rather than on the day the benefit payments are due—typically the first business day of a month—as had previously been the case. Accordingly, the Part D account includes a balance at the end of the previous year that is more substantial than it would have been prior to implementation of the new policy. For 2021, 2022, and 2023, the balances were larger than in prior years because of delayed settlement of the year-end reconciliation amounts from November to January. In addition, the balances since 2019 have also included an accumulated reserve for the administrative costs incurred by SSA on behalf of Medicare.

[6]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2010, actually occurred on December 31, 2009, payment of benefits normally due January 3, 2016, occurred on December 31, 2015, and payment of benefits normally due January 3, 2021, occurred on December 31, 2020. Consequently, the Part D premiums withheld from these benefits were added to the Part D account on December 31, 2009 (about $0.2 billion), December 31, 2015 (about $0.2 billion), and December 31, 2020 (about $0.1 billion), respectively. Similarly, the expected payment date for those benefits normally due January 3, 2027, is December 31, 2026. Accordingly, an estimated $0.2 billion will be added to the Part D account on December 31, 2026.
[7]Reflects a larger-than-usual downward adjustment of $0.3 billion for prior-year allocations among Part A, Part B, and Part D.

Note: Totals do not necessarily equal the sums of rounded components.

Table III.D4 shows prescription drug payment amounts in the aggregate, on a per capita basis, and relative to the Gross Domestic Product (GDP). The benefit amounts are shown on a cash basis and reflect net reconciliation payments that are made to adjust for prior-year differences between prospective payments made to plans and actual prescription drug expenditures.

The magnitude and timing of the year-end reconciliation payments can cause a volatile pattern of annual growth rates. This was the case during the COVID-19 pandemic, when the payments were delayed to the following calendar year because of deadline extensions for plans to submit risk-adjustment data.

Table III.D4.—Growth in Part D Benefits (Cash Basis) through December 31, 2034

Calendar year	Aggregate benefits [billions]	Percent change	Per capita benefits	Percent change	Part D benefits as a percentage of GDP
Historical data:					
2004	$0.4	—	$362	—	0.00%
2005	1.1	—	596	—	0.01
2006	47.1	—	1,708	—	0.34
2007	48.8	3.7%	1,556	−8.9%	0.34
2008	49.0	0.4	1,504	−3.3	0.33
2009	60.5	23.4	1,798	19.6	0.42
2010	61.7	2.0	1,775	−1.3	0.41
2011	66.7	8.1	1,868	5.3	0.43
2012	66.5	−0.4	1,776	−5.0	0.41
2013	69.3	4.2	1,772	−0.2	0.41
2014	77.7	12.1	1,919	8.3	0.44
2015	89.4	15.1	2,140	11.5	0.49
2016	99.5	11.2	2,302	7.6	0.53
2017	100.1	0.7	2,251	−2.2	0.51
2018	94.7	−5.4	2,068	−8.1	0.46
2019	97.0	2.5	2,057	−0.5	0.45
2020	104.6	7.7	2,147	4.4	0.49
2021	104.5	−0.1	2,091	−2.6	0.44
2022	125.2	19.8	2,435	16.5	0.48
2023	130.2	4.0	2,462	1.1	0.47
2024	145.7	11.9	2,638	7.2	0.50
Intermediate estimates:					
2025	177.5	21.9	3,129	18.6	0.58
2026	162.4	−8.5	2,771	−11.4	0.51
2027	182.4	12.3	3,017	8.9	0.55
2028	196.0	7.5	3,155	4.6	0.57
2029	205.7	5.0	3,241	2.7	0.57
2030	215.8	4.9	3,342	3.1	0.58
2031	220.5	2.2	3,369	0.8	0.57
2032	222.2	0.8	3,357	−0.4	0.55
2033	230.4	3.7	3,443	2.6	0.55
2034	238.4	3.5	3,524	2.3	0.54

Note: Percentages are affected by economic cycles.

Part D benefit payments have experienced an erratic growth pattern throughout the history of the program. Expenditures have been increasing substantially, reflecting not only rapid growth in enrollment but also multiple prescription drug cost and utilization trends that have varying effects on underlying costs. For example, while drug costs have been increasing more rapidly than other categories of medical spending, there has been a substantial increase in the proportion of prescriptions filled with low-cost generic drugs that has helped constrain cost growth and, at the same time, a significant increase in the cost of specialty drugs that has increased cost growth. Additionally, direct and indirect remuneration (DIR) has dramatically increased as a percentage of gross drug spending, a factor that has significantly slowed Part D spending growth.

Pent-up demand for certain classes of drugs or new drugs entering the market can also increase overall growth in drug expenditures and result in higher program costs. In 2023, actual drug expenditures were significantly higher because of the unanticipated rapid increase in the use of antidiabetic drugs. This increased use is projected to continue.

Legislation and policy changes also contribute to the volatility of the annual growth rates. For example, the coverage gap gradually closed from 2012 through 2020, increasing plan benefits and resulting in higher Part D expenditures and premiums. In addition, the policy to pay advanced reinsurance amounts to the employer/union-only group waiver plans, beginning in 2017, affects the timing of the reinsurance payments, which were previously provided exclusively through the reconciliation process.

Two recent legislation and policy changes have significantly affected Part D expenditures. First, a pharmacy price concessions policy (published in a May 9, 2022, CMS final rule) shifts pharmacy rebates to reduce point-of-sale drug prices, effective January 1, 2024. The reduction in rebates results in increased Medicare expenditures.

Second, the Inflation Reduction Act of 2022 has redesigned the standard Part D benefit to provide reduced beneficiary out-of-pocket costs while increasing Federal spending beginning in 2023, with the full effects of the benefit redesign to be implemented in 2025. More than offsetting these additional costs by the end of the short-range projection are program savings resulting from the lowering of drug price growth through price negotiation and inflation rebates. The impact of negotiated prices begins in 2026 and will phase in over the following several years as the prices for more drugs are negotiated.

Accordingly, over the next 10 years, aggregate benefits are projected to increase at a rate of 5.0 percent annually, on average, while the average per capita rate of growth is projected to be 2.9 percent.

The Trustees have also prepared estimates using two alternative sets of assumptions. Table III.D5 summarizes the estimated operations of the Part D account under the intermediate assumptions and under the two alternative sets of assumptions. Section IV.B2 presents the assumptions underlying the intermediate estimates in substantial detail, and it outlines the assumptions used in preparing estimates under the low-cost and high-cost alternatives.

Table III.D5.—Estimated Operations of the Part D Account in the SMI Trust Fund during Calendar Years 2024–2034, under Alternative Sets of Assumptions
[Dollar amounts in billions]

Calendar year	Premiums from enrollees	Other income[1]	Total income	Total expenditures	Balance in account at end of year	Expenditures as a percentage of GDP
Intermediate:						
2024[2]	$19.3	$130.0	$149.3	$146.2	$18.8	0.50%
2025	15.0	161.9	176.9	178.1	17.5	0.58
2026	21.9[3]	141.8	163.7	163.0	18.2	0.51
2027	27.0[3]	156.9	183.9	183.0	19.1	0.55
2028	31.3	165.9	197.2	196.7	19.6	0.57
2029	34.1	173.1	207.3	206.4	20.4	0.57
2030	39.3	177.8	217.1	216.6	20.9	0.58
2031	40.6	180.8	221.4	221.2	21.1	0.57
2032	41.2	182.3	223.5	223.0	21.5	0.55
2033	42.5	189.4	231.9	231.2	22.2	0.55
2034	44.2	195.7	239.9	239.2	22.9	0.55
Low-cost:						
2024[2]	19.3	130.0	149.3	146.2	18.8	0.50
2025	15.0	153.8	168.8	171.3	16.2	0.55
2026	21.5[3]	121.8	143.3	143.0	16.6	0.44
2027	26.0[3]	139.1	165.1	164.6	17.1	0.48
2028	30.2	145.1	175.3	175.0	17.3	0.48
2029	33.0	149.1	182.1	181.6	17.8	0.47
2030	38.1	150.4	188.6	188.3	18.1	0.46
2031	39.2	150.9	190.1	190.1	18.0	0.44
2032	39.6	150.2	189.9	189.7	18.2	0.42
2033	40.7	154.2	194.9	194.5	18.5	0.41
2034	42.1	157.2	199.3	199.0	18.9	0.40
High-cost:						
2024[2]	19.3	130.0	149.3	146.2	18.8	0.50
2025	15.0	170.7	185.6	185.7	18.7	0.63
2026	22.4[3]	161.9	184.3	183.2	19.8	0.61
2027	28.1[3]	173.5	201.6	200.2	21.2	0.64
2028	32.5	188.4	221.0	220.0	22.2	0.68
2029	35.4	200.6	236.0	234.9	23.3	0.70
2030	44.6	206.6	251.2	250.3	24.2	0.73
2031	46.3	213.5	259.8	259.4	24.7	0.73
2032	47.2	218.3	265.5	264.6	25.5	0.73
2033	48.8	230.2	279.0	277.8	26.7	0.74
2034	51.1	241.5	292.5	291.4	27.9	0.76

[1]Other income contains government contributions, payments from States, inflation rebates as specified under the Inflation Reduction Act of 2022, interest, and settlement collections.
[2]Figures for 2024 represent actual experience.
[3]See footnote 6 of table III.D3.

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. Percentages are affected by economic cycles.

Because of the price assumptions for these alternative scenarios, the expenditures presented in these scenarios represent a narrow range of outcomes, and actual experience could easily fall outside of this range. For the low-cost scenario, the Trustees assume higher price inflation, which leads to higher spending. Similarly, under the high-cost scenario, the Trustees assume lower price inflation, which leads to lower spending. These price inflation assumptions partially offset the effects of the other assumptions in the high-cost and low-cost scenarios, resulting in a narrow range of expenditures. Given the considerable variation in the factors affecting health care spending, actual Part D experience could easily fall outside of this range. Because the GDP assumptions in these scenarios are similarly affected by the price inflation assumptions, Part D expenditures as a percent of GDP provide better insight into the variability of spending than the nominal dollar amounts, as shown in table III.D5.

The alternative projections shown in table III.D5 illustrate two important aspects of the financial operations of the Part D account:

- Despite the differing assumptions underlying the three alternatives, the balance between Part D income and expenditures remains relatively stable. This result occurs because the premiums and government contributions underlying the Part D financing are reestablished annually. Thus, Part D income automatically tracks Part D expenditures fairly closely, regardless of the specific economic and other conditions.

- As a result of the close matching of income and expenditures described above, together with anticipated continuing flexibility in the apportionment of government contributions, the need for a contingency reserve to handle unanticipated fluctuations is minimal.

Adequacy of Part D Financing Established for Calendar Year 2024

As noted previously, the Part D account in the SMI trust fund will be in financial balance indefinitely because the premiums paid by enrollees and the amounts apportioned from the general fund of the Treasury are determined each year so as to adequately finance Part D expenditures. Moreover, the appropriation for Part D government contributions has included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.[64] One exception for the unnecessary contingency fund in recent years is that a reserve has accumulated for the future settlement of the portion of administrative expenses incurred by SSA on behalf of Medicare.

As described in section III.C on the financial status of the Part B account, it is important to maintain an appropriate level of assets to

[64]The indefinite authority applies to all Part D expenditures other than Federal administrative expenses, which are specifically appropriated each year.

cover the liability for claims that have been incurred but not yet reported or paid. In the case of Part D, however, most such claims are the responsibility of the prescription drug plans rather than the Part D program. Accordingly, the Part D account is generally not at risk for incurred-but-unreported claim amounts, and no asset reserve is necessary for this purpose.

Another potential Part D liability exists to the extent that Part D reinsurance payments and low-income cost-sharing subsidy payments are based on plan estimates.[65] Since actual Part D costs, as subsequently determined, will generally differ from plan bids, payment adjustments are made after the close of the year as needed to reconcile the accounts. When plan bids have been below actual costs, Medicare has made reconciliation payments to the plans from the following year's appropriated government contributions; thus, creation of a reserve for payment of such settlement amounts is not required.

For these reasons, the Trustees have concluded that maintenance of Part D account assets for drug plan contingency or liability purposes is unnecessary at this time. Accordingly, evaluation of the adequacy of Part D assets is also unnecessary, and the Part D account is considered to be in satisfactory financial condition for 2025 and all future years as a consequence of its basis for financing.

3. Long-Range Estimates

Section III.D2 presented the expected operations of the Part D account over the next 10 years. This section describes the long-range expenditures of the account under the intermediate assumptions. Because of its automatic financing provisions, the Trustees expect adequate financing of the Part D account into the indefinite future and so have not conducted a long-range analysis using high-cost and low-cost assumptions.

Table III.D6 shows the estimated Part D incurred expenditures under the intermediate assumptions expressed as a percentage of GDP, for selected years over the calendar-year period 2024–2099.[66]

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[65]These estimates are subject to actuarial review by the CMS Office of the Actuary.

[66]These estimated incurred expenditures are for benefit payments and administrative expenses combined, unlike the values in table III.D4, which express only benefit payments on a cash basis as a percentage of GDP.

Table III.D6.—Part D Expenditures (Incurred Basis) as a Percentage of the Gross Domestic Product[1]

Calendar year	Part D expenditures as a percentage of GDP
2024	0.51%
2025	0.53
2026	0.54
2027	0.56
2028	0.57
2029	0.58
2030	0.58
2031	0.57
2032	0.55
2033	0.55
2034	0.54
2035	0.54
2040	0.52
2045	0.51
2050	0.52
2055	0.54
2060	0.56
2065	0.58
2070	0.59
2075	0.61
2080	0.62
2085	0.63
2090	0.63
2095	0.63
2099	0.64

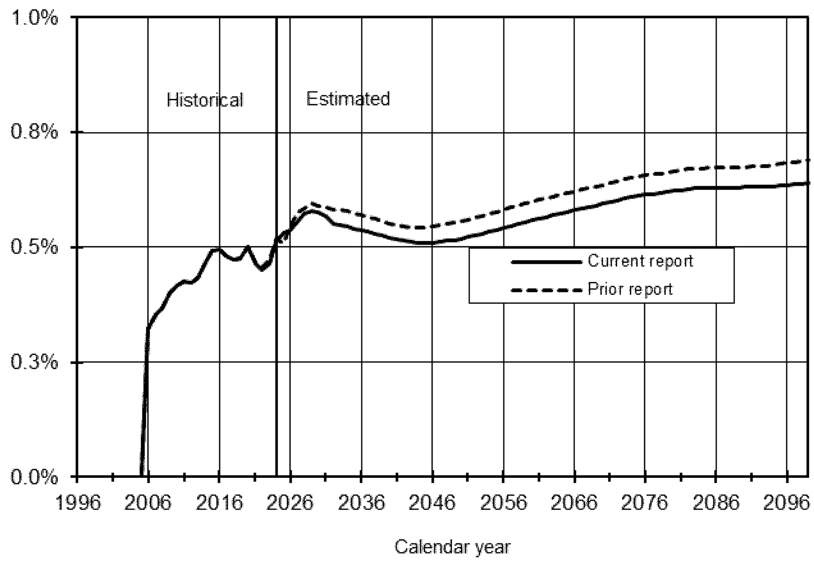
[1]Expenditures are the sum of benefit payments and administrative expenses.

Note: Percentages are affected by economic cycles.

The Trustees assume that, during the initial 25-year period, increases in Part D costs per enrollee will vary while gradually converging to the growth rates described in sections II.C and IV.D. Based on these assumptions and projected demographic changes, incurred Part D expenditures as a percentage of GDP would increase from 0.51 percent in 2024 to 0.64 percent in 2099.

Figure III.D1 compares the year-by-year Part D expenditures as a percentage of GDP for the current annual report with the corresponding projections from 2024. For Part D, the expenditure share of GDP is lower than the share in last year's report in most years. This is the case because Part D enrollment is lower than projected in last year's report, and it is disproportionately lower for those eligible for low-income subsidies.

Figure III.D1.—Comparison of Part D Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



Note: Percentages are affected by economic cycles.

IV. ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR COST ESTIMATES FOR THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS

This section describes the basic methodology and assumptions used in the estimates for the HI and SMI trust funds under the intermediate assumptions and presents projections of HI and SMI costs under two alternative sets of assumptions.

The economic and demographic assumptions underlying the projections of HI and SMI costs shown in this report are consistent with those in the 2025 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.[67] That report describes these assumptions in more detail.

A. HOSPITAL INSURANCE

1. Cost Projection Methodology

The principal steps involved in projecting future HI costs are as follows: (i) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (ii) projecting increases in HI payments for inpatient hospital services; (iii) projecting increases in HI payments for skilled nursing, home health, and hospice services covered; (iv) projecting increases in payments to private health plans; and (v) projecting increases in administrative costs.

a. Projection Base

To establish a suitable base from which to project future HI costs, the incurred payments for services provided must be constructed for the most recent period for which a reliable determination can be made. Accordingly, payments to providers must be attributed to dates of service, rather than to payment dates; in addition, the nonrecurring effects of any changes in regulations, legislation, or administration, and of any items affecting only the timing and flow of payments to providers, must be eliminated. As a result, the rates of increase in the HI incurred costs differ from the increases in cash expenditures shown in the tables in section III.B.

[67]The non-health-specific intermediate assumptions for this report were set in December 2024. The Trustees will continue to monitor developments, reevaluate the assumptions, and modify the projections in later reports.

For those expenses still reimbursed on a reasonable-cost basis, the costs for covered services are determined on the basis of provider cost reports. Because of the time required to obtain cost reports from providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the original costs by as much as several years for some providers. Additional complications arise from legislative, regulatory, and administrative changes, the effects of which cannot always be determined precisely.

The process of allocating the various types of HI payments made to the proper incurred period—using incomplete data and estimates of the impact of administrative actions—presents difficult problems, and the solutions to these problems can be only approximate. Under the circumstances, the best that one can expect is that the actual HI incurred cost for a recent period can be estimated within a few percent. This process increases the projection error directly by incorporating any error in estimating the base year into all future years.

b. Fee-for-Service Payments for Inpatient Hospital Costs

Payment for almost all inpatient hospital services for fee-for-service beneficiaries occurs under a prospective payment system. The law stipulates that the annual increase in the payment rate for each admission relate to a hospital input price index (also known as the hospital market basket), which measures the increase in prices for goods and services purchased by hospitals for use in providing care to hospital inpatients.

For fiscal year 2025, the prospective payment rates have already been determined. For fiscal years 2026 and later, the statute mandates that the annual increase in the payment rate per admission equal the annual increase in the hospital input price index (for those hospitals submitting required quality measure data), minus a specified percentage. For this report, the Trustees assume that all hospitals will submit these data.

Increases in aggregate payments for inpatient hospital care covered under HI can be analyzed in five broad categories, presented in table IV.A1:

(1) Hospital input price index—the increase in prices for goods and services purchased by the hospital;

(2) Update factor adjustment—an amount added to or subtracted from the input price index (generally called for in legislation) to yield the prospective payment update factor;

(3) Volume of services—the increase in total output of units of service (as measured by covered HI hospital admissions);

(4) Case mix—the financial effect of changes in the average complexity of hospital admissions; and

(5) Other sources—a residual category reflecting all other factors affecting hospital cost increases (such as enacted legislative changes).

Table IV.A1 shows the estimated historical values of these principal components, as well as the projected trends used in the estimates. The impact of sequestration during April 1, 2013, through January 31, 2033, with the exception of May 1, 2020, through March 31, 2022, when it was suspended, is reflected in the table. Unless otherwise indicated, the following discussions apply to projections under the intermediate assumptions.

Table IV.A1.—Components of Historical and Projected Increases in HI Inpatient Hospital Payments[1]

			Volume of services					
Calendar year	Input price index	Update Factor Adjustment [2]	HI enrollment	Managed care shift effect	Admission incidence	Case mix	Other sources	HI inpatient hospital payments
Historical data:								
2015	2.8%	−0.7%	2.7%	−2.1%	−0.8%	0.5%	−2.4%	−0.1%
2016	2.5	−0.8	2.7	−1.1	−1.9	3.1	−0.2	4.2
2017	2.7	−1.1	5.5	−4.7	−0.7	0.4	−1.0	0.8
2018	2.8	−1.4	−0.3	−0.2	−2.0	1.8	0.5	1.1
2019	2.9	−1.3	2.5	−2.7	−2.7	1.0	2.1	1.7
2020	2.9	−0.3	2.2	−4.1	−14.6	3.8	7.7	−4.1
2021	2.5	−0.2	1.8	−5.3	−1.0	2.9	0.7	1.1
2022	3.1	−0.6	1.9	−4.8	−0.3	−0.3	0.0	−1.3
2023	3.9	−0.3	2.2	−4.7	1.9	−1.0	−0.5	1.2
2024	3.3	−0.3	1.5	−4.3	2.8	−0.3	1.3	4.0
Intermediate estimates:								
2025	3.4	−0.6	2.8	−1.2	1.5	−0.0	0.4	6.4
2026	3.4	−0.8	2.2	−2.5	1.8	0.2	0.8	5.1
2027	3.6	−0.8	2.3	−2.4	0.7	0.5	0.6	4.5
2028	3.6	−0.8	2.2	−2.1	0.7	0.5	0.5	4.6
2029	3.6	−0.8	2.0	−1.8	1.0	0.5	0.4	4.9
2030	3.5	−0.9	1.6	−1.6	0.4	0.5	0.4	3.9
2031	3.4	−0.7	1.2	−1.5	0.5	0.5	0.4	3.8
2032	3.5	−0.8	1.1	−1.3	0.5	0.5	0.3	3.8
2033	3.5	−0.8	1.0	−1.1	0.5	0.5	2.0	5.7
2034	3.4	−0.8	1.0	−0.8	0.4	0.5	0.4	4.1

[1]Percent increase in year indicated over previous year, on an incurred basis.
[2]Reflects the adjustments to the prospective payment update for the 10-year moving average of economy-wide productivity growth and additional decreases in updates ranging from 0.1 percentage point to 0.75 percentage point through 2019.

The input price index is a weighted average of the price proxies (prices of specific inputs) used in delivery of HI inpatient services. The first 2 years of the projection period are based on the methodology underlying the regulatory updates. Thereafter, the methodology uses the historical relationship of three macroeconomic series (average hourly compensation, GDP deflator, and CPI) to each price proxy and applies this relationship to the projected macroeconomic series.

The update factor adjustment is generally the amount subtracted from the input price index to yield the prospective payment update factor.[68] As indicated in table IV.A1, the negative adjustment throughout the first 10-year projection period is associated with the legislatively required adjustment for the 10-year moving average economy-wide productivity growth. While the law also requires that hospitals that do not submit quality measure data receive a reduced update, the Trustees assume that all hospitals will submit these data.

Increases in payments for inpatient hospital services also reflect growth in the number of inpatient hospital admissions covered under HI fee-for-service. As shown in table IV.A1, increases in admissions are attributable to growth in both HI enrollment and admission incidence (admissions per beneficiary). A very large decrease in admissions occurred in 2020 because of the pandemic, and some of these admissions returned over the next few years. Admissions are assumed to grow for the next few years until stabilizing by fiscal year 2027. The historical and projected growth in enrollment reflects a more rapid increase in the population aged 65 and over than in the total population of the United States, as well as trends in the number of disabled beneficiaries and persons with end-stage renal disease. Growth in enrollment is expected to continue and to mirror the ongoing demographic shift into categories of the population eligible for HI benefits and reduced by an increasing proportion of beneficiaries enrolling in private health plans.

The choice of more beneficiaries to join private health plans has been an offsetting factor to the HI enrollment growth, as shown in the "Managed care shift effect" column of table IV.A1. In other words, greater enrollment in private health plans reduced the number of beneficiaries with fee-for-service Medicare coverage and thereby reduced hospital admissions paid through fee-for-service. Private

[68]The update factors are generally prescribed on a fiscal-year basis, while table IV.A1 is on a calendar-year basis. Calculations have therefore been performed to estimate the update factor adjustment on the basis of calendar years. The sum of the input price index and the update factor adjustment generally reflects the prescribed prospective payment update factor, but on a calendar-year, rather than a fiscal-year, basis.

Actuarial Methodology

Medicare health plan membership is projected to continue to grow for most of the projection period.

Since the beginning of the prospective payment system (PPS), inpatient hospital payments have varied based on the complexity of admissions. These variations are primarily due to two factors. The first is the changes in diagnosis-related group (DRG) coding as hospitals continue to adjust to the PPS, and the second factor is the trend toward treating less complicated (and thus less expensive) cases in outpatient settings, which results in an increase in the average prospective payment per admission.

After decreasing in fiscal year 2024, the average complexity of hospital admissions (case mix) is expected to increase gradually until reaching 0.5 percent annually in fiscal years 2027 through 2034. This steady increase is a result of an assumed continuation of the current trend toward treating less complicated cases in outpatient settings, ongoing changes in DRG coding, and the overall impact of new technology.

Hospital payments are also affected by other factors, as reflected in the "Other sources" column of table IV.A1. For example, statutory budget neutrality adjustments offset costs from significant increases in case mix that occurred when the new Medicare severity diagnosis-related group (MS-DRG) system was introduced in 2008. Although the law limited the size of these adjustments in 2008 and 2009, it allows subsequent recovery of any extra payments that resulted. The "Other sources" column reflects all of these actual and anticipated effects and adjustments.

In addition, one can attribute part of the increase from "other sources" to the increase in payments for certain costs, not included in the DRG payment, that are generally growing at a rate slower than the input price index. These other costs include capital, medical education (both direct and indirect), disproportionate share hospital (DSH) payments, and payments to hospitals not included in the PPS.

A particularly important change affecting these costs is the reduction in Medicare DSH payments. This change reflects the major coverage expansions that began in 2014 and that continue to result in significantly fewer uninsured hospital patients. In 2019, however, the elimination of the individual mandate increased the number of uninsured, resulting in an increase in this factor. The "Other sources" column also reflects the impact of the 20-percent add-on for COVID-19 admissions during the public health emergency.

Additional possible sources of changes in payments include the following: (i) a shift to higher-cost or lower-cost admissions because of changes in the demographic characteristics of the covered population; (ii) changes in medical practice patterns; and (iii) adjustments in the relative payment levels for various DRGs, or addition/deletion of DRGs, in response to changes in technology.

The "Other sources" column reflects, as appropriate, the impact of certain enacted legislation, including the sequestration process. Also reflected in this column is the impact of the estimated bonus payments and penalties for hospitals resulting from the health information technology incentives.

The increases in the input price index (less any intensity allowance specified in the law), units of service, and other sources are compounded to calculate the total increase in payments for inpatient hospital services. The last column of table IV.A1 shows these overall increases.

c. *Fee-for-Service Payments for Skilled Nursing Facility, Home Health Agency, and Hospice Services*

To project fee-for-service payments for skilled nursing facilities (SNFs), a method similar to that for inpatient hospitals is used. First, the number of covered days is determined, and then the average reimbursement per day is calculated.

Historically, the number of days of care covered in SNFs under HI has varied widely. This extremely volatile experience has resulted, in part, from legislative and regulatory changes and from judicial decisions affecting the scope of coverage. Since 2015, there have been significant decreases in the number of covered SNF days, with the exception of 2022, when the effects of the waiver of the 3-day inpatient stay requirement are reflected. The intermediate projections assume that changes in covered SNF days will continue to reflect the aging of the population, but the underlying trend will be 0 percent in 2025 and beyond.

The methodology used to develop the market basket increases for SNFs is consistent with the methodology used to develop the hospital market basket increases. These market basket increases are reduced by the increase in economy-wide productivity beginning in 2012. Cost per day also increases by a case mix increase.

Case mix increases dropped from 0.8 percent in 2015 to 0.1 percent in 2019. In 2020, a new payment system was implemented, leading to an increase in case mix of 4.9 percent. This increase dropped afterward, and, for the projection, the case mix increases are assumed to remain at a level of 1.5 percent annually beginning in 2025. The required reduction in costs attributable to sequestration is also reflected in the projected expenditures. These assumed trends result in projected rates of increase in cost per day that are assumed to decline to a level slightly higher than increases in general earnings throughout the projection period.

Table IV.A2 shows the resulting increases in fee-for-service expenditures for SNF and other types of services. The sequestration impact is reflected in the table.

Table IV.A2.—Relationship between Increases in HI Expenditures and Increases in Taxable Payroll[1]

Calendar year	Inpatient hospital	Skilled nursing facility	Home health agency[2]	Hospice	Private plans	Weighted average	HI admin-istrative costs[3]	HI expendi-tures[3]	HI taxable payroll	Growth rate differential[4]
Historical data:										
2015	−0.2%	1.9%	4.3%	5.2%	8.0%	2.7%	20.8%	3.1%	4.9%	−1.8%
2016	4.3	−2.2	−1.0	6.0	7.2	4.3	−9.1	4.1	2.7	1.3
2017	0.8	−1.2	−0.6	6.4	10.7	3.9	4.2	3.9	4.6	−0.7
2018	1.1	−1.6	−0.5	7.3	9.2	3.8	4.4	3.8	5.0	−1.1
2019	1.8	−1.8	−2.1	8.4	15.4	6.4	3.0	6.3	4.5	1.7
2020	−4.1	5.3	−7.7	6.5	14.7	4.2	−18.2	3.8	1.8	1.9
2021	1.1	−4.7	−0.7	3.7	9.0	3.9	15.9	4.1	10.3	−5.6
2022	−1.3	6.6	−3.0	3.3	14.8	6.4	2.8	6.3	7.3	−0.9
2023	1.2	−5.3	−0.4	8.0	13.3	6.6	5.2	6.6	5.6	1.0
2024	4.0	0.0	2.9	10.4	4.8	4.5	11.1	4.6	4.8	−0.2
Intermediate estimates:										
2025	6.4	8.5	6.5	10.1	6.1	6.7	5.7	6.7	4.8	1.8
2026	5.1	6.9	6.2	9.0	10.0	7.9	3.9	7.9	4.7	3.0
2027	4.5	6.2	7.6	8.8	10.1	7.7	3.9	7.6	4.5	3.0
2028	4.6	6.2	7.4	9.1	9.6	7.6	4.2	7.5	4.5	2.9
2029	4.9	6.3	7.0	8.9	9.3	7.5	4.0	7.5	4.4	3.0
2030	3.9	5.4	6.2	8.7	7.8	6.4	3.9	6.3	4.2	2.0
2031	3.8	5.6	6.4	8.8	7.5	6.3	3.7	6.2	4.2	1.9
2032	3.8	5.7	6.5	9.5	7.1	6.2	3.7	6.1	4.2	1.8
2033	5.7	7.7	8.5	10.2	8.4	7.7	9.6	7.7	4.2	3.4
2034	4.1	5.9	6.7	9.2	6.3	5.8	4.6	5.8	4.1	1.7

[1]Percent increase in year indicated over previous year.
[2]Includes the declining share of costs drawn from HI for coverage of certain home health services transferred from HI to SMI Part B.
[3]Includes costs of Quality Improvement Organizations.
[4]The ratio of the increase in HI costs to the increase in taxable payroll. This ratio is equivalent to the percent increase in the ratio of HI expenditures to taxable payroll (the cost rate).

A methodology similar to the one for inpatient hospitals and SNFs is used to project home health agency (HHA) payments. For most historical years, HI experience with HHA payments had shown an upward trend, frequently with sharp increases in the number of visits from year to year. After decreases in utilization in previous years, there was a rebound in 2014 and 2015, followed by decreases again for 2016 through 2019. Then utilization dropped significantly in 2020 because of the pandemic before rebounding beginning in 2021. Beginning in 2025 and throughout the rest of the short-range projection period, utilization increases are assumed to be equal to the growth and aging of the population plus 1 percent annually.

Reimbursement per episode of care[69] is assumed to increase at a slightly higher rate than increases in general earnings, but adjustments to reflect statutory limits on HHA reimbursement per episode are included where appropriate. As with other services, a least-squares regression model was used to develop market basket increases, which are reduced by the increase in economy-wide productivity beginning in 2015.

Costs also increase by a case mix increase factor. Case mix increases were modest from 2014 through 2019. There were decreases in 2020 and 2021, followed by slight rebounds in 2022 and 2023. Beginning in 2025, case mix increases are projected to grow at a rate of 1.5 percent annually.

HHA payment rates were rebased in 2014, and an estimated 14-percent reduction in payments was phased in over a 4-year period. Additionally, projected HHA costs reflect regulatory reductions that were made to the base payment rate from 2023 through 2026 in order to maintain budget neutrality for the switch to 30-day periods. Table IV.A2 shows the resulting increases in fee-for-service expenditures for HHA services.

HI covers certain hospice care for terminally ill beneficiaries. Hospice payments were originally very small relative to total HI benefit payments, but they have grown rapidly in most years and now substantially exceed the level of HI home health expenditures. This growth rate is composed of two factors. One is the price update, which is a function of the hospital market basket with an adjustment for economy-wide productivity, and the other is a residual, which reflects other factors excluding the impact of changes in enrollment. This residual was negative in 2014 and rebounded in 2016 through 2020. There was lower growth in the residual for 2021 and 2022, another rebound in 2023, and then strong growth in 2024, which is assumed to phase down to an increase of 3 percent per year for the remainder of the short-range projection period. Estimates for hospice benefit payment increases are based on mandated daily payment rates and

[69]Under the HHA prospective payment system, Medicare payments are made for each episode of care rather than for each individual home health visit.

annual payment caps, and these estimates assume a deceleration in the growth in the number of covered days.

d. Private Health Plan Costs

HI payments to private health plans have generally increased significantly from the time that such plans began to participate in the Medicare program in the 1970s. Most of the growth in expenditures has been attributable to the increasing numbers of beneficiaries who have enrolled in these plans. Section IV.C of this report contains a description of the private health plan assumptions and methodology.

e. Administrative Expenses

Historically, the cost of administering the HI trust fund has remained relatively small in comparison with benefit amounts. The ratio of administrative expenses to benefit payments has generally fallen within the range of 1 to 3 percent. The short-range projection of administrative cost is based on estimates of workloads and approved budgets for Medicare Administrative Contractors and CMS. In addition, because of sequestration, the administrative costs reflect an estimated 5- to 7-percent reduction for the period April 1, 2013, through January 31, 2033, with the exception of May 1, 2020, through March 31, 2022, when it was suspended. In the long range, administrative cost increases are based on assumed increases in workloads, primarily as a result of growth and aging of the population, and on assumed unit cost increases equal to the increases in average annual covered wages.

2. Summary of Aggregate Reimbursement Amounts on an Incurred Basis under the Intermediate Assumptions

Table IV.A3 shows aggregate historical and projected reimbursement amounts by type of service on an incurred basis under the intermediate assumptions. The sequestration impact is reflected in the table.

Table IV.A3.—Aggregate Part A Reimbursement Amounts on an Incurred Basis
[In millions]

Calendar year	Inpatient hospital	Skilled nursing facility	Home health agency	Hospice	Total FFS	Private health plans	Total Part A
Historical data:							
2015	$139,424	$29,556	$7,027	$15,918	$191,926	$79,557	$271,483
2016	145,244	28,894	6,956	16,873	197,967	85,270	283,237
2017	146,357	28,517	6,912	17,947	199,734	94,392	294,126
2018	147,912	28,082	6,881	19,254	202,128	103,077	305,206
2019	150,231	27,573	6,737	20,874	205,415	118,921	324,336
2020	143,607	29,042	6,219	22,239	201,107	136,380	337,486
2021	145,524	27,657	6,177	23,060	202,418	148,607	351,025
2022	143,348	29,456	5,993	23,820	202,618	170,579	373,197
2023	144,755	27,689	5,970	25,734	204,148	193,340	397,488
2024	150,381	28,511	6,144	28,403	213,438	202,541	415,979
Intermediate estimates:							
2025	159,918	30,947	6,541	31,270	228,676	214,942	443,618
2026	168,182	33,084	6,948	34,083	242,297	236,504	478,801
2027	175,648	35,143	7,476	37,098	255,365	260,332	515,697
2028	183,728	37,308	8,028	40,464	269,528	285,211	554,739
2029	192,477	39,648	8,587	44,070	284,783	311,789	596,572
2030	199,997	41,780	9,116	47,882	298,776	336,103	634,879
2031	207,698	44,113	9,703	52,078	313,592	361,201	674,793
2032	215,687	46,630	10,333	57,003	329,653	386,820	716,473
2033	227,977	50,207	11,211	62,837	352,231	419,474	771,705
2034	237,312	53,153	11,962	68,640	371,067	445,759	816,826

3. Financing Analysis Methodology

Because payroll taxes are the primary basis for financing the HI trust fund, HI costs can be compared on a year-by-year basis with the taxable payroll in order to analyze costs and evaluate the financing.

a. Taxable Payroll

Taxable payroll increases occur as a result of increases in both average covered earnings and the number of covered workers. The taxable payroll projection used in this report is based on the same economic assumptions used in the 2025 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds (OASDI). Table IV.A2 shows the projected increases in taxable payroll for this report, under the intermediate assumptions.

b. Relationship between HI Costs and Taxable Payroll

The most meaningful measure of HI cost increases, with regard to the financing of the system, is the relationship between cost increases and taxable payroll increases. If costs increase more rapidly than taxable payroll, either income rates must be increased or costs reduced (or some combination thereof) to finance the system in the future. Table IV.A4 shows the projected increases in HI costs relative to taxable payroll over the 10-year projection period. For the intermediate assumption, these relative increases start at 1.8 percent per year in 2025, remain steady at around 3.0 percent in 2026 through 2029, decrease to 1.8 percent in 2032, increase to 3.4 percent in 2033 because of sequestration, and decrease again to 1.7 percent in 2034.

Table IV.A4.—Summary of HI Alternative Projections

	Changes in the relationship between expenditures and payroll[1]				
Calendar year	HI expenditures[2,3]	Taxable payroll	Ratio of expenditures to payroll	HI effective interest rate[4]	Nominal interest rate[4]
Intermediate estimates:					
2025	6.7%	4.8%	1.8%	3.577%	4.177%
2026	7.9	4.7	3.0	3.634	4.125
2027	7.6	4.5	3.0	3.755	4.125
2028	7.5	4.5	2.9	3.930	4.125
2029	7.5	4.4	3.0	4.096	4.125
2030	6.3	4.2	2.0	4.265	4.125
2031	6.2	4.2	1.9	4.321	4.125
2032	6.1	4.2	1.8	4.235	4.125
2033	7.7	4.2	3.4	6.148	4.125
2034	5.8	4.1	1.7	1.434	4.135
Low-cost:					
2025	5.3	6.7	−1.3	3.680	4.802
2026	6.3	6.8	−0.5	3.920	5.063
2027	7.2	6.1	1.0	4.245	5.250
2028	6.8	5.9	0.9	4.551	5.250
2029	6.8	5.8	1.0	4.782	5.250
2030	5.7	5.7	0.0	4.952	5.250
2031	5.5	5.7	−0.1	5.075	5.250
2032	5.4	5.6	−0.2	5.156	5.250
2033	7.1	5.6	1.4	5.200	5.302
2034	5.1	5.4	−0.3	5.241	5.438
High-cost:					
2025	7.7	0.8	6.9	3.558	3.938
2026	8.4	1.7	6.6	3.619	3.438
2027	9.0	4.4	4.4	3.870	3.031
2028	9.3	4.2	4.9	4.313	3.000
2029	8.8	3.7	5.0	11.773	3.000
2030	7.3	3.1	4.0	1.227	3.000
2031	7.0	2.9	3.9	2.072	3.000
2032	6.8	2.9	3.8	2.348	3.000
2033	8.4	2.9	5.4	2.466	3.000
2034	6.5	2.7	3.7	2.558	3.063

[1]Percent increase for the year indicated over the previous year.
[2]On an incurred basis.
[3]Includes hospital, SNF, HHA, private health plan, and hospice expenditures; administrative costs; and costs of Quality Improvement Organizations.
[4]The Trustees calculate present values by discounting the future annual amounts of income and expenditures using the projected effective rates of interest credited to the HI trust fund for the first 10 years and grade to the ultimate nominal interest rate assumption by year 15. The ultimate nominal interest rates for the intermediate, low-cost, and high-cost projections are 4.7, 5.8, and 3.6 percent, respectively.

4. Projections under Alternative Assumptions

Projected HI expenditures under current law are subject to considerable uncertainty. To illustrate this uncertainty, HI costs have been projected under three alternative sets of assumptions.

Under the low-cost and high-cost alternatives over the 10-year projection period, increases in HI expenditures relative to increases in taxable payroll vary for the first few years of the projection and, by 2049, reach 2.0 percentage points less than the intermediate scenario for the low-cost estimates and 2.0 percentage points more for the high-cost estimates.

Beyond the first 25-year projection period, HI costs under the intermediate assumptions are based on the assumption that average per beneficiary expenditures (excluding demographic impacts) will increase at the baseline rates determined by the economic model described in sections II.C and IV.D less the economy-wide productivity adjustments. This rate is assumed to be roughly the same as the increase in the Gross Domestic Product (GDP) per capita in 2049 but would decelerate to 0.3 percentage point slower than GDP per capita by 2099. HI expenditures, which were 3.3 percent of taxable payroll in 2024, increase to 4.6 percent by 2049 and remain at roughly 4.6 percent until 2099 under the intermediate assumptions. Accordingly, if all the projection assumptions were realized over time, the HI income rates (4.10 percent of taxable payroll summarized over 75 years) would be inadequate to support the HI cost.

For the HI low-cost and high-cost projections, Medicare expenditures are determined by changing the assumption for the ratio of aggregate costs to taxable payroll (the cost rate). These changes are intended to provide an indication of how Medicare expenditures could vary in the future as a result of different economic, demographic, and health care trends.

During the first 25-year projection period, the low-cost and high-cost alternatives contain assumptions that result in HI costs increasing, relative to taxable payroll increases, approximately 2 percentage points less rapidly and 2 percentage points more rapidly, respectively, than the results under the intermediate assumptions. Costs beyond the first 25-year projection period assume that the 2-percentage-point differential gradually decreases until 2073, when HI cost increases relative to taxable payroll are approximately the same as under the intermediate assumptions.

Assumptions regarding income to the HI trust fund—including payroll taxes, income from the taxation of benefits, interest, and other income items—and assumptions regarding administrative costs are consistent with those underlying the 2025 OASDI report.

B. SUPPLEMENTARY MEDICAL INSURANCE

SMI consists of Part B and, since 2004, Part D. The benefits provided by each part are quite different. The actuarial methodologies used to produce the estimates for each part reflect these differences and thus appear in separate sections (IV.B1 and IV.B2).

1. Part B

a. Cost Projection Methodology

Estimates under the intermediate assumptions are calculated separately for each category of enrollee and for each type of service. The estimates are prepared by establishing the allowed charges or costs incurred per enrollee for a recent year (to serve as a projection base) and then projecting these charges through the estimation period. The per enrollee charges are then converted to reimbursement amounts by subtracting the per enrollee values of the deductible and coinsurance. Aggregate reimbursement amounts are calculated by multiplying the per enrollee reimbursement amounts by the projected enrollment. In order to estimate cash expenditures, an allowance is made for the delay between receipt of, and payment for, the service.

(1) Projection Base

To establish a suitable base from which to project the future Part B costs, the incurred payments for services provided must be constructed for the most recent period for which a reliable determination can be made. Accordingly, payments to providers must be attributed to dates of service, rather than to payment dates; in addition, the nonrecurring effects of any changes in regulations, legislation, or administration, and of any items affecting only the timing and flow of payments to providers, must be eliminated. As a result, the rates of increase in the Part B incurred cost differ from the increases in cash expenditures. As a check on the validity of the projection base, incurred reimbursement amounts are compared with cash expenditures.

(a) Practitioner Services

Private contractors acting for the Centers for Medicare & Medicaid Services (CMS) pay reimbursement amounts for services billed by practitioners, including physician services, durable medical equipment (DME), laboratory tests performed in physician offices and independent laboratories, and other services (such as physician-administered drugs, free-standing ambulatory surgical center facility services, ambulance services, and supplies). These Medicare

Administrative Contractors (MACs) use CMS guidelines to determine whether Part B covers billed services, establish the allowed charges for covered services, and transmit to CMS a record of the allowed charges, the applicable deductible and coinsurance, and the amount reimbursed after reduction for coinsurance and the deductible.

(b) Institutional Services

The same MACs also pay reimbursement amounts for institutional services covered under Part B. These include outpatient hospital services, home health agency services, laboratory services performed in hospital outpatient departments, and such services as renal dialysis performed in free-standing dialysis facilities, services in outpatient rehabilitation facilities, and services in rural health clinics.

Separate payment systems exist for almost all the Part B institutional services. For these systems, the MACs determine whether Part B covers billed services, establish the allowed payment for covered services, and send to CMS a record of the allowed payment, the applicable deductible and coinsurance, and the amount reimbursed after reduction for coinsurance and the deductible.

For those services still reimbursed on a reasonable-cost basis, the costs for covered services are determined on the basis of provider cost reports. Reimbursement for these services occurs in two stages. First, bills are submitted by providers to the MACs, and interim payments are made on the basis of these bills. The second stage takes place at the close of a provider's accounting period, when a cost report is submitted and lump-sum payments or recoveries are made to correct for the difference between interim payments and final settlement amounts for providing covered services (net of coinsurance and deductible amounts). Tabulations of the bills are prepared by date of service, and the lump-sum settlements, which are reported only on a cash basis, are adjusted (using approximations) to allocate them to the time of service.

(c) Private Health Plan Services

Private health plans with contracts to provide Part B services to Medicare beneficiaries are reimbursed directly by CMS on either a reasonable-cost or capitation basis. Section IV.C of this report contains a description of the assumptions and methodology used to estimate payments to private plans.

(2) Projected Fee-for-Service Payments for Aged Enrollees and Disabled Enrollees without End-Stage Renal Disease (ESRD)

Part B enrollees with ESRD have per enrollee costs that are substantially higher and quite different in nature from those of most other beneficiaries. Accordingly, the analysis in this section excludes their Part B costs. Those costs, as well as costs associated with beneficiaries enrolled in private health plans, are discussed later in this section.

(a) Practitioner Services

i. Physician Services

Medicare payments for physician services are based on a fee schedule, which reflects the relative level of resources required for each service. The fee schedule amount is equal to the product of the procedure's relative value, a conversion factor, and a geographic adjustment factor. Payments are based on the lower of the actual charge and the fee schedule amount.

The physician fee schedule updates are specified by law for every future year. Prior to enactment of the Consolidated Appropriations Act, 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act, the Consolidated Appropriations Act, 2023, and the Consolidated Appropriations Act, 2024, the update for 2021 through 2025 was statutorily set at 0 percent. Together these laws put in place the following updates: 3.75 percent for 2021, −0.7 percent for 2022, −0.5 percent for 2023, 0.1 percent for 2024, and −2.5 percent for 2025. Starting in 2026, the annual update for qualified physicians in advanced alternative payment models (advanced APMs) will be 0.75 percent, and, for all other physicians, the update each year will be 0.25 percent.

Per capita physician charges have also changed each year as a result of a number of other factors besides fee increases, including more physician visits and related services per enrollee, the demographic changes of the Medicare population, greater use of specialists and more expensive techniques, and certain administrative actions.

Table IV.B1 shows increases in total allowed charges per fee-for-service enrollee for the physician fee schedule and practitioner services. The sequestration of Medicare benefits during April 1, 2013, through January 31, 2033, with the exception of May 1, 2020, through March 31, 2022, when it was suspended, does not affect allowed charges and therefore is not reflected in table IV.B1; rather, that impact is included in table IV.B2.

Table IV.B1.—Increases in Total Allowed Charges per Fee-for-Service Enrollee for Practitioner Services
[In percent]

Calendar year	Physician fee schedule	DME	Lab	Physician-administered drugs	Other
Aged:					
2015	−0.7%	5.7%	−2.7%	14.2%	0.9%
2016	−0.7	−7.5	−5.7	9.1	−0.4
2017	1.2	−5.6	3.9	6.7	4.3
2018	1.6	17.7[1]	11.3[2,3]	12.1	2.2
2019	4.0[4]	7.0	4.6	12.2	2.3
2020	−11.4	2.0	8.8	3.2	−0.8
2021	18.5	5.4	20.4	10.7	5.4
2022	1.8	12.8	−5.9	10.8	17.8
2023	4.0	10.0	4.6	24.5	20.6
2024	3.0	17.3	8.3	29.6	−4.7
2025	−0.2	10.0	4.7	7.3	9.8
2026	3.2	6.3	5.1	4.3	7.2
2027	3.0	5.7	11.0	7.8	6.8
2028	3.3	5.0	5.1	2.6	5.6
2029	3.4	5.1	5.2	7.9	4.8
2030	3.1	4.8	41.6	5.1	4.4
2031	3.2	4.8	5.3	7.0	4.2
2032	3.0	4.6	5.2	7.2	4.1
2033	3.1	4.7	13.1	7.2	4.2
2034	3.0	4.6	5.2	7.6	4.1
Disabled (excluding ESRD):					
2015	−0.5	6.0	5.6	8.4	4.8
2016	−0.7	−6.3	−23.0	10.4	0.0
2017	−0.8	0.5	−2.1	4.0	8.6
2018	1.8	15.8[1]	6.3[2,3]	10.4	4.2
2019	3.0[4]	2.3	8.1	9.6	2.5
2020	−8.9	−0.9	−7.8	8.8	7.5
2021	15.5	3.5	18.1	14.1	3.7
2022	−1.3	7.6	−6.9	15.1	10.9
2023	2.9	9.4	−1.2	28.5	15.6
2024	3.4	13.1	8.9	42.5	−2.0
2025	1.0	7.5	5.9	8.5	10.7
2026	3.6	7.0	5.5	4.9	7.7
2027	1.2	4.2	9.1	6.0	5.0
2028	2.7	4.8	4.6	2.1	5.1
2029	3.1	5.0	4.8	7.6	4.5
2030	2.9	4.8	41.3	4.9	4.2
2031	3.2	5.0	5.3	7.0	4.2
2032	3.0	5.0	5.1	7.2	4.1
2033	2.8	4.7	12.7	6.9	3.8
2034	2.6	4.5	4.7	7.1	3.6

[1]Reflects a significant increase in the utilization of certain orthotic braces beginning in 2018. This allegedly fraudulent utilization was stopped early in 2019.
[2]Beginning in 2018, payments under the laboratory fee schedule no longer include an adjustment for economy-wide productivity. Instead, payments reflect a survey of private sector lab payments and are updated every 3 years.
[3]Reflects a significant increase in the utilization of genetic cancer testing services in 2018 and 2019. This allegedly fraudulent utilization was stopped late in 2019.
[4]For 2019–2025, qualified physicians in an advanced APM will receive an incentive payment amounting to 5 percent of their Medicare payments for 2019–2024 and 3.5 percent for 2025. For those same years, a total of $500 million is available for additional payment adjustment under the merit-based incentive payment system (MIPS) for certain high-performing physicians.

Based on the increases in table IV.B1, and incorporating the sequestration of Medicare expenditures, table IV.B2 shows the estimates of the average incurred reimbursement for practitioner services per fee-for-service enrollee.

Table IV.B2.—Incurred Reimbursement Amounts per Fee-for-Service Enrollee for Practitioner Services

Calendar year	Fee-for-service enrollment [millions]	Physician fee schedule	DME	Lab	Physician-administered drugs	Other
Aged:						
2015	27.441	$2,123.70	$178.52	$152.86	$389.75	$275.58
2016	27.987	2,090.95	164.46	144.10	423.18	274.27
2017	28.056	2,103.31	155.13	149.78	450.72	286.28
2018	28.102	2,137.43	183.25	166.81	505.24	292.30
2019	28.195	2,242.48	195.90	174.01	566.34	298.34
2020	27.841	2,007.88	202.19	192.11	591.50	300.48
2021	26.972	2,418.85	214.12	232.55	658.35	318.68
2022	26.271	2,387.54	238.66	215.69	720.21	377.90
2023	25.660	2,464.75	262.11	223.40	894.39	460.48
2024	25.259	2,540.96	308.55	241.89	1,159.77	426.81
2025	25.742	2,528.86	339.41	255.31	1,244.68	468.98
2026	25.923	2,595.87	360.63	268.33	1,296.75	502.68
2027	25.961	2,664.29	381.11	297.92	1,398.55	536.76
2028	26.023	2,747.17	400.29	313.22	1,434.43	566.89
2029	26.112	2,834.08	420.67	329.37	1,548.47	594.06
2030	26.204	2,914.59	440.56	466.28	1,626.64	620.09
2031	26.277	3,000.55	461.42	491.12	1,741.06	645.78
2032	26.350	3,083.81	482.65	516.75	1,867.27	672.17
2033	26.418	3,229.68	514.64	595.14	2,039.23	712.84
2034	26.540	3,324.08	539.13	627.10	2,196.99	742.71
Disabled (excluding ESRD):						
2015	5.609	1,804.74	306.93	256.93	320.54	274.63
2016	5.503	1,775.78	286.39	197.76	353.79	274.47
2017	5.361	1,748.25	287.84	193.59	367.34	302.71
2018	5.027	1,778.35	333.27	205.67	404.44	315.00
2019	4.665	1,844.03	340.65	221.15	442.50	321.91
2020	4.202	1,699.71	341.55	206.76	486.67	354.55
2021	3.713	1,993.34	354.82	245.66	560.27	372.81
2022	3.253	1,907.37	376.33	225.54	638.38	412.54
2023	2.860	1,946.23	409.47	220.67	819.90	477.84
2024	2.521	2,007.83	464.79	240.68	1,181.37	459.39
2025	2.134	2,018.45	489.51	257.10	1,280.71	508.85
2026	1.864	2,082.69	523.58	271.17	1,342.97	547.95
2027	1.825	2,102.08	545.81	295.85	1,423.81	575.25
2028	1.796	2,156.81	572.14	309.46	1,453.26	604.56
2029	1.756	2,217.66	600.65	324.42	1,563.27	631.56
2030	1.693	2,275.43	629.02	458.41	1,638.61	657.94
2031	1.615	2,341.73	660.28	482.79	1,753.79	685.20
2032	1.560	2,405.08	693.29	507.61	1,880.37	712.88
2033	1.540	2,510.34	739.43	582.61	2,047.66	753.63
2034	1.540	2,571.58	773.57	611.10	2,195.70	781.66

Starting in 2019, qualified physicians who are part of an advanced APM receive payments that are different from those received by other physicians. Qualified physicians in an advanced APM will receive an annual incentive payment, which will be equal to 5 percent of their Medicare payments for 2019 through 2024, 3.5 percent of their Medicare payments for 2025, and 1.88 percent of their Medicare payments for 2026. Most physicians who are not qualified physicians in an advanced APM will instead be under the merit-based incentive payment system (MIPS) and will receive a payment adjustment according to their performance. The payment adjustment ranges from −9 percent to 2.2 percent in 2025 and could range from −9 percent to 27 percent for 2026 and later. In total across all physicians to whom the payment adjustment applies, the impact is to be budget neutral.

For 2026 and later, qualified physicians in an advanced APM will receive an update of 0.75 percent while other physicians will receive a 0.25-percent update. Based on these payment mechanisms, the existing demonstration and payment models, and the requirements for becoming an advanced APM qualified physician, the Trustees assume that physician participation in advanced APMs will grow from 24.3 percent of spending in 2024 to 100 percent by 2065.

ii. Durable Medical Equipment (DME), Laboratory, Physician-Administered Drugs, and Other Practitioner Services

Unique fee schedules or reimbursement mechanisms have been established not only for physician services but also for virtually all other non-physician practitioner services. Table IV.B1 shows the increases in the allowed charges per fee-for-service enrollee for DME, laboratory services, and other services. As noted previously, allowed charges are not affected by the sequestration of Medicare expenditures. Based on the increases in table IV.B1, table IV.B2 shows the corresponding estimates of the average incurred reimbursement amounts for these services per fee-for-service enrollee; these amounts are affected by the sequestration.

Prior to 2011, DME items and laboratory services were updated by increases in the CPI, together with any applicable legislated limits on payment updates. Since 2011, these items and services have been updated by the increase in the CPI minus the increase in the 10-year moving average of economy-wide productivity.

A competitive-bidding program was implemented in 2011 to determine Medicare payment for a certain portion of DME items, and as a result this portion is no longer statutorily updated by the CPI or affected by the annual productivity adjustments. Round 1 of the competitive-bidding program was implemented on January 1, 2011, in nine metropolitan statistical areas (MSAs), and it lowered total DME spending by less than 2 percent. Round 2, which included both an expansion to 91 additional MSAs and the implementation of a national mail-order program for diabetic supplies, was effective on July 1, 2013, and lowered total DME spending by about 20 percent. The spending was lowered by an additional 4 percent by January 1, 2017, when national pricing for these services was fully implemented. CPI growth is used as a proxy for the updates for these items in the projections. The non-competitive-bidding portion of DME items continues to be updated by the increase in the CPI minus the increase in economy-wide productivity.

Beginning in 2018, Medicare payments for laboratory services are linked to private payment rates, and consequently these services are no longer updated by the CPI minus the productivity adjustments.[70] For laboratory services, as is the case with DME services, growth in the CPI is used as a proxy for updating the private payment rates, a process that is to occur every 3 years. The initial survey was from 2016 and was implemented in 2018. The next survey is from 2019 and is scheduled to be implemented in 2027 as a result of several legislated delays.

Medicare pays average sales price plus 6 percent for most physician-administered drugs. Beginning in 2028, certain Part B drugs will have their Medicare price determined through negotiation, as specified in the Inflation Reduction Act of 2022. Drug price negotiations are expected to lower estimated total 2028 Part B drug spending by about 5 percent.

Skin substitutes are included in physician-administered drugs and are paid based on average sales price plus 6 percent. Part B spending for skin substitutes increased from $0.8 billion in 2021 to $7.8 billion in 2024 because of higher average prices and increased utilization. The Trustees assume that spending for skin substitutes will grow at the same rate as other physician-administered drugs in the projection period.

Per capita charges for these expenditure categories have also grown as a result of other factors, including increased number of items and services provided, demographic change, more expensive items and services, and certain administrative actions. This expenditure growth is projected based on recent past trends in growth per enrollee.

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[70]Under the Protecting Access to Medicare Act of 2014, these changes were to be effective in 2017; however, CMS delayed implementation until 2018. These changes also apply to outpatient hospital laboratory services.

(b) Institutional Services

Over the years, legislation has established new payment systems for virtually all Part B institutional services, including a fee schedule for tests performed in laboratories in hospital outpatient departments. A prospective payment system (PPS) was implemented on August 1, 2000, for services performed in the outpatient department of a hospital. Similarly, a PPS for home health agency services was implemented on October 1, 2000. Table IV.B3 shows the historical and projected increases in charges and costs per fee-for-service enrollee for institutional services, excluding the impact of sequestration.

Certain outpatient prospective payment system (OPPS) drugs are purchased at a significant discount under the 340B program. For 2018 through September 27, 2022, Medicare payments changed from average sales price (ASP) plus 6 percent generally for these 340B drugs to ASP minus 22.5 percent. This change was made on a budget-neutral basis by increasing payments for other OPPS services over this same period.

Effective September 28, 2022, the courts ruled that the differential 340B drug payment rates were unlawful because, prior to implementation, the Department of Health and Human Services failed to conduct a survey of hospital acquisition costs under the relevant statute. In response to this ruling and beginning September 28, 2022, Medicare is again paying 340B drugs ASP plus 6 percent generally, and payments for other OPPS services have been reduced to make this change budget neutral.

The remedy for the lower payments for 340B drugs for 2018 through September 27, 2022, and for the offsetting higher payments for other OPPS services over that same period, is being implemented in several parts. To offset the lower 340B drug payments, the 2022 claims were reprocessed. In addition, to remedy the lower 2018 through 2021 340B drug payments, a one-time payment to affected OPPS facilities was made in 2024 totaling $9 billion. (This amount includes the cost sharing that would have otherwise been paid by Part B beneficiaries.) To offset the higher payments made for other OPPS services during 2018 through September 27, 2022, payments for these OPPS services to affected OPPS providers will be reduced by 0.5 percent starting in 2026 and continuing until a total of $7.8 billion is recovered. These lower payments are expected to continue for 16 years.

Table IV.B3.—Increases in Costs per Fee-for-Service Enrollee for Institutional Services

[In percent]

Calendar year	Outpatient hospital	Home health agency	Outpatient lab	Other
Aged:				
2015	7.4%	1.2%	2.3%	5.0%
2016	5.2	−0.9	3.0	2.4
2017	7.4	−1.9	1.1	4.7
2018	11.4	1.5	−1.0[1]	7.5
2019	5.2	0.6	−1.5	5.9
2020	−5.8	−2.3	7.4	−6.1
2021	19.7	4.0	16.2	6.1
2022	4.7	−1.3	−1.3	2.5
2023	8.4	0.6	−5.3	7.1
2024	9.4	2.4	3.4	6.6
2025	9.4	5.6	2.6	5.1
2026	9.2	6.2	2.8	5.2
2027	9.5	7.7	6.1	5.0
2028	7.6	7.2	2.6	5.0
2029	9.1	6.7	2.6	5.1
2030	7.8	6.0	22.9	5.2
2031	8.5	6.4	2.8	5.3
2032	8.3	6.4	2.6	5.1
2033	8.6	8.3	7.2	5.2
2034	8.6	6.3	2.6	5.2
Disabled (excluding ESRD):				
2015	6.9	−1.5	0.2	9.5
2016	4.6	−5.4	3.1	5.9
2017	4.6	−3.4	−1.7	5.7
2018	11.0	3.3	2.1[1]	6.6
2019	3.8	1.0	−1.8	9.9
2020	−8.1	10.1	6.4	−5.1
2021	12.7	4.7	19.5	12.8
2022	0.9	0.3	−1.7	4.6
2023	5.7	2.8	−9.5	9.7
2024	9.0	2.6	2.8	11.2
2025	11.1	7.1	3.8	6.3
2026	10.2	7.8	3.2	6.3
2027	8.2	5.0	4.5	4.1
2028	7.3	6.8	2.3	5.3
2029	9.3	6.6	2.5	5.5
2030	7.9	6.2	22.8	5.7
2031	8.9	6.8	2.9	6.0
2032	8.9	6.3	2.8	5.8
2033	8.8	7.6	7.1	5.6
2034	8.6	5.3	2.4	5.4

[1]See footnote 2 of table IV.B1.

Based on the increases in table IV.B3, table IV.B4 shows the estimates of the incurred reimbursement for the various institutional services per fee-for-service enrollee. Each of these expenditure categories is projected on the basis of recent trends in growth per enrollee, along with applicable legislated limits on payment updates. The sequestration impact is reflected in the table.

Table IV.B4.—Incurred Reimbursement Amounts per Fee-for-Service Enrollee for Institutional Services

Calendar year	Fee-for-service enrollment [millions]	Outpatient hospital	Home health agency	Outpatient lab	Other
Aged:					
2015	27.441	$1,283.38	$356.67	$82.05	$463.91
2016	27.987	1,350.89	353.53	84.55	471.42
2017	28.056	1,460.01	346.89	85.45	490.90
2018	28.102	1,639.91	352.13	84.57	527.34
2019	28.195	1,738.46	354.10	83.28	556.72
2020	27.841	1,663.57	345.94	90.74	529.44
2021	26.972	2,021.31	359.67	106.03	561.24
2022	26.271	2,072.33	354.90	103.36	559.50
2023	25.660	2,230.61	357.19	97.07	587.88
2024	25.259	2,450.22	365.81	100.34	622.57
2025	25.742	2,700.77	386.41	102.94	655.49
2026	25.923	2,952.52	410.49	105.79	688.64
2027	25.961	3,237.60	442.14	112.26	722.32
2028	26.023	3,487.60	474.14	115.15	757.67
2029	26.112	3,810.97	506.14	118.19	795.02
2030	26.204	4,113.87	536.42	145.22	835.03
2031	26.277	4,469.68	570.53	149.22	878.41
2032	26.350	4,850.05	606.96	153.08	921.79
2033	26.418	5,367.79	657.47	167.16	986.63
2034	26.540	5,845.07	698.69	171.83	1,037.94
Disabled (excluding ESRD):					
2015	5.609	1,515.37	260.64	87.47	333.69
2016	5.503	1,597.88	246.53	90.14	350.91
2017	5.361	1,683.79	238.18	88.64	370.38
2018	5.027	1,901.93	246.02	90.54	393.48
2019	4.665	1,981.16	248.55	88.89	432.50
2020	4.202	1,834.18	273.62	95.93	415.94
2021	3.713	2,097.72	286.57	115.34	475.95
2022	3.253	2,068.16	287.42	111.99	487.27
2023	2.860	2,165.27	295.34	100.56	526.25
2024	2.521	2,389.51	302.90	103.39	585.61
2025	2.134	2,677.42	324.38	107.36	621.06
2026	1.864	2,956.78	349.58	110.82	659.39
2027	1.825	3,207.28	366.93	115.79	685.98
2028	1.796	3,447.36	391.76	118.39	722.26
2029	1.756	3,775.11	417.64	121.34	761.31
2030	1.693	4,080.46	443.41	149.06	803.79
2031	1.615	4,453.27	473.46	153.43	851.39
2032	1.560	4,858.15	503.20	157.78	900.45
2033	1.540	5,387.52	541.57	172.10	968.18
2034	1.540	5,871.79	570.41	176.49	1,021.43

(3) Projected Fee-for-Service Payments for Persons with End-Stage Renal Disease (ESRD)

Most persons with ESRD are eligible to enroll for Part B coverage. For analytical purposes, this section includes two groups of enrollees. The first group comprises those who qualify for Medicare as a result of ESRD alone. The second group consists of those who qualify not only because they have ESRD but also because they are disabled.

Enrollees in this latter group, who are eligible as Disability Insurance beneficiaries, are included in this section because their per enrollee costs are both higher and different in nature from those of most other disabled persons. Specifically, most of the Part B reimbursements for both groups are related to kidney transplants and renal dialysis.

The estimates under the intermediate assumptions reflect the payment mechanism for reimbursing ESRD services. Payment for dialysis services occurs through a bundled payment system, which began in 2011. The bundled payment rate is updated annually by an annual ESRD market basket less the increase in economy-wide productivity. Starting in 2021, eligible individuals with ESRD may enroll in a Medicare private health plan to obtain their Part A and Part B coverage. Table IV.B5 shows the historical and projected enrollment and costs for Part B benefits. The sequestration impact is reflected in the table.

Table IV.B5.—Fee-for-Service Enrollment and Incurred Reimbursement for Beneficiaries under Age 65 with End-Stage Renal Disease

	Average enrollment [thousands]		Reimbursement [millions]	
Calendar year	Disabled	Non-disabled	Disabled	Non-disabled
2015	125	87	$5,605	$2,752
2016	130	82	5,869	2,615
2017	130	82	5,944	2,606
2018	129	82	6,451	2,804
2019	127	82	6,463	2,859
2020	121	82	6,171	2,796
2021	96	65	4,844	2,405
2022	80	57	3,973	2,109
2023	66	53	3,425	1,999
2024	57	53	3,102	2,000
2025	52	52	3,060	2,142
2026	49	51	2,998	2,177
2027	49	50	3,133	2,219
2028	50	48	3,315	2,252
2029	51	47	3,487	2,299
2030	50	46	3,623	2,367
2031	49	46	3,712	2,437
2032	49	45	3,825	2,517
2033	49	45	4,075	2,659
2034	49	45	4,292	2,760

(4) Projected Payments for Persons with Immunosuppressive Drug Coverage Only

The Consolidated Appropriations Act, 2021 specifies that, in 2023 and later, Part B will provide coverage of immunosuppressive drug costs for individuals who previously were covered by Medicare Part B because they have permanent kidney failure and who received a kidney transplant that functioned for 3 years, resulting in a loss of Part B coverage. These individuals will pay a premium that is 15 percent of twice the aged actuarial rate instead of the standard Part B premium (which is 25 percent of twice the aged actuarial rate plus a repayment amount, if applicable). Transfers from the general fund of the Treasury will be made to Part B to make up the difference between the immunosuppressive drug premium and the standard Part B premium. (These transfers will be treated as premium income for general fund matching purposes.) In 2023, approximately 155 immunosuppressive drug coverage enrollees had roughly $90,000 in Part B benefits.

(5) Private Health Plan Costs

Part B payments to private health plans have generally increased significantly from the time that such plans began to participate in the Medicare program in the 1970s. Most of the growth in expenditures has been due to the increasing numbers of beneficiaries who have enrolled in these plans. Section IV.C of this report contains a description of the assumptions and methodology for the private health plans that provide coverage of Part B services for certain enrollees.

(6) Administrative Expenses

The ratio of Part B administrative expenses to total expenditures was 1.0 percent in 2024. Projections of administrative costs are based on estimates of changes in average annual wages, fee-for-service enrollment, and an estimated 5- to 7-percent reduction in expenditures resulting from sequestration for the period April 1, 2013, through January 31, 2033, with the exception of May 1, 2020, through March 31, 2022, when it was suspended.

b. Summary of Aggregate Reimbursement Amounts on an Incurred Basis under the Intermediate Assumptions

Table IV.B6 shows aggregate historical and projected reimbursement amounts by type of service on an incurred basis under the intermediate assumptions.

Table IV.B6.—Aggregate Part B Reimbursement Amounts on an Incurred Basis
[In millions]

	Practitioner						Institutional							
Calendar year	Physician fee schedule	DME	Lab	Physician-administered drugs	Other	Total	Hospital	Lab	Home health agency	Other	Total	Total FFS	Private health plans	Total Part B
Historical data:														
2015	$70,150	$6,744	$5,686	$12,658	$9,412	$104,650	$44,712	$2,789	$11,375	$19,392	$78,267	$182,917	$94,998	$277,914
2016	70,032	6,298	5,167	13,951	9,483	104,931	47,644	2,911	11,369	20,031	81,955	186,886	103,541	290,427
2017	70,061	6,016	5,290	14,782	9,964	106,113	51,125	2,923	11,123	20,683	85,854	191,967	115,028	306,996
2018	70,679	6,961	5,791	16,423	10,122	109,976	56,833	2,886	11,247	22,305	93,270	203,246	132,925	336,171
2019	73,529	7,257	6,026	18,224	10,262	115,298	59,446	2,818	11,258	23,207	96,729	212,027	154,579	366,606
2020	64,676	7,207	6,338	18,712	10,218	107,151	55,140	2,990	10,911	21,685	90,726	197,877	180,747	378,624
2021	74,034	7,208	7,337	20,049	10,242	118,871	63,311	3,347	10,864	20,852	98,374	217,245	203,487	420,733
2022	70,067	7,600	6,536	21,197	11,475	116,874	61,993	3,132	10,339	19,628	95,092	211,965	235,783	447,748
2023	69,786	7,997	6,456	25,508	13,380	123,128	64,159	2,824	10,080	19,592	96,655	219,782	275,650	495,433
2024	70,090	9,063	6,797	32,566	12,125	130,641	68,607	2,835	10,067	20,003	101,513	232,154	302,650	534,804
Intermediate estimates:														
2025	70,205	9,877	7,202	35,072	13,355	135,710	75,963	2,919	10,702	21,104	110,687	246,398	330,422	576,820
2026	71,955	10,420	7,542	36,417	14,256	140,590	82,805	2,988	11,356	21,943	119,091	259,681	383,203	642,885
2027	73,794	10,990	8,363	39,224	15,200	147,570	90,720	3,167	12,215	22,923	129,025	276,595	429,253	705,848
2028	76,176	11,549	8,800	40,264	16,066	152,854	97,825	3,251	13,114	24,024	138,215	291,069	472,480	763,548
2029	78,732	12,149	9,268	43,529	16,860	160,539	107,093	3,342	14,027	25,184	149,645	310,184	524,562	834,746
2030	81,073	12,723	13,131	45,761	17,608	170,296	115,719	4,110	14,887	26,382	161,097	331,394	579,871	911,265
2031	83,485	13,309	13,826	48,964	18,327	177,910	125,721	4,221	15,840	27,645	173,427	351,336	633,442	984,778
2032	85,881	13,921	14,554	52,539	19,082	185,978	136,533	4,333	16,865	28,941	186,672	372,650	689,394	1,062,044
2033	90,096	14,864	16,787	57,463	20,264	199,474	151,372	4,739	18,296	30,952	205,359	404,832	764,505	1,169,337
2034	93,119	15,636	17,760	62,161	21,199	209,875	165,553	4,892	19,520	32,628	222,592	432,467	829,012	1,261,479

c. Projections under Alternative Assumptions

Projections of Part B cash expenditures under the low-cost and high-cost alternatives were developed by modifying the growth rates estimated under the intermediate assumptions. Beginning in calendar year 2025, the low-cost and high-cost alternatives contain assumptions that result in benefits increasing, relative to the Gross Domestic Product (GDP), 2 percent less rapidly and 2 percent more rapidly, respectively, than the results under the intermediate assumptions. Administrative expenses under the low-cost and high-cost alternatives are projected on the basis of their respective wage series growth.

2. Part D

Part D is a voluntary Medicare prescription drug benefit that offers beneficiaries a choice of private drug insurance plans. Low-income beneficiaries can receive additional assistance on the cost sharing and premiums. Each year drug plan sponsors submit bids that include estimated total plan costs, reinsurance payments, and low-income cost-sharing subsidies for the coming year. Upon approval of these bids, a national average monthly bid amount is calculated, and the result is used to determine the base beneficiary premium. The individual plan premium is calculated as the difference between the plan bid and the national average monthly bid amount, which is then applied to the base beneficiary premium.

Each drug plan receives monthly risk-adjusted direct subsidies, prospective reinsurance payments, and prospective low-income cost-sharing subsidies from Medicare, as well as premiums from the beneficiaries and premium subsidies from Medicare on behalf of low-income enrollees. At the end of the year, the prospective reinsurance and low-income cost-sharing subsidy payments are reconciled to match the plan's actual experience. During the annual reconciliation process, if actual experience differs from the plan's bid beyond specified risk corridors, Medicare shares in the plan's gain or loss.

Expenditures for this voluntary prescription drug benefit are determined by combining estimated Part D enrollment with projections of per capita spending. The base experience for the estimates consists of preliminary 2025 Part D enrollment data, nearly complete 2024 Part D spending by enrollment category, and 2025 Part D plan bid information.

In addition, Medicare pays special subsidies on behalf of beneficiaries retaining primary drug coverage through retiree drug subsidy (RDS) plans. Total expenditures for these plans are determined by tabulating actual enrollment and per capita spending data separately and then projecting forward using both the enrollment and Part D expenditure growth rates throughout the estimation period.

Government contributions primarily finance the various Medicare drug subsidies. Since Medicaid is no longer the primary payer of drug costs for full-benefit dually eligible beneficiaries, States are required to pay the Part D account in the SMI trust fund a portion of their estimated forgone drug costs for this population. From 2006 through 2015, the percentage of estimated costs paid by States was phased down from 90 percent to the current 75 percent.

Beneficiaries can choose to have their drug insurance premiums withheld from their Social Security benefits and then forwarded to the drug plans on their behalf.[71] In 2024, around 21 percent of the non-low-income premium dollars were withheld and forwarded to Part D drug plans.

a. Participation Rates

All individuals entitled to Medicare Part A or enrolled in Part B are eligible to enroll in the voluntary prescription drug benefit.

(1) Employer-Sponsored Plans

There are two ways that employer-sponsored plans can benefit from the Part D program. One way is the retiree drug subsidy (RDS), in which, for qualifying employer-sponsored plans, Medicare subsidizes a portion of their qualifying retiree drug expenses. As a result of tax deduction changes included in the Affordable Care Act, RDS program participation has declined significantly since 2012 and is assumed to decline further over the next several years. The Trustees expect that most of the retirees losing drug coverage through RDS plans will participate in other Part D plans.

The other way that an employer-sponsored plan can benefit from Part D is to enroll in an employer/union-only group waiver plan (EGWP) by either wrapping around an existing Part D plan or becoming a prescription drug plan itself. The subsidies for these types of arrangements are generally calculated in the same way as for other

[71] The Part D income-related premium adjustment amount for each beneficiary is deposited into the Part D account.

Part D plans. The Trustees expect that such plans will offer additional benefits beyond the standard Part D benefit package.

Participation in EGWPs steadily increased from 2014 to 2023, with the vast majority of the enrollment increases occurring in Medicare Advantage Prescription Drug Plans (MA-PDs). MA-PD EGWP enrollment grew from approximately 1.8 million in 2014 to 3.6 million in 2023; for Prescription Drug Plans (PDPs), on the other hand, the number of enrollees decreased from approximately 4.7 million to 4.0 million over the same time frame.

In 2024, driven by provisions in the Inflation Reduction Act of 2022, a change in Federal policy allowed Federal Employees Health Benefits (FEHB) plans to enroll beneficiaries in Part D PDP EGWPs. Additionally, the Postal Service Reform Act of 2022 legislated that all postal retiree benefits be transferred to a Part D PDP EGWP no later than 2025. As a result, approximately 1 million beneficiaries who were formerly considered to have creditable coverage have been enrolled in Part D EGWPs, leading to enrollment of 3.9 million and 4.9 million for MA-PD and PDP EGWPs, respectively, in 2024.

An elevated, residual increase has been observed in 2025 as additional FEHB beneficiaries have continued to join Part D EGWPs, resulting in EGWP participation that totals approximately 3.9 million MA-PD and 5.1 million PDP enrollees. Over the next several years, the Trustees assume that EGWP participation will increase at a slightly higher rate before converging to the rate of overall Part D enrollment in 2029 and beyond.

(2) Low-Income Subsidy

Qualifying low-income beneficiaries can receive various degrees of additional Part D subsidies based on their resource levels to help finance premium and cost-sharing payments. From 2016 to 2024, low-income subsidy enrollment in MA-PDs increased while enrollment in PDPs declined. This pattern is primarily due to continued and substantial growth in the number of enrollees in Medicare Advantage Special Needs Plans (SNPs). Because the Medicaid continuous enrollment condition that was effective during the COVID-19 public health emergency has ended, low-income enrollment has decreased in 2025 for both MA-PDs and PDPs. MA-PD enrollment has decreased from 9.6 million in 2024 to 9.5 million in 2025, while PDP enrollment has declined from 4.9 million to 4.4 million. Overall, the number of low-income enrollees constitutes a projected 25 percent of total Part D beneficiaries in 2025 and is assumed to grow at the same rate as that for Medicare beneficiaries who are enrolled in Part B.

(3) Other Part D Beneficiaries

Medicare beneficiaries not covered by employer-sponsored plans and not qualified for the low-income subsidy have the option to enroll in a Part D plan. Once enrolled, they pay for premiums and any applicable deductible, coinsurance, and/or copayment. Because of the influx of enrollment in Part D plans in 2024 from beneficiaries who were formerly receiving coverage in FEHB plans, the participation rate for non-employer and non-low-income Medicare beneficiaries[72] rose from 69 percent in 2023 to 72 percent in 2024. In 2025, the participation rate is expected to remain at 72 percent as the continued shift of FEHB beneficiaries is offset by the reduction in the number of low-income enrollees. After 2025, the participation rate for non-employer and non-low-income beneficiaries is projected to gradually grow to 76 percent throughout the short-range projection period.

(4) Medicare Advantage Prescription Drug Plan (MA-PD) versus Prescription Drug Plan (PDP) Beneficiaries

Enrollment in MA-PDs has been increasing more rapidly than in PDPs every year except 2013. In 2013, MA-PD beneficiaries accounted for 36.5 percent of the enrollment in Part D plans. This ratio grew to 57.6 percent in 2024 and is projected to increase to 58.2 percent in 2025 before reaching 65.3 percent by 2034.

Table IV.B7 provides a summary of the estimated average enrollment in Part D, by category.

[72]A significant portion of the remaining eligible beneficiaries who do not participate in Part D plans receive creditable coverage through another source (such as the Federal Employees Health Benefits Program, TRICARE for Life, the Department of Veterans Affairs, and the Indian Health Service).

Table IV.B7.—Part D Enrollment

[In millions]

			Low-income subsidy						
Calendar year	Retiree drug subsidy[1]	EGWP[2]	Medicaid full-benefit dual eligible	Other, with full subsidy	Other, with partial subsidy[3]	Total	All others	Total	MA-PD share of Part D[4]
Historical data:									
2015	2.3	6.5	7.6	4.2	0.3	12.1	20.9	41.8	39.1
2016	1.9	6.6	7.8	4.3	0.3	12.4	22.2	43.2	39.8
2017	1.7	6.7	8.0	4.4	0.3	12.7	23.4	44.5	41.0
2018	1.5	6.9	8.1	4.5	0.3	12.9	24.5	45.8	42.3
2019	1.4	7.0	8.2	4.5	0.3	13.1	25.7	47.2	44.3
2020	1.2	7.1	8.2	4.7	0.3	13.1	27.2	48.7	47.0
2021	1.1	7.3	8.3	4.7	0.3	13.2	28.4	50.0	50.6
2022	1.0	7.4	8.7	4.7	0.3	13.7	29.3	51.4	53.6
2023	0.9	7.6	9.3	4.8	0.3	14.3	30.1	52.9	56.7
2024	0.8	8.7	9.6	4.9	0.0	14.5	31.2	55.2	57.6
Intermediate estimates:									
2025	0.7	9.0	9.1	4.9	—	14.0	33.1	56.7	58.2
2026	0.6	9.4	9.3	5.0	—	14.3	34.3	58.6	59.4
2027	0.5	9.8	9.6	5.1	—	14.7	35.5	60.5	60.5
2028	0.5	10.1	9.8	5.2	—	15.0	36.6	62.1	61.5
2029	0.5	10.3	10.0	5.4	—	15.4	37.4	63.5	62.4
2030	0.5	10.5	10.2	5.5	—	15.6	38.0	64.6	63.2
2031	0.5	10.6	10.3	5.5	—	15.9	38.5	65.4	63.9
2032	0.5	10.7	10.5	5.6	—	16.1	38.9	66.2	64.5
2033	0.5	10.9	10.6	5.7	—	16.2	39.3	66.9	65.0
2034	0.5	11.0	10.7	5.7	—	16.4	39.7	67.6	65.3

[1]Excludes Federal Government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program. Such programs qualify for the retiree drug subsidy, but the subsidy will not be paid since it would amount to the Federal Government subsidizing itself.
[2]In 2024, several major insurers under the Federal Employees Health Benefits (FEHB) program converted most of their enrollees to new Part D EGWP options. Additionally, most Federal postal retirees converted into Part D EGWP in 2024, before the January 1, 2025, effective date under the Postal Service Reform Act of 2022.
[3]Low-income beneficiaries currently receiving partial subsidies started receiving full subsidies effective January 1, 2024, as required by the Inflation Reduction Act of 2022.
[4]This calculation does not include retiree drug subsidy beneficiaries but does include EGWP, low-income subsidy, and all other beneficiaries.

b. Cost Projection Methodology on an Incurred Basis

(1) Drug Benefit Categories

Projected drug expenses are allocated to the beneficiary premium, direct subsidy, and reinsurance subsidy by the Part D premium formula based on the benefit formula specifications. Meanwhile, the additional premium and cost-sharing subsidies are projected for low-income beneficiaries. In addition, under the Inflation Reduction Act of 2022, for drugs that are selected for price negotiation, there will be government subsidies for expenditures that are below the catastrophic threshold to compensate for the exemption from the manufacturer discount program for negotiated drugs.

The statute specifies that the base beneficiary premium is equal to 25.5 percent of the sum of the national average monthly bid amount and the estimated catastrophic reinsurance. The average premium amount per enrollee is estimated using the base beneficiary premium with an adjustment to reflect enrollees' tendency to select plans with below-average premium costs.

Moreover, Part D collects income-related premiums for individuals whose modified adjusted gross income exceeds a specified threshold. The amount of the income-related premium depends upon the individual's income level. Before 2019, the extra premium amount was the difference between 35, 50, 65, or 80 percent and 25.5 percent applied to the national average monthly bid amount adjusted for reinsurance. Starting in 2019, the Bipartisan Budget Act of 2018 requires a portion of the beneficiaries currently in the 80-percent group to pay the difference between 85 percent and 25.5 percent.

Under the Inflation Reduction Act of 2022, the increase in base beneficiary premiums is limited to 6 percent per year from 2024 through 2030. For 2030 and later, the base beneficiary premium percentage will be reset according to the specifications of the law.

Premiums for stand-alone prescription drug plans would have increased substantially in 2025 because of certain factors, including the new Part D benefit structure under the Inflation Reduction Act. However, to limit the increase in premiums and stabilize the year-by-year changes for these plans, a 3-year voluntary demonstration was implemented beginning with contract year 2025. These premium reductions result in a corresponding increase in the direct premium subsidies paid by Medicare.

(2) Projections

The projections are based in part on actual Part D spending data through 2024. These data include amounts for total prescription drug costs, costs above the catastrophic threshold, plan payments, and low-income cost-sharing payments.

The estimates under the intermediate assumptions are calculated by establishing the total prescription drug costs for 2024 and then projecting these costs with both Part D expenditure and enrollment growth rates through the estimation period. The growth rate assumptions for Part D costs are based on a Part D-specific, short-term model that provides the 2025 and 2026 drug-specific and therapeutic-class-specific growth rate projections. A transition factor is applied for 2027 and 2028 to converge to the long-term projection of Part D costs.

The growth in expensive specialty and antidiabetic drugs has been a major factor driving the increases in gross drug costs over time, which in turn have resulted in fast-growing reinsurance in recent years. Therefore, the trend rates for the catastrophic portion of the Part D benefits are also assumed to generally grow slightly more rapidly than the overall growth rates. Table IV.B8 shows the historical and projected Part D per capita growth rates.

In addition, the Trustees incorporate the estimated impact from recent new legislation and policy. Effective January 1, 2024, a pharmacy price concessions policy (published in a May 9, 2022, CMS final rule) shifts the pharmacy-specific direct and indirect remuneration (DIR) to the point of sale, thus reducing total DIR, lowering drug prices for beneficiaries at the point of sale, and increasing Federal Part D spending. In addition, while the drug trend will slow because of drug price negotiations and inflation rebate assessments that are required by the Inflation Reduction Act of 2022, Part D plan benefits will increase because of the redesigned benefit structure under the new legislation. Meanwhile, the Trustees project that DIR will be reduced in response to the lower negotiated drug prices.

To determine the estimated benefits for Part D, the total per capita drug benefits are adjusted for two key factors. One is the projected total amount of DIR, and the other is the administrative costs that plans are projected to incur related to plan operations and profits.

Table IV.B8 displays these key factors affecting Part D expenditure estimates.

Table IV.B8.—Key Factors for Part D Expenditure Estimates[1]

Calendar year	Part D per capita cost trend	Direct and indirect remuneration (DIR)[2]	Plan administrative expenses and profits[3]
Historical data:			
2015	8.3%	18.3%	11.7%
2016	1.9	19.9	11.4
2017	2.2	21.9	10.3
2018	4.9	25.0	10.7
2019	5.2	26.5	9.3
2020	4.7	27.0	9.2
2021	5.5	29.1	8.1
2022	8.2	31.3	7.3
2023	11.2	33.5	6.7
Intermediate estimates:			
2024	−1.2	29.9	7.7
2025	5.9	28.0	11.2
2026	−9.0	22.8	11.4
2027	−0.1	20.6	11.2
2028	1.1	19.4	11.1
2029	−0.2	18.7	11.2
2030	5.1	19.8	11.3
2031	1.3	19.9	11.6
2032	−1.4	19.5	12.0
2033	0.8	19.5	12.3
2034	3.3	20.2	12.5

[1]These factors do not reflect the impact of the sequestration for years 2015–2033.
[2]Expressed as a percentage of total drug costs.
[3]Expressed as a percentage of total net plan benefit payments, which include plan benefits and administrative expenses with profits and which are reduced by DIR.

(3) Direct and Indirect Remuneration

Until January 1, 2024, direct and indirect remuneration (DIR) primarily consisted of drug manufacturer rebates and pharmacy rebates that PDPs and MA-PDs negotiate.[73] The average projected DIR from plan bids increased substantially through 2023, but then, in 2024, pharmacy rebates were removed from DIR by the pharmacy price concessions policy, causing a DIR reduction. DIR is projected to decrease significantly in 2026 as a result of the following three factors:

- Implementation of the Inflation Reduction Act of 2022, which introduces changes to the Part D benefit structure;
- An inflation rebate from manufacturers to the government if drug prices increase above the CPI; and
- A gradual roll-out of government negotiated prices with manufacturers of high-impact drugs.

[73]The safe harbor protection for manufacturer rebates was eliminated in a final rule released in November 2020. This final rule imposed a January 1, 2022, effective date; however, the implementation date was initially delayed until January 1, 2023. In 2021, the Infrastructure Investment and Jobs Act imposed a moratorium on implementation of this rule until January 1, 2026; in 2022, the Bipartisan Safer Communities Act extended the moratorium from 2026 to 2027; and most recently the Inflation Reduction Act of 2022 extended it until 2032. Since the likelihood of this rule taking effect is highly uncertain, the impact is not reflected in the Part D projections.

The Trustees expect that these cost pressures on brand-name drugs will considerably reduce the amount of DIR over the projection period, as shown in table IV.B8.[74]

(4) Administrative Expenses

Administrative costs and profit margins are estimated from the 2025 plan bids. Administrative expenses are projected to grow at the same rate as wages, while profit margins are projected to grow at the same rate as per capita benefits. Beginning in 2014, the law assessed an annual insurer fee on health insurance plans, which was subsequently suspended in 2017 and 2019 before being terminated in 2021. The level of administrative expenses as a percentage of benefits has increased substantially in 2025, and it is expected to continue to do so, mainly because of the cost of the voluntary Medicare Prescription Payment Plan, which helps beneficiaries manage their out-of-pocket costs.

(5) Incurred Per Capita Reimbursements

Table IV.B9 shows estimated enrollments and average per capita reimbursements for beneficiaries in private plans, low-income beneficiaries, and beneficiaries in RDS plans. The direct subsidy and retiree drug subsidy are affected by the sequestration of Medicare benefit expenditures, which applies from April 1, 2013, through January 31, 2033, with the exception of May 1, 2020, through March 31, 2022, when it was suspended. Under the sequestration, Medicare administrative expenses are reduced by an estimated 5 to 7 percent for the period April 1, 2013, through January 31, 2033, with the exception of May 1, 2020, through March 31, 2022, when it was suspended.

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[74]These are average DIR percentages across all prescription drugs—including for EGWP plans, which do not submit bids. Generic drugs, which represent about 88 percent of all Part D drugs dispensed and 14 percent of drug spending in 2024, typically carry little to no rebates, while many brand-name prescription drugs carry substantial rebates.

Table IV.B9.—Incurred Reimbursement Amounts per Enrollee for Part D Expenditures

	Private plans (PDPs and MA-PDs)							
	All beneficiaries				Low-income subsidy		Retiree drug subsidy	
Calendar year	Enrollment (millions)	Direct subsidy	Reinsur-ance	Risk sharing and other[1]	Enrollment (millions)	Subsidy amount	Enrollment (millions)	Subsidy amount
Historical data:								
2015	39.5	$485	$841	−$28	12.1	$2,112	2.3	$502
2016	41.2	441	861	−27	12.4	2,126	1.9	505
2017	42.8	352	878	−11	12.7	2,156	1.7	493
2018	44.2	305	918	−1	12.9	2,204	1.5	482
2019	45.8	247	1,007	10	13.1	2,273	1.4	490
2020	47.5	199	1,021	31	13.1	2,507	1.2	513
2021	48.9	121	1,065	25	13.2	2,645	1.1	518
2022	50.4	79	1,128	18	13.7	2,872	1.0	537
2023	52.0	54	1,214	32	14.3	3,090	0.9	596
2024	54.4	372	1,255	33	14.5	2,848	0.8	583
Intermediate estimates:								
2025	56.1	1,855	517	−38	14.0	1,313	0.7	617
2026	58.0	1,710	522	37	14.3	1,337	0.6	561
2027	60.0	1,708	575	55	14.7	1,339	0.5	559
2028	61.7	1,741	625	61	15.0	1,353	0.5	564
2029	63.0	1,743	666	66	15.4	1,379	0.5	562
2030	64.1	1,764	693	52	15.6	1,422	0.5	590
2031	64.9	1,782	697	48	15.9	1,439	0.5	596
2032	65.7	1,780	691	51	16.1	1,455	0.5	586
2033	66.4	1,834	702	54	16.2	1,467	0.5	601
2034	67.1	1,875	718	55	16.4	1,511	0.5	621

[1]Included in this category are government subsidies specified under the Inflation Reduction Act of 2022, which limit the out-of-pocket costs for insulins in 2023 and, starting in 2026, replace the discounts on negotiated drugs in the initial coverage phase.

(6) Incurred Aggregate Reimbursements

Table IV.B10 shows the projected incurred aggregate reimbursements to plans and employers by type of payment.

Table IV.B10.—Aggregate Part D Reimbursement Amounts on an Incurred Basis
[In billions]

Calendar year	Premiums[1]	Direct subsidy	Reinsurance	Low-income subsidy	Retiree drug subsidy	Risk sharing and other[2]	Total
Historical data:							
2015	$11.5	$19.2	$33.2	$25.6	$1.1	−$1.1	$89.6
2016	12.7	18.2	35.5	26.4	1.0	−1.1	92.7
2017	14.0	15.1	37.6	27.3	0.8	−0.5	94.4
2018	14.2	13.5	40.6	28.5	0.7	−0.0	97.4
2019	13.8	11.3	46.1	29.7	0.7	0.5	102.1
2020	13.6	9.4	48.5	33.0	0.6	1.5	106.6
2021	15.0	5.9	52.1	35.0	0.6	1.2	109.7
2022	15.5	4.0	56.8	39.4	0.6	0.9	117.1
2023	15.7	2.8	63.1	44.2	0.5	1.7	128.0
2024	16.7	20.2	68.3	41.3	0.5	1.8	148.7
Intermediate estimates:							
2025	12.1	104.0	29.0	18.3	0.4	−2.1	161.8
2026	18.4	99.2	30.3	19.1	0.3	2.1	169.5
2027	23.4	102.4	34.5	19.6	0.3	3.3	183.5
2028	27.0	107.3	38.5	20.3	0.3	3.8	197.3
2029	29.4	109.8	42.0	21.2	0.3	4.2	206.8
2030	31.8	113.0	44.4	22.2	0.3	3.3	215.0
2031	32.6	115.7	45.3	22.8	0.3	3.1	219.8
2032	32.9	117.0	45.4	23.4	0.3	3.4	222.3
2033	33.7	121.8	46.6	23.8	0.3	3.6	229.8
2034	34.8	125.8	48.2	24.8	0.3	3.7	237.8

[1]Total premiums paid to Part D plans by enrollees (directly, or indirectly through premium withholding from Social Security benefits), excluding late-enrollment penalties.
[2]Negative amounts are net gain-sharing receipts from plans, while positive amounts are net loss-sharing payments to plans. The government subsidies specified under the Inflation Reduction Act of 2022 are included in this category.

c. Projections under Alternative Assumptions

Part D expenditures for the low-cost and high-cost alternatives were developed by modifying the estimates under the intermediate assumptions. Separate modifications were applied to the assumptions for the 2024 base projection and to the assumptions for projected years 2025–2034.

The 2024 base modifications include the following adjustments, since final data for 2024 will not be available until later in 2025:

- ±2 percent to account for the uncertainty of the completeness of the actual spending in 2024. The high-cost scenario increases the spending by 2 percent, and the low-cost scenario decreases the spending by 2 percent.

- ±2 percent for the average rebate that drug plans negotiate. The high-cost scenario decreases the average rebate by 2 percent, and the low-cost scenario increases the average rebate by 2 percent.

For the projections beyond 2024, the per capita drug costs for the high-cost and low-cost scenarios are increased, relative to GDP, 2 percent more rapidly and 2 percent less rapidly, respectively, than under the intermediate assumptions. The 2-percent base-year modification to rebate percentage is also maintained throughout the short-range projection period. In addition, for RDS participation, participation in the low-income subsidy, and the participation rate for Part D-eligible individuals who do not qualify for the low-income subsidy or receive coverage through employer-sponsored plans, assumptions vary in the alternative scenarios. Table IV.B11 compares these varying assumptions.

Table IV.B11.—Part D Assumptions under Alternative Scenarios for Calendar Years 2024–2034

		Alternatives	
Calendar year	Intermediate assumptions	Low-cost	High-cost
Participation of retiree drug subsidy beneficiaries as a percentage of Part D enrollees			
2024	1.4%	1.4%	1.4%
2025	1.2	1.2	1.2
2026	1.0	1.2	0.7
2027	0.8	1.2	0.4
2028	0.8	1.2	—
2029	0.8	1.2	—
2030	0.8	1.2	—
2031	0.8	1.2	—
2032	0.8	1.2	—
2033	0.8	1.2	—
2034	0.8	1.2	—
Participation of low-income beneficiaries as a percentage of Part D enrollees			
2024	26.2	26.2	26.2
2025	24.6	24.6	24.6
2026	24.4	24.3	24.5
2027	24.3	24.1	24.4
2028	24.2	23.6	24.8
2029	24.2	23.2	25.3
2030	24.2	22.8	25.8
2031	24.2	22.4	26.3
2032	24.3	22.0	26.8
2033	24.3	21.6	27.4
2034	24.3	21.2	27.9
Part D participation rate of the non-employer and non-low-income Part D-eligible individuals			
2024	71.6	71.6	71.6
2025	72.1	72.1	72.1
2026	73.3	71.3	75.3
2027	74.2	70.2	78.2
2028	74.9	70.9	78.9
2029	75.1	71.1	79.1
2030	75.2	71.2	79.2
2031	75.2	71.2	79.2
2032	75.3	71.3	79.3
2033	75.4	71.4	79.4
2034	75.5	71.5	79.5

C. PRIVATE HEALTH PLANS

Dating back to the 1970s, some Medicare beneficiaries have chosen to receive their coverage for Part A and Part B services through private health plans. Over time, numerous changes have been made to these plans that have increased or decreased the attractiveness of private plan coverage.

The foundation of the current program was established in 2003, when most of the private plans were renamed as Medicare Advantage (MA) plans and all private health insurance coverage options available through Medicare were formally designated as Part C.[75] Since then, there has been a continuous increase in MA enrollment.

Beginning in 2006, payments are based on competitive bids and their relationship to corresponding benchmarks, which are based on an annually developed ratebook. Also, rebates were introduced to provide additional benefits not covered under Medicare, reduce cost sharing, and/or reduce Part B or Part D premiums. From 2006 through 2011, rebates were calculated as 75 percent of the difference, if any, between the benchmark and the bid.

In addition to the plan types that already existed, regional preferred provider organizations (RPPOs) and special needs plans (SNPs) were established in 2006. Unlike other MA plans, which define their own service areas, RPPOs operate in pre-defined service areas referred to as regions and have special rules for capitation payment benchmarks, and they received special incentives.

SNPs are products designed for, and marketed to, these special population groups: Medicaid dual-eligible beneficiaries, individuals with specialized chronic conditions, and institutionalized beneficiaries. The statutory authority for SNPs, which had been extended several times previously, was permanently extended under the Bipartisan Budget Act of 2018.

Beginning in 2012, the MA county-level benchmarks are based on a multiple of estimated fee-for-service costs in the county. The factor applied for a given county is based on the ranking of its fee-for-service cost relative to that for other counties. The 25 percent, or quartile, of counties with the highest fee-for-service costs have a factor of

[75]Of Medicare beneficiaries enrolled in private plans, about 98 percent are in MA plans. The remainder are in certain holdover plans reimbursed on a cost basis rather than through capitation payments, in Program of All-Inclusive Care for the Elderly (PACE) plans, or in Medicare-Medicaid Plans (MMPs).

95 percent of county fee-for-service costs; the second quartile, 100 percent; the third quartile, 107.5 percent; and the lowest quartile, 115 percent. Prior to 2012, most county benchmarks were in the range of 100 to 140 percent of local fee-for-service costs.

Plans are eligible to receive specified increases to their benchmark based on their quality rating scores. The statutory provisions call for a bonus of 5 percent for plans with at least a 4-star rating. The bonuses are doubled for health plans in a qualifying county, defined as a county that meets the following three criteria: per capita spending in original Medicare is lower than average; 25 percent or more of eligible[76] beneficiaries were enrolled in the MA program as of December 2009; and the benchmark rate in 2004 was based on the minimum amount applicable to an urban area.

There are special bonus provisions for newly established and low-enrollment plans. Additionally, the phased-in benchmarks, including bonuses, are capped at the pre-2012 benchmark level.

The share of the excess of benchmarks over bids, which is paid to the plan sponsors as rebates, varies based on quality. The highest quality plans (4.5 stars or higher) receive a 70-percent rebate, plans with a quality rating of at least 3.5 stars and less than 4.5 stars receive a 65-percent rebate, and plans with a rating of less than 3.5 stars receive a 50-percent rebate.

Beginning in 2014, private insurers were required to pay an assessment, or fee, based on their revenues from the prior year. There was a 1-year moratorium on the annual fee in 2017 and again in 2019. The fee was in place for calendar year 2020, with the assessment on MA sponsors expected to represent approximately 1.4 percent of plan revenues. The Further Consolidated Appropriations Act, 2020 permanently repealed the annual fee for calendar year 2021 and future years.

It is important to note that Medicare coverage provided through private health plans does not have separate financing or an associated trust fund. Rather, the Part A and Part B trust funds are the source for payments to such private health plans.

[76]Beneficiaries are eligible for the MA program if they are entitled to coverage in Medicare Part A and enrolled in Medicare Part B.

1. Participation Rates

a. Background

To account for the distinct benefit, enrollment, and payment characteristics of private health plans, enrollment and spending trends for such plans are analyzed at the product level:

- Local coordinated care plans (LCCPs), which include health maintenance organizations (HMOs), HMOs with a point-of-service option, and local preferred provider organizations (PPOs).
- Private fee-for-service (PFFS) plans.
- Regional PPO (RPPO) plans.
- Special needs plans (SNPs).
- Other products, which include cost plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and Medicare-Medicaid plans (MMPs) under the capitated model.

In table IV.C1, all types of coverage except for those represented in the "Other" category are MA plans. Also, the values represented in each category include enrollment not only in plans available to all beneficiaries residing in the plan's service area, but also in plans available only to members of employer or union groups.

b. Historical

Table IV.C1 shows historical and projected private health plan enrollment by type of plan. From 2015 through 2024, private plan enrollment grew by 16.6 million or 95 percent, compared with growth in the overall Medicare population of 22 percent for the same period.

PFFS enrollment dropped 87 percent during these years primarily because of plan reaction to new statutory provider network requirements beginning in 2011. Most of the enrollees in terminating PFFS plans transferred to LCCP or RPPO plans.

The 2024 enrollment includes 5.8 million beneficiaries with coverage through employer/union-only group waiver plans (EGWPs), the majority of whom are in LCCPs. Beginning in 2017, the bidding requirements for these types of plans have been waived, and payments to these EGWPs, including RPPOs, are based on individual market bids.

Table IV.C1.—Private Health Plan Enrollment[1]
[In thousands]

	Local CCP								
Calendar year	HMO	PPO	Regional PPO	PFFS	SNP	Other	Total private health plan	Total Medicare	Ratio of private health plan to total Medicare
2015	9,122	4,034	1,019	256	2,086	978	17,495	55,589	31.5%
2016	9,630	4,158	1,086	231	2,231	1,058	18,393	57,073	32.2
2017	10,051	4,943	1,085	184	2,421	1,133	19,817	58,683	33.8
2018	10,646	5,696	1,003	148	2,729	1,115	21,338	60,020	35.6
2019	11,325	6,880	866	111	3,065	701	22,950	61,535	37.3
2020	12,159	7,893	747	81	3,497	697	25,075	62,887	39.9
2021	12,802	9,282	625	57	4,079	701	27,547	63,980	43.1
2022	13,137	10,533	501	44	4,899	726	29,840	65,165	45.8
2023	13,203	11,834	386	35	6,093	610	32,161	66,585	48.3
2024	13,233	13,138	294	32	6,864	553	34,114	67,601	50.5
2025	13,550	13,607	171	38	7,634	494	35,494	69,537	51.0[2]
2026	14,200	14,236	154	38	8,217	288	37,134	71,101	52.2
2027	14,892	14,908	146	38	8,553	293	38,831	72,778	53.4
2028	15,536	15,537	140	38	8,859	297	40,407	74,402	54.3
2029	16,119	16,109	133	38	9,139	301	41,838	75,888	55.1
2030	16,624	16,612	127	38	9,374	303	43,079	77,134	55.9
2031	17,049	17,042	121	38	9,564	306	44,120	78,105	56.5
2032	17,417	17,418	115	38	9,723	307	45,018	78,945	57.0
2033	17,744	17,750	109	38	9,862	309	45,813	79,711	57.5
2034	18,052	18,054	104	38	9,995	310	46,554	80,520	57.8

[1]Most private plan enrollees are eligible for Medicare Part A and enrolled in Medicare Part B. Some enrollees have coverage for only Medicare Part B. For example, in 2021 the Part B-only private plan enrollment consisted of 28,000 in local CCPs and 70,000 in the "Other" coverage category.
[2]This table presents the ratio of private health plan to total Medicare enrollment. The ratio of private health plan enrollees to Medicare beneficiaries with both Part A and Part B coverage in 2023 is 53.3 percent.

c. Projected

The MA enrollment projection model groups counties by common characteristics and models each of these groups using 2015 through 2024 base data. Ten equally distributed groups (based on 2021 enrollment) are created, as defined by the 2010 rural-urban commuting area (RUCA) codes designation. The ten groups are sorted on 2021 enrollment-weighted RUCA scores with an approximately equal number of MA-eligible beneficiaries in each group. A separate group consists of enrollees residing in Puerto Rico.

The private health plan enrollment projections are based on three cohorts of beneficiaries: dual-eligible beneficiaries; beneficiaries with employer-sponsored coverage; and all others, including individual-market enrollees.

Private plan enrollment for the individual market and for dual-eligible beneficiaries is projected by calculating the penetration growth rates in years 2015 through 2024 for each category described above and extrapolating those results through 2034. These growth rates are applied to the enrollment distribution for each county's specific 2024 plan type (for example, LCCP, PFFS, and RPPO) and are adjusted to reflect applicable legislative changes to the program, as described in more detail below. Enrollment for dual-eligible beneficiaries has increased more rapidly in recent years than has enrollment for both EGWPs and the individual market, and for this reason dual-eligible enrollment has been projected separately.

The category of MA enrollees with employer coverage is modeled at the national level. Historically, EGWP enrollment has had much larger enrollment variation from year to year while individual-market enrollment has trended at a more consistent level. Because of the fluctuations in enrollment, the cohort method does not work as well for beneficiaries with employer-sponsored coverage.

The private Medicare health plan enrollment projections for the 2025 Trustees Report are similar to those in the 2024 report. As shown in table IV.C1, the share of Medicare enrollees in private health plans is projected to increase from 50.5 percent in 2024 to 57.8 percent in 2034. The increases that are expected in private plan penetration rates for 2025 through 2034 are partly due to higher relative rebates, which are used to lower premiums and expand benefits.

SNP enrollment is expected to grow by 11 percent in 2025 after increasing by 13 percent in 2024. In 2026 and later years, the enrollment growth rate for these plans is expected to slow, ranging from 8 percent in 2026 to 1 percent in 2034.

Compared with enrollment for the average private Medicare health plan, enrollment for LCCP-HMOs is expected to grow at a slower rate, increasing by 2.4 percent in 2025 following growth of 0.2 percent in 2024. For LCCP-PPOs, enrollment is expected to increase by 4 percent in 2025 after growth of 11 percent in 2024.

The "Other" category is expected to fluctuate over the next several years because of enrollment in the MMP capitated model and enrollment in cost plans. The MMP capitated model represents health plans that are capitated by CMS and States to provide comprehensive and coordinated care for Medicare-Medicaid enrollees. After the introduction of MMPs in October 2013, enrollment grew nationally from approximately 3,400 enrollees in a single State to over 253,000 enrollees across eight States in September 2024. Most contracts were originally set to expire in 2023 but have been extended to 2025 as a way of transitioning from MMPs to SNPs, as described in a Medicare Advantage and Part D final rule that was published by

CMS on May 9, 2022.[77] It is assumed that once the contracts expire, the majority of MMP enrollees will remain in the MA program by switching to SNPs.

Additionally, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended the cost plan competition requirements specified in section 1876(h)(5)(C) of the Social Security Act. The amended competition requirements provide that CMS not renew cost plans in service areas where two or more competing local or regional MA coordinated care plans meet enrollment requirements over the course of the entire prior contract year. Under MACRA, cost plans were permitted to transition to the MA program until the beginning of calendar year 2019.

Enrollment in the "Other" category increased by 14 percent from 2015 through 2018 before decreasing by 37 percent in 2019 because of the reduction in the number of cost plans required by MACRA provisions. During the period 2020 through 2026, enrollment in the "Other" category is expected to decrease by 59 percent as a result of the expiration of the MMP contracts; for 2027 and later, it is expected to grow at a rate of less than 2 percent.

2. Cost Projection Methodology

a. Background

Benchmarks form the foundation for payments to MA plans. Along with geographic, demographic, and risk characteristics of plan enrollees, these values determine the monthly prospective payments made to private health plans. MA benchmarks vary substantially by county. Benchmarks range between 95 and 115 percent of county-level fee-for-service costs, plus applicable quality bonuses.

For individual non-RPPO plans, a plan's benchmark is an average of the statutory capitation ratebook values, weighted by projected plan enrollment in each county in the plan's service area. For RPPOs, the benchmark is a blend of the weighted ratebook values for all Medicare-eligible beneficiaries in the region and an enrollment-weighted average of RPPO bids for the region. The weight applied to the bid component to calculate the blended benchmark is the national MA participation rate.

Plans submit bids equal to their projected per enrollee cost of providing the standard Medicare Part A and Part B benefits. Plans with bids

[77]See https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf.

below the benchmark apply the rebate share of the *savings* to aid plan enrollees through coverage of Part A and Part B cost sharing, coverage of additional non-drug benefits, and/or reduction in the Part B or Part D premium. The rebate percentage is based on the quality rating of the health plan and ranges from 50 to 70 percent. Beneficiaries choosing plans with bids above the benchmark must pay for both the full amount of the difference between the bid and the benchmark and the projected cost of the plans' supplemental benefits.

Medicare capitation payments to an MA plan are a product of the standardized plan bid, which is equal to the bid divided by the plan's projected risk score, and the actual enrollee risk score, which is based on demographic characteristics and medical diagnosis data. The risk score for a given enrollee may be adjusted retrospectively since CMS receives diagnosis data after the payment date.

Rebate payments are based on the projected risk profile of the plan and are not adjusted based on subsequent actual risk scores.

b. Incurred Basis

Private health plan expenditures are forecast on an incurred basis by coverage type. The bid-based expenditures for each quarter are a product of the average enrollment and the projected average per capita bid. Similarly, the rebate expenditures are a product of enrollment and projected average rebates.

Annual per capita benchmarks, bids, and rebates were determined on an incurred basis for calendar years 2007–2024 for each coverage category. These amounts include adjustments processed after the payment due date for retroactive enrollment and risk score updates.

Since 2017, when the phase-in of the fee-for-service-based ratebook was completed, benchmark growth has been higher than bid growth (as shown in table IV.C4). For 2018 through 2024, average benchmark growth was 1.8 percent higher than average bid growth, resulting in per capita rebates that increased by 119 percent during those years. Overall benchmark growth averaged 5.2 percent, and bid growth averaged 3.4 percent. Benchmark growth was higher than expenditure growth for beneficiaries enrolled in Medicare fee-for-service during this period partly because of increases in quality rating bonuses, increases in rebate share, and increases in payment risk scores. The large increase in SNP enrollment from 2018 through 2024 (described in section IV.C1) is one factor that resulted in higher payment risk scores and increased benchmark growth. Another factor leading to faster payment risk score growth is coding behavior by MA plans.[78]

Private health plan expenditures are affected by the sequestration required by current law, which will reduce benefit payments by specified percentages through January 2033.

c. Cash Basis

Cash MA expenditures are largely identical to incurred amounts, since both arise primarily from the monthly capitation payments to plans. Small cash payment adjustments are developed from incurred spending by accounting for the payment lag that results from CMS' receipt of post-payment diagnosis data, retroactive enrollment notifications, and corrections in enrollees' demographic characteristics.

Table IV.C2 shows Medicare private plan expenditures on an incurred and cash basis. The incurred payments are reported separately for the bid-related and rebate expenditures. As noted, most payments to plans are made as they are incurred, and cash and incurred amounts are generally the same.

[78]See https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf.

Table IV.C2.—Medicare Payments to Private Health Plans, by Trust Fund
[Dollar amounts in billions]

Calendar year	Incurred basis[1] Bid	Rebate	Total	Part A as a percentage of total[2]	Cash basis
2015	$161.9	$12.7	$174.6	45.6%	$172.3
2016	174.4	14.4	188.8	45.2	188.6
2017	193.7	15.7	209.4	45.1	209.6
2018	217.9	18.1	236.0	43.7	232.7
2019	250.6	23.0	273.5	43.5	273.8
2020	288.4	28.7	317.1	43.0	317.1
2021	315.3	36.8	352.1	42.2	349.9
2022	359.9	46.5	406.4	42.0	403.3
2023	405.8	63.2	469.0	41.2	466.7
2024	437.4	67.7	505.1	40.1	503.7
2025	474.8	70.5	545.3	39.4	544.1
2026	534.1	85.6	619.7	38.2	617.4
2027	593.2	96.4	689.6	37.7	687.5
2028	650.3	107.4	757.7	37.6	755.6
2029	715.6	120.8	836.4	37.3	833.9
2030	781.7	134.3	916.0	36.7	913.5
2031	846.8	147.8	994.6	36.3	992.2
2032	913.8	162.4	1,076.2	35.9	1,073.7
2033	1,002.6	181.4	1,184.0	35.4	1,180.7
2034	1,077.2	197.6	1,274.8	35.0	1,272.0

[1]The bid category includes all expenditures for non-MA coverage.
[2]The remaining percentage is paid from the Part B account of the SMI trust fund.

d. Incurred Expenditures per Enrollee

Table IV.C3 shows estimated incurred per enrollee expenditures for beneficiaries enrolled in private health plans. It combines the values for expenditures from the Part A and Part B trust funds.

Table IV.C3.—Incurred Expenditures per Private Health Plan Enrollee[1]

Calendar year	Local CCP HMO	Local CCP PPO	Regional PPO	PFFS	SNP	Other	Total
Bid-based expenditures[2]							
2015	$8,809	$8,825	$8,436	$9,540	$12,934	$8,204	$9,264
2016	8,891	9,272	9,029	10,254	13,158	8,394	9,495
2017	9,109	9,632	9,015	10,805	13,691	8,734	9,793
2018	9,456	10,025	9,471	11,138	14,368	9,046	10,232
2019	10,035	10,369	10,008	12,129	15,258	13,169	10,936
2020	10,483	10,829	10,604	13,098	16,281	14,517	11,522
2021	10,423	10,592	10,213	12,627	16,385	14,475	11,463
2022	10,890	11,015	10,563	13,319	17,223	15,198	12,075
2023	11,242	11,376	11,041	14,320	17,891	15,639	12,634
2024	11,383	11,531	11,222	13,986	17,923	16,290	12,835
2025	11,829	11,909	12,088	14,474	18,586	17,171	13,390
2026	12,711	12,868	13,120	15,558	19,901	16,346	14,395
2027	13,500	13,680	14,048	16,552	21,135	17,860	15,289
2028	14,219	14,423	14,923	17,459	22,265	19,273	16,104
2029	15,112	15,349	15,987	18,579	23,653	20,847	17,115
2030	16,033	16,305	17,093	19,733	25,081	22,403	18,158
2031	16,960	17,271	18,218	20,890	26,517	23,906	19,206
2032	17,939	18,292	19,409	22,110	28,027	25,441	20,312
2033	19,342	19,748	21,079	23,851	30,198	27,594	21,899
2034	20,454	20,899	22,460	25,238	31,916	29,359	23,154

	Local CCP						
Calendar year	HMO	PPO	Regional PPO	PFFS	SNP	Other	Total
Rebate expenditures[2]							
2015	$1,048	$212	$298	$217	$954	$0	$731
2016	1,123	290	310	199	925	0	788
2017	1,120	281	403	194	1,082	0	796
2018	1,183	324	421	176	1,183	0	851
2019	1,327	445	535	198	1,448	0	1,004
2020	1,506	546	585	189	1,615	0	1,147
2021	1,708	706	692	524	1,939	0	1,337
2022	1,941	898	807	674	2,277	0	1,562
2023	2,358	1,183	1,117	1,031	2,885	0	1,966
2024	2,306	1,236	1,045	1,501	3,011	0	1,988
2025	2,193	1,251	986	1,594	3,083	0	1,988
2026	2,555	1,390	1,141	1,658	3,563	0	2,306
2027	2,759	1,509	1,247	1,811	3,804	0	2,483
2028	2,953	1,622	1,350	1,959	4,078	0	2,661
2029	3,202	1,766	1,483	2,150	4,429	0	2,889
2030	3,455	1,911	1,617	2,343	4,781	0	3,119
2031	3,711	2,058	1,754	2,542	5,144	0	3,352
2032	3,995	2,221	1,909	2,767	5,536	0	3,610
2033	4,381	2,440	2,112	3,062	6,085	0	3,962
2034	4,682	2,613	2,265	3,289	6,552	0	4,245
Total expenditures[2]							
2015	$9,858	$9,038	$8,734	$9,757	$13,888	$8,204	$9,995
2016	10,014	9,562	9,339	10,453	14,083	8,394	10,283
2017	10,230	9,913	9,418	10,998	14,774	8,734	10,589
2018	10,640	10,349	9,892	11,314	15,551	9,046	11,083
2019	11,362	10,814	10,543	12,327	16,705	13,169	11,940
2020	11,989	11,374	11,190	13,287	17,896	14,517	12,669
2021	12,131	11,297	10,905	13,150	18,325	14,475	12,801
2022	12,831	11,913	11,370	13,993	19,500	15,198	13,636
2023	13,601	12,558	12,158	15,352	20,776	15,639	14,600
2024	13,689	12,766	12,267	15,487	20,933	16,290	14,823
2025	14,022	13,160	13,073	16,068	21,669	17,171	15,378
2026	15,265	14,259	14,261	17,216	23,464	16,346	16,701
2027	16,259	15,189	15,295	18,363	24,940	17,860	17,772
2028	17,171	16,046	16,272	19,418	26,343	19,273	18,765
2029	18,313	17,115	17,470	20,728	28,081	20,847	20,004
2030	19,488	18,217	18,710	22,076	29,862	22,403	21,277
2031	20,671	19,329	19,972	23,433	31,661	23,906	22,559
2032	21,934	20,513	21,319	24,877	33,564	25,441	23,921
2033	23,723	22,188	23,191	26,914	36,282	27,594	25,860
2034	25,136	23,512	24,725	28,527	38,468	29,359	27,399

[1]Values represent the sum of per capita expenditures for Part A and Part B.
[2]The bid category includes all expenditures for non-MA coverage.

Average Medicare payments per private plan enrollee vary by geographic location of the plan, plan efficiency, and average reported health status of plan enrollees. LCCPs and SNPs tend to be located in urban areas where prevailing health care costs tend to be above average. Conversely, PFFS plans and RPPOs generally reflect a more rural enrollment. These factors complicate meaningful comparisons of average per capita costs by plan category.

Per capita bids are expected to increase from $12,835 in 2024 to $13,390 in 2025 (or by 4.3 percent), as shown in table IV.C3. For years 2026 through 2034, the per capita bid trend is expected to be equal to the average of growth in per capita Medicare fee-for-service expenditures and benchmark growth for each specific coverage category. After 2034, average Medicare payments to private plans per enrollee are assumed to follow the aggregate growth trends of the HI and SMI Part B per capita benefits, as described in section IV.D of this report.

Per capita benchmarks are based on the fee-for-service United States Per Capita Cost (USPCC) growth rates, with adjustments for MA risk score patterns and quality rating bonus changes. Table IV.C4 shows the fee-for-service USPCC average amount per member per month (PMPM) and the MA benchmark PMPM for individual and SNP beneficiaries. MA benchmark growth for years 2026 and later is estimated to be higher than USPCC expenditure growth since benchmark growth includes adjustments to MA risk scores for differences in diagnosis coding between MA and fee-for-service beneficiaries, as well as other minor factors.

Two policy changes are assumed to be phased in over 3 years beginning in 2024. The first is a change to exclude medical education expenses associated with MA enrollees from the fee-for-service per capita costs that are used in the development of the MA benchmarks; this change will reduce Part A MA payments in all future years. The second policy change is an updated risk adjustment model that slows the growth in the MA benchmarks. Changes in rebates as a percentage of bids show that these additional benefits increased dramatically in recent years and are projected to grow again after these policy changes are fully phased in.

Table IV.C4.—Key Factors for Medicare Advantage Expenditure Estimates

Calendar year	FFS USPCC PMPM[1]	Benchmark PMPM[2]	Bid PMPM[2]	Bid to benchmark ratio	Rebate PMPM[2]	Rebate to bid ratio	Average final risk scores
2015	$769	$879	$761	86.6%	$77	10.1%	1.118
2016	800	900	778	86.4	81	10.4	1.108
2017	825	930	795	85.4	90	11.3	1.115
2018	848	978	832	85.0	96	11.6	1.142
2019	891	1,044	876	83.9	111	12.6	1.143
2020	941	1,098	911	83.0	123	13.5	1.154
2021	975	1,102	890	80.7	141	15.9	1.110
2022	1,028	1,195	944	79.0	166	17.5	1.149
2023	1,079	1,301	992	76.2	209	21.1	1.160
2024	1,105	1,323	1,005	75.9	211	21.0	[3]
2025	1,131	1,365	1,049	76.9	208	19.9	[3]
2026	1,195	1,495	1,129	75.5	239	21.2	[3]
2027	1,260	1,592	1,199	75.3	257	21.5	[3]
2028	1,310	1,683	1,262	75.0	275	21.8	[3]
2029	1,392	1,797	1,341	74.6	299	22.3	[3]
2030	1,462	1,915	1,423	74.3	323	22.7	[3]
2031	1,539	2,034	1,506	74.0	347	23.0	[3]
2032	1,622	2,161	1,593	73.7	373	23.4	[3]
2033	1,706	2,296	1,686	73.4	402	23.9	[3]
2034	1,799	2,431	1,780	73.2	430	24.2	[3]

[1]For 2025 and earlier, the USPCC value is the amount that was included in the Medicare Advantage rate announcement for that year. Represents the average amount per member per month (PMPM).
[2]Individual and SNP coverages only (excludes EGWP, ESRD, and other enrollment and payments).
[3]The Trustees do not explicitly project average risk scores.

D. LONG-RANGE MEDICARE COST GROWTH ASSUMPTIONS

Sections IV.A, IV.B, and IV.C have described the detailed assumptions and methodology underlying the projected expenditures for HI (Part A), SMI (Parts B and D), and private health plans (Part C) during 2025 through 2034. These projections are made for individual categories of Medicare-covered services, such as inpatient hospital care and physician services.

As the projection horizon lengthens, it becomes increasingly difficult to anticipate changes in the delivery of health care, the development of new medical technologies, and other factors that will affect future health care cost increases. Accordingly, rather than extending the detailed projections by individual type of service for all future years, the Trustees use a more aggregated basis for setting cost growth assumptions in the long range. Such increases also reflect the substantial uncertainty associated with payments that are specified through statute, which may present challenges for the Medicare program.

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[79] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[80]

The output and key assumptions of the factors model that are used in this year's report are similar to those used in the 2024 report. In subsequent reports, the Trustees will determine if additional historical data warrant a re-evaluation of these assumptions and a re-estimation of the factors model output. The remainder of section IV.D discusses the factors model and its role in the Medicare projections. Section V.C

[79]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the sex composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

[80]The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010–2011 Medicare Technical Review Panel and with Finding 3-2 of the 2016–2017 Medicare Technical Review Panel. The Panels' final reports are available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf and at https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf.

explains the methods used to derive the long-range cost growth assumptions underlying the illustrative alternative projection.

1. Long-Range Growth Assumptions for the Overall Health Sector

The first step to estimate the long-range Medicare trends is to determine the long-range assumptions affecting the overall health sector. The Trustees use the factors model to determine the year-by-year growth rates for the overall health sector over the last 50 years of the projection. Based on the factors model, the Trustees assume that the long-range per capita overall health spending growth is GDP plus 0.7 percent (or 4.3 percent) for 2049, gradually declining to GDP plus 0.4 percent by 2099 (or 4.1 percent).[81] The per capita increase in overall health care costs is due to the combined effects of general inflation, medical-specific *excess* price inflation (above general price growth), and changes in the utilization of services per person and the intensity or average complexity per service. The Trustees assume the following for years beginning in 2049: (i) price inflation for goods and services produced in the U.S., as measured by the GDP deflator, will remain constant at 2.05 percent per year; (ii) excess medical price inflation will remain constant at 0.75 percent per year; and (iii) the annual increase in the volume and intensity of services per person will decline gradually from approximately 1.5 percent in 2049 to 1.3 percent in 2099 based on the key economic assumptions and elasticity estimates from the factors model, as described below.

Excess medical price inflation for the overall health sector is assumed to grow at 0.75 percent annually from 2049 through 2099. This assumption is roughly equivalent to the difference between the growth in the personal health care deflator over the past three decades and the growth in the GDP deflator over this same period.[82] Combining this assumption with the ultimate assumed growth rate of 2.05 percent per year in the GDP deflator yields the Trustees' estimate of the long-range rate of medical price growth of 2.8 percent annually. Using the relationship between medical price growth and resource-based health

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[81]These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as *GDP plus X percent*.

[82]Calculated through 2019. Information on the personal health care deflator is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

sector productivity growth[83] allows for the determination of medical input price growth.[84] For resource-based health sector productivity, the Trustees assume that the rate of growth will be equivalent to published research[85] of 0.4 percent per year. Hence, the Trustees' estimate of the long-range rate of growth of medical input prices is 3.2 percent.

As stated earlier, the factors model is based on economic research that separates health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual that primarily reflects the impact of technological development.[86] The factors model provides the ability to model the expected behavioral effects associated with a continuing increase in the share of national income devoted to consumption of health care services. In particular, this approach is based on historically estimated income and price elasticities and uses measurable key variables, providing a foundation for developing the long-range growth assumptions.[87]

In the factors model, the sensitivity of health cost growth to each of the three factors must be estimated. Each sensitivity is measured as an elasticity, which is the percentage change in cost growth that is caused by a 1-percent change in a factor. The first elasticity, the income-technology elasticity, reflects the increase in demand for health care and new medical technologies in response to growth in income. The second elasticity, the relative medical price elasticity, reflects the sensitivity of consumers and purchasers in consuming health care to

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[83]Resource-based productivity is defined as the real value of provider goods and services divided by the real value of the resources (inputs) used to produce the goods and services, whereas price changes are measured across constant products—that is, defined health services with a constant mix of inputs. Resource-based productivity is used for this decomposition, rather than outcomes-based productivity (which incorporates the estimated value of improvements in health resulting from the services), because Medicare and most other payers reimburse providers based on their resource use.

[84]A third factor, provider profit margins, is assumed to remain constant over the long range.

[85]Information on updated estimates of hospital productivity is available at https://www.cms.gov/files/document/productivity-memo.pdf; Fisher, Charles. "Multifactor Productivity in Physicians' Offices: An Exploratory Analysis." *Health Care Financing Review,* 29, no. 2 (2007): 15–32.

[86]Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs,* 28, no. 5 (2009): 1276–1284.

[87]Additional information on the "factors contributing to growth" model is available in a memorandum by the CMS Office of the Actuary titled "A Conceptual View of the Long-Term Projection Methods for Medicare and Aggregate National Health Expenditures," available at https://www.cms.gov/files/document/conceptual-view-long-term-projection-methods-medicare-and-aggregate-national-health-expenditures.pdf.

changes in excess medical price inflation. The final key elasticity is the insurance elasticity, which reflects the change in demand for medical care as the level of insurance coverage changes.

For the income-technology elasticity, the Trustees developed a time-trend-based method for projecting the elasticity that reflects the historical declining trend, produces results consistent with the elasticity implied by the most recent short-range national health expenditure projections, and converges to 1.0 within a range of roughly 75 to 150 years. In the resulting projection, the income-technology elasticity is 1.23 in the 25th year of the projection period (2049) and declines at a slowing pace to 1.06 in the 75th year of the period (2099). This methodology results in an income-technology elasticity that reaches 1.0 in 2125. These are the same elasticity assumptions that were used for 2049 and 2099 in the 2024 report.

For the medical price elasticity, the Trustees assume a rising sensitivity of demand for health care to changes in relative medical price as the share of income devoted to health care rises. The medical price elasticity is determined for a given year by subtracting an income effect from a pure substitution effect. The income effect is determined by multiplying the share of income devoted to health care in that year by the estimated yearly income-technology elasticity. The substitution effect is assumed to be equal to −0.2 and represents the change in demand in response to a change in the relative price of health care holding utility constant. For the 2025 report, the Trustees project the price elasticity to be −0.50 for the 25th year of the projection (2049) and assume that it will follow a non-linear path until it reaches −0.57 in the 75th year of the projection (2099). Based on the RAND Health Insurance Experiment, the insurance elasticity was estimated at −0.2 and was assumed to be unchanged over the long range.[88]

Two additional assumptions are required to complete the factors model determination. First, relative medical price inflation must be estimated over the long-range projection period. As discussed previously, the Trustees assume a relative medical price growth rate of 0.75 percent per year. Second, insurance coverage is assumed to be unchanged over the long range in order to maintain consistency with

[88]Newhouse, Joseph P., and the Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment*. Cambridge: Harvard University Press, 1993. The coefficient of this elasticity is negative because the level of insurance coverage is measured using individuals' cost-sharing requirements (such as deductibles and coinsurance).

the concept of a Medicare projection in which the Medicare benefit package is not altered.

2. Long-Range Growth Assumptions for Medicare

The Trustees have assumed since 2001 that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010–2011 Medicare Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Medicare payment rates for most non-physician provider categories are updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range. The Trustees assume that the full market basket increase will be approximately 3.2 percent annually, or about 0.4 percent greater than the net price increase of 2.8 percent per year described above for the total health sector. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for five categories of health care provider services:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

The annual increase in Medicare payment rates for these services is reduced by the 10-year moving average increase in economy-wide productivity. These gains are estimated to be 1.0 percent per year over the long-range projection period. Combined with an assumed market basket increase of 3.2 percent, the statutory price update for these services is 2.2 percent per year over the long range. The initial projected increase in the volume and intensity of these Medicare services is assumed to be equivalent to the average projected growth in the volume and intensity of services for the overall health sector. The Trustees believe that the use of a common baseline rate of volume and intensity growth across all Medicare services is reasonable, as there would be only a small likelihood that one part of the health sector could continue to grow indefinitely at significantly faster rates of growth than do other parts.

Additionally, the Trustees assume that the growth in Medicare payment rates will reduce the volume and intensity growth of these services by 0.1 percent per year relative to the assumption from the factors model. The Trustees' assumption is based on the work of the 2010–2011 and 2016–2017 Medicare Technical Review Panels,[89,90] both of which concluded that there would likely be a small net negative impact on volume and intensity growth because of the following:

- Reduced incentives to develop new technologies: Medicare would pay lower fees than would otherwise be the case, and providers would be less likely to adopt new services and innovations, thereby lowering the demand for, and intensity of, the medical care provided.
- Fewer providers participating in Medicare: As fee-for-service fees decline relative to those assumed for private health insurance plans, providers—particularly facilities of marginal profitability—will become more likely to exit the Medicare market. Additionally, a more bifurcated health system may emerge in which only providers that could operate profitably under Medicare would offer services to Medicare beneficiaries, with a tendency to provide only the more basic services not associated with new medical technologies.
- Increased efficiencies associated with bundled payments and other innovations: As providers increase participation in innovations being tested for the Medicare program, such as bundled payments or accountable care organizations, there will be reduced incentives to adopt new cost-increasing technologies and increased incentives to adopt new cost-decreasing technologies. These innovations could contribute to greater efforts to avoid services of limited or no value within the service bundle.

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[89]See Recommendation III-3 of the 2010–2011 Medicare Technical Review Panel and Finding 3-2 of the 2016–2017 Medicare Technical Review Panel.

[90]Other factors, such as reduced beneficiary cost-sharing requirements, would tend to increase the volume and intensity of services. The assumption of −0.1 percent reflects the Technical Panel's assessment that the overall impact would be a small net decrease in volume and intensity growth.

Reflecting all of these considerations, the year-by-year long-range cost growth rate assumption for these HI and SMI Part B services starts at 3.6 percent in 2049, or GDP plus 0.0 percent, and gradually declines to 3.4 percent by 2099, or GDP minus 0.3 percent.

(ii) *Physician services*

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced alternative payment models (advanced APMs) and 0.25 percent for those assumed to be participating in the merit-based incentive payment system (MIPS) in the long range. The year-by-year cost growth rates for physician payments are assumed to decline from 3.1 percent in 2049, or GDP minus 0.5 percent, to 2.8 percent in 2099, or GDP minus 0.9 percent.

(iii) *Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in productivity.*

Such services include durable medical equipment (DME) that is not subject to competitive bidding,[91] care at ambulatory surgical centers, ambulance services, and medical supplies, which are updated by the CPI and reduced by the 10-year moving average increase in economy-wide productivity. For these services, the Trustees initially assume that the rate of per beneficiary volume and intensity growth is equivalent to that derived for the overall health sector using the factors model. This volume and intensity growth is assumed to be reduced by 0.1 percent per year, as described above. The volume and intensity assumption is combined with the long-range CPI assumption (2.4 percent) minus the productivity factor (1.0 percent) to produce a long-range growth assumption for these SMI Part B services. The corresponding year-by-year cost growth rates gradually decline from 2.8 percent in 2049, or GDP minus 0.8 percent, to 2.6 percent in 2099, or GDP minus 1.1 percent.

(iv) *The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.*

The Trustees assume that per beneficiary costs for these other Part B services grow at the same rate as the overall health sector

[91]The portion of DME that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process.

as determined from the factors model. The services are assumed to grow similarly because their payments are established through market processes. For physician-administered Part B drugs, the key inflation provisions in the Inflation Reduction Act of 2022 are not expected to affect such payments over the long range. The year-by-year cost growth rates gradually decline from 4.3 percent in 2049, or GDP plus 0.7 percent, to 4.1 percent by 2099, or GDP plus 0.4 percent.

(v) *Prescription drugs provided through Part D.*

Medicare payments to Part D plans are based on a competitive-bidding process, and prior to the Inflation Reduction Act these payments were assumed to grow at the same rate as the overall health sector as determined from the factors model. While the negotiation provisions of this law are not anticipated to affect the long-range growth rates for Part D drugs, the inflation provisions would likely lower these trends relative to previous expectations. Analysis of Part D pricing trends over recent years has consistently shown price growth in excess of the CPI, with a portion of these trends offset by increasing rebate percentages, and it was assumed, prior to this legislation, that such trends would continue over the long range.

The Inflation Reduction Act is expected to change this dynamic because it requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. The inflation provisions would likely lower price trends, though it is anticipated that they would outpace the CPI because of certain manufacturer adaptations to the new law that may mitigate some of the pricing constraints, including new approaches regarding the development and release of new drugs. As a result, they are assumed to grow over the long range slightly more slowly than would be the case if they were determined strictly through market processes. The corresponding year-by-year cost growth rates decline from 4.1 percent in 2049, or GDP plus 0.5 percent, to 3.9 percent by 2099, or GDP plus 0.2 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. Beginning with the 2020 report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death adjustment. This adjustment reflects the fact that the closer an individual is to death, the higher his or her health care spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on health care is offset somewhat.[92]

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent, or GDP plus 0.3 percent in 2049,[93] declining to 3.8 percent, or GDP plus 0.1 percent by 2099. When Parts A, B, and D are combined, the weighted average cost growth rate is 3.8 percent in 2049, or GDP plus 0.2 percent, declining to 3.7 percent, or GDP plus 0.0 percent by 2099.

As in the past, the Trustees have established detailed growth rate assumptions for the initial 10 years of the projection period by individual type of service (for example, inpatient hospital care and physician services), reflecting recent trends and the impact of all applicable statutory provisions. For each of Parts A, B, and D, the assumed growth rates for years 11 through 25 of the projection period are set by interpolating between the rate at the end of the short-range period and the rate at the start of the final 50 years of the long-range period described above. The 2016–2017 Medicare Technical Review Panel concluded that both the current length of the transition period and the current approach to the transition are reasonable, and they recommended that the Trustees continue to use the same approach to transitions between short-range and long-range projections for both HI and SMI.[94]

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[92]More information on the time-to-death adjustment is available at https://www.cms.gov/files/document/incorporation-time-death-medicare-demographic-assumptions.pdf.

[93]In 2049, the shares of Part B spending are 28 percent for services updated by input price indexes, 16 percent for physician services, 6 percent for services updated by the CPI, and 51 percent for the remaining Part B services.

[94]See Findings 6-2 and 6-3 and Recommendation 6-1.

V. APPENDICES

A. MEDICARE AMENDMENTS SINCE THE 2024 REPORT

Since Appendix V.A. for the 2024 annual report was written, and prior to this report's preparation, four laws have been enacted that have an effect on the Medicare trust funds.[95] The more important provisions, from an actuarial standpoint, are described, in brief, in the following paragraphs. Certain provisions with a relatively minor financial impact, but which are important from a policy perspective, are briefly described as well.

1. **The Consolidated Appropriations Act, 2024 (Public Law 118-42, enacted on March 9, 2024) included provisions that affect the HI and SMI programs.**

   Provisions Affecting All Parts of Medicare

   - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through November 30, 2032. (In other words, the benefit payment reductions for the month of November 2032 are changed from 0 percent to 2 percent.)

   - Funding for the National Quality Forum from the HI and SMI trust funds is extended through December 31, 2024 (from September 30, 2023).

   - Funding from the HI and SMI trust funds for certain low-income outreach and assistance programs is extended through December 31, 2024 (from September 30, 2023).

   Provision Affecting HI and Part B of SMI

   - The funding amount of $2,197,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after fiscal year 2022, as discussed under Public Law 118-35 in last year's report, is reduced to $0. (This fund is intended to be available for improvements to the original fee-for-service program under Parts A and B, and funding is provided from the HI and SMI trust funds in such

[95]Because of the timing and the limited effect on the financial outlook of the trust funds, the projections in the 2024 report did not reflect the impact of the Medicare provisions in the Consolidated Appropriations Act, 2024 (Public Law 118-42), which was enacted on March 9, 2024. Those provisions are included here.

proportions as deemed appropriate by the Secretary of Health and Human Services.)

Provisions Affecting HI

- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through December 31, 2024 (from September 30, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After December 31, 2024, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2024, is extended through December 31, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)

- For the hospice aggregate cap, the change made by previous legislation—whereby a hospice payment update percentage is used for the annual updates for fiscal years 2017–2032 rather than the Consumer Price Index for All Urban Consumers—is extended through fiscal year 2033.

Provisions Affecting Part B of SMI

- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through December 31, 2024 (from March 8, 2024).

- In the formula used for determining payment rates under the physician fee schedule, the physician payment update is changed for services furnished March 9, 2024, through December 31, 2024. As a result, the update of −1.22 percent, which was to be in effect throughout 2024, is now to apply only through March 8, and an update of 0.42 percent (as compared with the 2023 payment level) is to apply for the remainder of the year.

- For physicians participating in advanced alternative payment models, incentive payment availability is extended 1 year, through performance year 2024. However, for payment year 2026 (which applies to performance year 2024), the incentive payments are to equal 1.88 percent of fee schedule payments (as compared with 5 percent for 2019–2024 and 3.5 percent for 2025). In addition, the current freeze on the participation thresholds that must be met to qualify for the incentive payments is extended for the same additional year. (The more stringent thresholds will now first apply in 2027.)

2. **The Continuing Appropriations and Extensions Act, 2025 (Public Law 118-83, enacted on September 26, 2024) included provisions that affect the HI and SMI programs.**

Provision Affecting HI and Part B of SMI

- The funding amount of $0 that was previously provided to the Medicare Improvement Fund for services furnished during and after fiscal year 2022, as discussed under Public Law 118-42, is increased to $3,197 million for services furnished during and after fiscal year 2026.

Provision Affecting Part B of SMI

- For clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests, changes are made to the market-based system used to update the Medicare clinical laboratory fee schedule. First, laboratories are exempted for another year from the requirement that they report private payer rates; that is, the next data-reporting period is now the first quarter of 2026 (instead of the first quarter of 2025). Next, for the caps in place to limit reductions in fee schedule payments during the phase-in period, the timing is changed. Specifically, tests furnished during 2021–2025 (rather than 2021–2024) are to be paid at the same rates as under the 2020 fee schedule, and payments for tests provided during 2026–2028 (rather than 2025–2027) may not be reduced by more than 15 percent per year.

3. The American Relief Act, 2025 (Public Law 118-158, enacted on December 21, 2024) included provisions that affect the HI and SMI programs.

Provisions Affecting All Parts of Medicare

- Funding for the National Quality Forum from the HI and SMI trust funds is extended through March 31, 2025 (from December 31, 2024).

- Funding from the HI and SMI trust funds for certain low-income outreach and assistance programs is extended through March 31, 2025 (from December 31, 2024).

Provision Affecting HI and Part B of SMI

- The funding amount of $3,197 million that was previously provided to the Medicare Improvement Fund for services furnished during and after fiscal year 2026, as discussed under Public Law 118-83, is decreased to $1,251 million.

Provisions Affecting HI

- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through March 31, 2025 (from December 31, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After March 31, 2025, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 31, 2024, is extended through March 31, 2025. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)

- The Acute Hospital Care at Home initiative is extended through March 31, 2025 (from December 31, 2024).

Provisions Affecting Part B of SMI

- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through March 31, 2025 (from December 31, 2024).

- Certain ground ambulance add-on payments that had been extended through December 31, 2024, under previous legislation are now extended through March 31, 2025. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.

- The telehealth flexibilities that were provided in response to the COVID-19 pandemic are extended through March 31, 2025 (from December 31, 2024). These flexibilities are described in the 2021 report.

Provision Affecting Part D of SMI

- The temporary Part D coverage of certain prescription oral antiviral drugs used for the treatment of COVID-19 under an emergency authorization by the Food and Drug Administration (FDA) is extended through March 31, 2025 (from December 31, 2024). (Generally, products need to be fully approved or licensed by the FDA to be covered by Part D; these drugs have emergency use authorization only.)

4. **The Full-Year Continuing Appropriations and Extensions Act, 2025 (Public Law 119-4, enacted on March 15, 2025) included provisions that affect the HI and SMI programs.**

Provisions Affecting All Parts of Medicare

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 2 months, through January 31, 2033. (In other words, the benefit payment reductions for the months of December 2032 and January 2033 are changed from 0 percent to 2 percent.)

- Funding for the National Quality Forum from the HI and SMI trust funds is extended through September 30, 2025 (from March 31, 2025).

- Funding from the HI and SMI trust funds for certain low-income outreach and assistance programs is extended through September 30, 2025 (from March 31, 2025).

Provision Affecting HI and Part B of SMI

- The funding amount of $1,251 million that was previously provided to the Medicare Improvement Fund for services furnished during and after fiscal year 2026, as discussed under Public Law 118-158, is increased to $1,804 million.

Provisions Affecting HI

- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through September 30, 2025 (from March 31, 2025). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After September 30, 2025, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.

- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after March 31, 2025, is extended through September 30, 2025. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)

- The Acute Hospital Care at Home initiative is extended through September 30, 2025 (from March 31, 2025).

Provisions Affecting Part B of SMI

- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through September 30, 2025 (from March 31, 2025).

- Certain ground ambulance add-on payments that had been extended through March 31, 2025, under Public Law 118-158 are now extended through September 30, 2025. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.

- The telehealth flexibilities that were provided in response to the COVID-19 pandemic are extended through September 30, 2025 (from March 31, 2025). These flexibilities are described in the 2021 report.

Provision Affecting Part D of SMI

- The temporary Part D coverage of certain prescription oral antiviral drugs used for the treatment of COVID-19 under an emergency authorization by the Food and Drug Administration (FDA) is extended through September 30, 2025 (from March 31, 2025). (Generally, products need to be fully approved or licensed by the FDA to be covered by Part D; these drugs have emergency use authorization only.)

B. TOTAL MEDICARE FINANCIAL PROJECTIONS

Medicare is the nation's second largest social insurance program, exceeded only by Social Security (OASDI). Although Medicare's two components—Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)—are very different from each other in many key respects, it is important to consider the overall cost of Medicare and its financing. By reviewing Medicare's total expenditures, readers can assess the financial obligation created by the program. Similarly, the sources and relative magnitudes of HI and SMI revenues are an important policy matter.

The issues of Medicare's total cost to society and the means of financing that cost are different from the question of the financial status of the Medicare trust funds. The latter focuses on whether a specific trust fund's income and expenditures are in balance. The separate HI and SMI financial projections prepared for this purpose, however, can be usefully combined for the broader purposes outlined above. To that end, this section presents information on combined HI and SMI costs and revenues. Sections III.B, III.C, and III.D of this report present detailed assessments of the financial status of the HI trust fund and the Part B and Part D accounts of the SMI trust fund, respectively.

1. 10-Year Actuarial Estimates (2025–2034)

Table V.B1 shows past and projected Medicare income, expenditures, and trust fund assets in dollar amounts for calendar years,[96] with projections shown under the intermediate set of assumptions for the short-range projection period 2025 through 2034.

[96]The table shows amounts on a *cash* basis, reflecting actual expenditures made during the year, even if the payments were for services performed in an earlier year. Similarly, income figures represent amounts actually received during the year, even if incurred in an earlier year.

Table V.B1.—Total Medicare Income, Expenditures, and Trust Fund Assets during Calendar Years 1970–2034
[In billions]

Calendar year	Total income	Total expenditures	Net change in assets	Assets at end of year
Historical data:				
1970	$8.2	$7.5	$0.7	$3.4
1975	17.7	16.3	1.3	12.0
1980	37.0	36.8	0.1	18.3
1985	76.5	72.3	4.2	31.4
1990	126.3	111.0	15.3	114.4
1995	175.3	184.2	−8.9	143.4
2000	257.1	221.8	35.3	221.5
2005	357.5	336.4	21.0	309.8
2010	486.1[1]	522.9	−36.8	344.0
2015	644.4[1]	647.6	−3.2	263.2
2016	710.2[1]	678.7	31.5	294.7
2017	705.1	710.2	−5.0	289.6
2018	755.7	740.6	15.1	304.7
2019	794.7	796.1	−1.4	303.3
2020	899.9[1,2]	925.8[3]	−25.9	277.4
2021	887.7[1,2]	839.4[3]	48.3	325.7
2022	988.5[2]	905.1[3]	83.4	409.1
2023	1,024.3[2]	1,036.7[3]	−12.4	396.7
2024	1,133.3	1,122.1	11.2	407.9
Intermediate estimates:				
2025	1,219.9	1,206.9	12.9	420.9
2026	1,329.1[1]	1,298.7	30.4	451.3
2027	1,428.2[1]	1,420.0	8.2	459.5
2028	1,535.8	1,532.0	3.8	463.2
2029	1,646.2	1,655.6	−9.3	453.9
2030	1,759.9	1,781.5	−21.6	432.4
2031	1,866.8	1,900.6	−33.7	398.6
2032	1,980.4	2,022.1	−41.7	356.9
2033	2,124.7	2,191.2	−66.5	290.4
2034	2,258.3	2,340.3	−82.0	208.4

[1]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2010, actually occurred on December 31, 2009, payment of benefits normally due January 3, 2016, occurred on December 31, 2015, and payment of benefits normally due January 3, 2021, occurred on December 31, 2020. Consequently, the Part B and Part D premiums withheld from these benefits and the associated Part B government contributions were added to the Part B or Part D account, as appropriate, on December 31, 2009 (about $14.8 billion for Part B and about $0.2 billion for Part D), December 31, 2015 (about $7.5 billion for Part B and about $0.1 billion for Part D), and December 31, 2020 (about $10.0 billion for Part B and about $0.1 billion for Part D), respectively. Similarly, the payment date for those benefits normally due January 3, 2027, will be on December 31, 2026. Accordingly, an estimated $6.3 billion will be added to the Part B account, and an estimated $0.1 billion will be added to the Part D account, on December 31, 2026.
[2]See footnote 9 of table III.C4.
[3]Includes net payments of $100.5 billion made through the Medicare Accelerated and Advance Payments Program in calendar year 2020 and subsequent net repayments of $47.9 billion, $51.5 billion, and $0.8 billion in calendar years 2021 through 2023, respectively.

Note: Totals do not necessarily equal the sums of rounded components.

As indicated in table V.B1, Medicare expenditures have increased rapidly during most of the program's history. From 1985 through 2024, expenditures grew at an average annual rate of 7.3 percent, and they are projected to increase at an average annual rate of 7.6 percent from 2025 through 2034.

Through most of Medicare's history, trust fund income has kept pace with increases in expenditures.[97] For this year's report, the Trustees estimate that, from 2025 through 2034, total Medicare income will increase at an average annual rate of 7.1 percent, which is slightly lower than the growth in expenditures.

The Department of the Treasury has invested past excesses of income over expenditures in U.S. Treasury securities, with total trust fund assets accumulating to $407.9 billion at the end of calendar year 2024. Combined assets fluctuated over the recent historical period for various reasons, including transfers from the general fund of the Treasury required by enacted legislation. The change in assets continues to fluctuate slightly over the remainder of the short-range projection period because of the timing of premium collections, as described in footnote 1 of table V.B1, and the return of HI deficits.[98]

2. 75-Year Actuarial Estimates (2025–2099)

Table V.B2 shows past and projected Medicare expenditures expressed as a percentage of GDP.[99] This percentage provides a relative measure of the size of the Medicare program compared to the general economy and represents the portion of the nation's total resources dedicated each year to providing health care services to beneficiaries through Medicare. Expenditures represented 0.7 percent of GDP in 1970 and had grown to 2.6 percent of GDP by 2005, reflecting rapid increases in the factors affecting health care cost growth. Starting in 2006, Medicare provided subsidized access to prescription drug coverage through Part D, which caused most of the increase in Medicare expenditures to 3.0 percent of GDP in the first year. The Trustees project much more moderate continuing growth in the long range, partially as a result of the lower price updates under current law, with total Medicare expenditures projected to reach about 6.7 percent of GDP by 2099.

The projections shown in table V.B2 for total Medicare as a share of GDP are higher than those in the 2024 report primarily as a result of

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[97]This balance resulted from periodic increases in HI payroll tax rates and other HI financing, from annual increases in SMI premium rates and government contributions (to cover the following year's estimated expenditures), and from frequent legislation designed to slow the rate of growth in expenditures.
[98]See sections III.B, III.C, and III.D regarding the asset projections for HI and Part B and Part D of SMI, separately.
[99]In contrast to the expenditure amounts shown in table V.B1, table V.B2 shows historical and projected expenditures on an incurred basis. Incurred amounts relate to the expenditures for services performed in a given year, even if payment for those expenditures occurs in a later year.

higher projected spending for outpatient hospital and physician-administered drugs.

Table V.B2.—HI and SMI Incurred Expenditures as a Percentage of the Gross Domestic Product

Calendar year	HI Part A	SMI Part B	SMI Part D	Total
Historical data:				
1970	0.51%	0.21%	—	0.71%
1975	0.69	0.29	—	0.98
1980	0.91	0.40	—	1.31
1985	1.11	0.55	—	1.66
1990	1.12	0.74	—	1.86
1995	1.55	0.87	—	2.42
2000	1.28	0.91	—	2.19
2005	1.44	1.18	0.01%	2.62
2010	1.63	1.43	0.42	3.48
2015	1.52	1.54	0.49	3.55
2016	1.54	1.57	0.50	3.60
2017	1.53	1.60	0.48	3.61
2018	1.51	1.66	0.47	3.64
2019	1.54	1.73	0.48	3.74
2020	1.61	1.80	0.50	3.91
2021	1.51	1.81	0.47	3.79
2022	1.46	1.75	0.45	3.67
2023	1.46	1.81	0.46	3.74
2024	1.46	1.86	0.51	3.83
Intermediate estimates:				
2025	1.49	1.92	0.53	3.94
2026	1.54	2.06	0.54	4.13
2027	1.59	2.17	0.56	4.32
2028	1.64	2.25	0.57	4.47
2029	1.69	2.36	0.58	4.63
2030	1.73	2.48	0.58	4.78
2031	1.77	2.57	0.57	4.90
2032	1.80	2.66	0.55	5.01
2033	1.86	2.81	0.55	5.22
2034	1.90	2.92	0.54	5.36
2035	1.92	3.02	0.54	5.48
2040	1.99	3.41	0.52	5.92
2045	2.01	3.63	0.51	6.15
2050	2.00	3.71	0.52	6.23
2055	1.98	3.78	0.54	6.30
2060	1.97	3.88	0.56	6.41
2065	1.98	3.98	0.58	6.54
2070	2.00	4.06	0.59	6.66
2075	2.01	4.14	0.61	6.76
2080	2.00	4.19	0.62	6.81
2085	1.98	4.21	0.63	6.82
2090	1.95	4.19	0.63	6.77
2095	1.91	4.18	0.63	6.73
2099	1.88	4.18	0.64	6.70

Note: Percentages are affected by economic cycles.

The 75-year projection period fully allows for the presentation of anticipated future developments, such as the impact of a large increase in enrollees from 2010 through 2031. This increase in the number of beneficiaries will occur because the relatively large number of persons born during the period between the end of World War II and the mid-1960s (known as the baby boom generation) will reach eligibility age and begin to receive benefits. Moreover, as this generation ages, these individuals will experience greater health care utilization and costs, thereby adding further to growth in program expenditures. Table V.B3 shows past and projected enrollment in the Medicare program.

As indicated in table V.B3, over the last 35 years the total number of Medicare beneficiaries approximately doubled, and the Trustees expect the total to increase by 35 percent over approximately the next 35 years. During this same historical period, the number of covered workers also increased rapidly (by about 39.3 percent), but the Trustees project this number to increase much more slowly (about 10 percent) over the next 35 years. This demographic shift and its implications for Medicare costs, relative to workers' earnings or to the GDP, are fairly well known.

The enrollment data also show that the number of Medicare beneficiaries enrolled in private health plans under Part C has increased substantially in recent years. (Section IV.C of this report describes the changes in enrollment growth since 2005.) By 2024, about 50 percent of eligible Medicare beneficiaries were enrolled in private Part C health plans. The Trustees expect modest increases in private plan penetration rates between 2025 and 2034, with the estimated proportion of beneficiaries in such plans ultimately stabilizing at about 58 percent.

Table V.B3.—Medicare Enrollment
[In thousands]

	HI	SMI			
Calendar year	Part A	Part B	Part D	Private health plans[1]	Total[2]
Historical data:					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	1,271	31,081
1990	33,747	32,567	—	2,017	34,251
1995	37,175	35,641	—	3,467	37,594
2000	39,257	37,335	—	6,856	39,688
2005	42,233	39,752	1,841	5,794	42,606
2010	47,365	43,882	34,772	11,693	47,720
2015	55,246	50,756	41,786	17,495	55,589
2016	56,729	52,094	43,198	18,393	57,073
2017	58,344	53,446	44,475	19,817	58,683
2018	59,677	54,679	45,798	21,338	60,020
2019	61,188	56,019	47,179	22,950	61,535
2020	62,544	57,320	48,697	25,075	62,887
2021	63,643	58,393	49,976	27,547	63,980
2022	64,822	59,502	51,393	29,840	65,165
2023	66,220	60,800	52,884	32,161	66,585
2024	67,216	62,034	55,222	34,114	67,601
Intermediate estimates:					
2025	69,130	63,484	56,738	35,494	69,537
2026	70,673	65,010	58,588	37,134	71,101
2027	72,332	66,704	60,457	38,831	72,778
2028	73,937	68,313	62,132	40,407	74,402
2029	75,405	69,795	63,479	41,838	75,888
2030	76,635	71,064	64,578	43,079	77,134
2031	77,593	72,099	65,447	44,120	78,105
2032	78,420	73,015	66,209	45,018	78,945
2033	79,174	73,857	66,909	45,813	79,711
2034	79,972	74,722	67,646	46,554	80,520
2035	80,790	75,578	68,399	47,240	81,349
2040	82,862	77,932	70,530	48,877	83,456
2045	83,969	79,144	71,626	49,653	84,582
2050	85,794	80,774	73,101	[3]	86,426
2055	88,303	83,057	75,168	[3]	88,956
2060	91,291	85,884	77,726	[3]	91,964
2065	94,004	88,621	80,203	[3]	94,698
2070	97,063	91,620	82,917	[3]	97,782
2075	100,134	94,608	85,622	[3]	100,880
2080	102,111	96,681	87,497	[3]	102,874
2085	103,297	97,997	88,688	[3]	104,071
2090	103,602	98,505	89,148	[3]	104,375
2095	104,699	99,523	90,070	[3]	105,477
2099	106,166	100,850	91,271	[3]	106,955

[1]Of Medicare beneficiaries enrolled in private plans, about 97 percent are in Medicare Advantage plans or Part C. The remainder are in certain holdover plans reimbursed on a cost basis rather than through capitation payments, in Program of All-Inclusive Care for the Elderly (PACE) plans, or in Medicare-Medicaid Plans (MMPs).
[2]Number of beneficiaries with HI and/or SMI coverage.
[3]The Trustees do not explicitly project enrollment in private health plans beyond 2045.

Table V.B4 shows the past and projected amounts of Medicare revenues as a percentage of total non-interest Medicare income, under the intermediate assumptions. The table excludes interest income, which would not be a significant part of program financing in the long range.

Table V.B4.—Medicare Sources of Income as a Percentage of Total Non-Interest Income

Calendar year	Payroll taxes	Tax on benefits	Premiums[1]	Brand-name drug fees	State payments	Government contribution[2]
Historical data:						
1970	61.8%	—	13.7%	—	—	24.6%
1980	68.0	—	8.6	—	—	23.4
1990	62.2	—	9.8	—	—	27.9
2000	59.8	3.6%	9.1	—	—	27.6
2010	38.9	2.9	13.3	—	0.9%	44.0
2015	38.1	3.2	13.6	0.5%	1.4	43.2
2016	36.3	3.3	12.8	0.4	1.4	45.7
2017	37.7	3.5	14.6	0.6	1.6	42.0
2018	36.0	3.2	15.2	0.5	1.6	43.4
2019	36.4	3.0	15.3	0.4	1.6	43.4
2020	34.0	3.0	14.8	0.3	1.3	46.6
2021	34.4	2.8	15.1	0.3	1.4	46.1
2022	36.1	3.3	15.7	0.3	1.4	43.2
2023	36.3	3.4	15.3	0.3	1.6	43.2
2024	35.4	3.5	14.7	0.2	1.6	44.5
Intermediate estimates:						
2030	29.2	4.4	17.3	0.2	1.1	47.7
2040	24.8	4.7	19.1	0.1	0.9	50.4
2050	23.9	4.7	19.5	0.1	0.8	51.0
2060	23.3	4.8	19.6	0.0	0.8	51.3
2070	22.8	4.9	19.8	0.0	0.8	51.6
2080	22.6	4.9	19.9	0.0	0.9	51.8
2090	22.8	4.8	19.9	0.0	0.9	51.7
2099	23.0	4.7	19.9	0.0	0.9	51.6

[1]Includes premium revenue from HI and both accounts in the SMI trust fund.
[2]Includes Part B repayment amounts in 2016–2025.

Note: Row sums may not exactly equal 100 percent because of rounding.

Transfers from the general fund of the Treasury (primarily those for SMI) represented 45 percent of total non-interest income to the Medicare program in 2024 and have constituted the largest share of Medicare financing since 2009. HI payroll taxes were the next largest source of overall financing at 35 percent. Beneficiary premiums (again, primarily for SMI) were third, at 15 percent.

Projected HI tax revenues fall short of projected HI expenditures in most future years. In contrast, SMI premium revenue and government contributions will keep pace with SMI expenditure growth, and State payments[100] (on behalf of Medicare beneficiaries who also qualify for full Medicaid benefits) will grow with Part D expenditures.

General fund transfers to the Part B account increased significantly in 2016, as required by the Bipartisan Budget Act of 2015 to compensate for premium revenue that was not received in 2016 because of the hold-harmless provision. They increased again in 2020 and 2021, as required by the Continuing Appropriations Act, 2021 and Other

[100]State payments to Part D amounted to 90 percent of their projected forgone Medicaid prescription drug costs in 2006, and this percentage phased down over a 10-year period to 75 percent in 2015.

Extensions Act to account for the outstanding balance of the Accelerated and Advance Payments (AAP) Program in 2020 and to compensate for premium revenue that was not received in 2021 because of the legislated specification of the aged actuarial rate calculation. Another source of Part B financing, from fees on manufacturers and importers of brand-name prescription drugs, increased from \$2.5 billion in 2011 to \$4.1 billion in 2018 but then decreased to \$2.8 billion for 2019 and later.

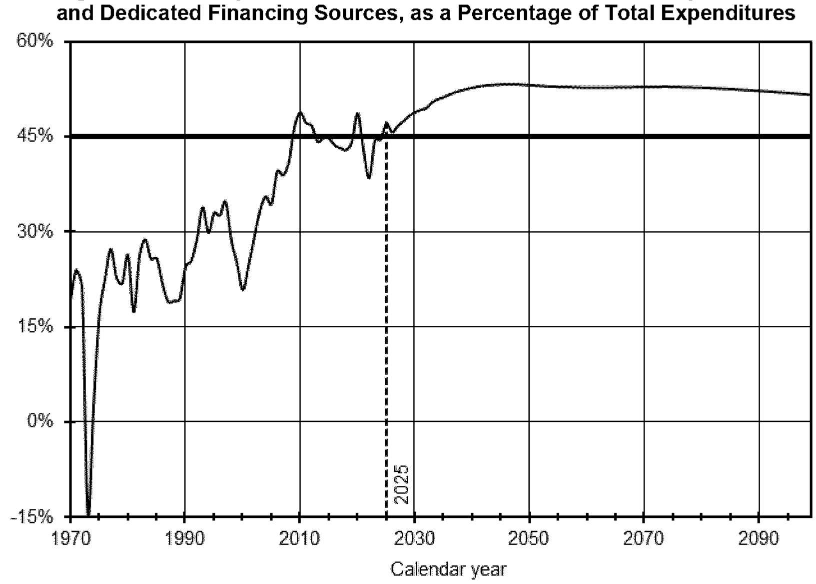
In the absence of legislation, HI tax income would represent a declining portion of total Medicare revenues. In 2033, for example, the projected year of depletion of the HI trust fund, currently scheduled HI payroll taxes would represent about 28 percent of total non-interest Medicare income. General fund transfers and beneficiary premiums would equal about 49 and 18 percent, respectively.

The law requires an expanded analysis of the combined expenditures and dedicated revenues of the HI and SMI trust funds. In particular, the law requires a determination as to whether the difference between total Medicare expenditures and its dedicated financing sources is projected to exceed 45 percent of total expenditures within the next 7 fiscal years (2025–2031). Dedicated Medicare financing sources include the following: HI payroll taxes; income from taxation of Social Security benefits; State payments for the prescription drug benefit; premiums paid under Parts A, B, and D; fees on brand-name prescription drugs paid to Part B; and any gifts received by the Medicare trust funds. The test uses expenditures adjusted to avoid temporary distortions arising from the payment of Medicare Advantage and Part D capitation amounts in September when the normal October payment date is a Saturday or Sunday.

The Trustees made determinations of excess general revenue Medicare funding in each of the reports for 2006 through 2013 and in the 2017 through 2024 reports. Two consecutive such determinations trigger a Medicare funding warning. The 2007 through 2013 reports, and the 2018 through 2024 reports, thus prompted Medicare funding warnings. The law specifies that in response to such findings the President must submit to Congress, within 15 days after the date of the Budget submission for the succeeding year, proposed legislation to respond to the warning. The law also requires Congress to consider the legislation proposed in response to Medicare funding warnings on an expedited basis. To date, elected officials have not enacted legislation responding to these funding warnings.

Figure V.B1 displays, on a calendar-year basis, the historical and projected ratio of the difference between total Medicare expenditures and dedicated financing sources to total Medicare expenditures. As indicated, this ratio exceeded 45 percent at the end of calendar years 2009 through 2012 and in calendar year 2020, and it is expected to again exceed that level at the end of calendar year 2025, the first year of the projection. Therefore, the Board of Trustees is issuing a determination of excess general revenue Medicare funding in this report. Since this is the ninth consecutive such finding, a Medicare funding warning is again triggered.

Figure V.B1.—Projected Difference between Total Medicare Expenditures and Dedicated Financing Sources, as a Percentage of Total Expenditures



As figure V.B1 also indicates, the Board projects that the difference between expenditures and dedicated funding sources will reach 53 percent of expenditures by 2049 and will decline to 52 percent by the end of the 75-year period. This difference between expenditures and dedicated funding sources, which the law refers to as general revenue Medicare funding, includes the following:

- Financing specified portions of SMI Part B and SMI Part D expenditures;
- Reimbursing the HI trust fund for the costs of certain uninsured beneficiaries;
- Paying interest on invested assets of the trust funds;

- Redeeming the special Treasury securities held as assets by the trust funds; and

- Financing the imbalance between HI expenditures and dedicated revenues after HI asset depletion.

Current law provides for the first four of these items. However, for the fifth—coverage of the HI shortfall—there is no provision under current law.

The law also requires a comparison of projected growth in the difference between expenditures and dedicated revenues with other health spending growth rates. Table V.B5 contains this comparison.

Table V.B5.—Comparative Growth Rates of Medicare, Private Health Insurance, National Health Expenditures, and GDP

	Average annual growth in:				
Calendar year	Incurred expenditures minus dedicated revenues	Incurred Medicare expenditures	GDP	National health expenditures[1]	Private health insurance[1]
2019	10.0%	7.3%	4.3%	4.4%	2.5%
2020	−0.4	3.6	−0.9	10.4	−0.4
2021	16.1	7.4	10.9	4.2	7.2
2022	−4.9	6.4	9.8	4.6	6.8
2023	15.8	8.7	6.6	7.5	11.5
2024	7.5	7.8	5.2	5.2	8.1
2025	13.8	7.5	4.5	4.9	5.3
2026	7.8	9.2	4.2	5.0	2.4
2027	10.5	8.8	4.1	5.9	4.9
2028	9.5	7.8	4.2	5.5	4.8
2029	9.9	8.1	4.2	5.8	4.8
2030	8.5	7.5	4.1	5.4	4.8
2031	7.6	6.7	4.1	5.4	4.8
2032	7.0	6.4	4.1	5.4	4.7
2033	10.6	8.5	4.1	6.0	4.7
2034	7.6	6.7	4.0	5.4	4.7
2035–2049	5.3	5.0	3.9	4.9	—
2050–2074	4.2	4.3	3.9	4.6	—
2075–2099	3.8	4.0	4.0	4.4	—

[1]Based on a national health expenditure projections article published in July 2024 (*Health Affairs*, vol. 43, no. 7). Data through 2023 are considered historical, and years after 2032 were determined based on the methods described in section IV.D. The findings presented in this article, along with the paper outlining its methodology, are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.

The COVID-19 pandemic had a significant effect on expenditures in 2020, but the impact on dedicated funding sources is delayed because program financing, which includes Part A payroll tax income and the Part B and Part D premiums, is set prospectively and is not able to be changed. This phenomenon results in the growth patterns shown in table V.B5. Beginning in 2025, the gap between expenditures and dedicated revenues will increase faster than expenditures in many years through 2049 since the dedicated sources of income to the HI trust fund will generally cover a decreasing percentage of HI expenditures.

In addition to projected Medicare expenditure growth, table V.B5 shows projected growth in GDP, total national health expenditures in the U.S., and private health insurance expenditures. The Trustees expect each of the health expenditure categories to continue the longstanding trend of increasing more rapidly than GDP in most years. Private health insurance expenditures equal the total premiums earned by private health insurers, including benefits incurred and the net cost of insurance. The net cost of insurance includes administrative costs, additions to reserves, rate credits and dividends, premium taxes, and profits or losses.

Several factors affect comparisons between aggregate Medicare and private health insurance cost growth:

- The number of Medicare beneficiaries is currently increasing by about 2 percent per year, and this growth rate will continue as more of the post-World War II baby boom generation reaches eligibility age. The number of individuals with private health insurance is estimated to increase at slower rates than the growth in the number of Medicare beneficiaries.

- Certain current-law provisions, such as the limitation on maximum out-of-pocket costs in 2014 and later, will also affect the average actuarial value of private health insurance benefits.

- The use of health care services differs significantly between Medicare beneficiaries (who are generally over 65) and individuals with private health insurance (who are predominantly below age 65). The former group, for example, has a higher incidence of hospitalization, skilled nursing care, and home health care. For the latter group, physician services represent a greater proportion of their total health care needs. Different cost growth trends by type of service will affect overall growth rates and reflect the distribution of services for each category of people.

- There is some overlap between people with Medicare and those with private health insurance. For example, many Medicare beneficiaries have supplemental health insurance coverage through private Medigap insurance policies or employer-sponsored retiree health benefits, and private health insurance includes both of these categories. About 10 million Medicare beneficiaries receive supplemental coverage through the Medicaid program; neither the growth rates for Medicare nor those for private health insurance reflect the Medicaid costs for these dual beneficiaries.

A number of research studies have attempted to control for some or all of these differences in comparing growth trends. Over long historical periods, average, demographically adjusted, per capita growth rates for common benefits have been somewhat lower for Medicare than for private health insurance. For shorter periods, however, the Medicare and private health insurance growth rates have often diverged substantially, and the differential has been negative in some years and positive in others. More information on past and projected national and private health expenditures, and on comparisons to Medicare growth rates, is available in the sources cited in table V.B5.

C. ILLUSTRATIVE ALTERNATIVE PROJECTIONS

The Social Security Act requires the Trustees to evaluate the financial status of the Medicare trust funds. To comply with this mandate, the Trustees must assess whether the financing provided under current law is adequate to cover the benefit payments and other expenditures required under current law. Accordingly, the estimates shown in this report are based on all of the current statutory requirements, including (i) the reductions in payment updates by the increase in economy-wide productivity for most non-physician provider categories and (ii) the physician payment updates specified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for all future years.

As discussed in the Introduction, there is substantial uncertainty regarding the adequacy of future Medicare payment rates under current law. This section illustrates the higher Medicare expenditures that would result if certain statutory Medicare payment provisions were not fully implemented in all future years. The assumptions that underlie the illustrative alternative and that transition from current law to the illustrative scenario are consistent with recommendations from the 2016–2017 Medicare Technical Review Panel.[101]

For all Part A services and some (non-physician) Part B services, payment updates have been reduced since 2012, and will be reduced in all future years, by the increase in economy-wide productivity.[102] In 2011, the Medicare payment rates for inpatient hospital services represented about 68 percent of those paid by private health insurance.[103] Based on price trends from the Bureau of Labor Statistics, this ratio fell to 55 percent in 2024.[104] If future improvements in productivity were to remain similar to what providers have achieved in the recent past (about 0.4 percent annually), then Medicare payment levels for inpatient hospital services at the end of the long-range projection period would be less than 40 percent of the corresponding level paid by private health insurance. This comparison assumes that private payer rate increases would continue to be set

[101]The 2016–2017 Medicare Technical Review Panel concluded that the ultimate assumptions underlying the illustrative alternative were reasonable (Finding 2-3) and recommended that they be implemented over a later time frame (Recommendation 2-4). These assumptions have been implemented since the 2018 report.

[102]In addition to the productivity adjustments, Medicare payments to providers will be affected by the sequestration of expenditures in April 2013 through October 2032.

[103]See https://www.aha.org/system/files/media/file/2020/10/TrendwatchChartbook-2020-Appendix.pdf. Private payer hospital payments are roughly 45 percent above costs while Medicare hospital payments are roughly 13 percent below costs.

[104]Based on the Producer Price Index for hospital inpatient care commodity prices by payer type. See https://www.bls.gov/ppi/.

through the same negotiation process used to date, independent of the Medicare reductions or other health system changes. Specifically, private payer rates would grow by 2.8 percent per year, or the increase in the price of inputs to the provision of health care (3.2 percent) less the assumed growth in hospital productivity (0.4 percent). By comparison, Medicare payment rates would grow by 2.2 percent per year, or 3.2 percent less the assumed growth in economy-wide productivity (1.0 percent).

Simulations that take into account the lower Medicare payment rates, other payment provisions, sequestration, changes to Medicare and Medicaid disproportionate share hospital payments, and coverage expansions collectively suggest a deterioration of facility margins for hospitals, skilled nursing facilities, and home health agencies, particularly over the long run. From 2023 through 2027, the simulations suggest that more hospitals would experience negative total facility margins and that roughly 5 percent more would experience negative Medicare margins. Other factors, such as efforts to improve efficiency in lower-performing hospitals, could mitigate some of the impact of the payment provisions under current law, though there is a wide range of uncertainty regarding these types of behavioral changes. By 2040, simulations suggest that over 40 percent of hospitals and over 50 percent of skilled nursing facilities and home health agencies would have negative total facility margins, raising the possibility of access and quality-of-care issues for Medicare beneficiaries. A memorandum on these provider margin simulations is available on the CMS website.[105]

Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers. Under such circumstances, lawmakers might feel substantial pressure to override the productivity adjustments, much as they did to prevent reductions in physician payment rates while the sustainable growth rate (SGR) system was in effect.

While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from

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[105]See https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf.

the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation. The law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.

A comparison with private rates provides some context. Medicare payment levels for physician services were roughly 82 percent of private health insurance rates in 2011. Medicare payment levels dropped to 71 percent of private rates by 2023[106] and are estimated to continue to fall to 64 percent of private rates by 2025. If Medicare rates continue to follow the prescribed current-law updates and private rates increase with Medicare Economic Index growth, then the Medicare rates will fall to 23 percent of private rates by the end of the 75-year projection period.

In view of these issues, it is important to note that the actual future costs for Medicare may exceed the projections shown in this report, possibly by substantial amounts. Use of an alternative projection can illustrate the potential magnitude of this difference.

It is conceivable that health care providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

A transformation of health care in the U.S., affecting both the means of delivery and the method of paying for care, is also a possibility. Private health insurance and Medicare are taking important steps in this direction by initiating programs of research into innovative payment and service delivery models, such as accountable care organizations, patient-centered medical homes, improvement in care coordination for individuals with multiple chronic health conditions,

[106]MedPAC Report to the Congress: Medicare Payment Policy, March 2025.

better coordination of post-acute care, payment bundling, pay for performance, and assistance for individuals in making informed health choices. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower health care spending to levels compatible with the lower price updates payable under current law.

The ability of new delivery and payment methods to lower cost growth rates is uncertain at this time. Preliminary indications are that some of these delivery reforms have had modest levels of success in lowering costs. It is too early to tell if these reductions in spending will continue or if they will grow to the magnitude needed to align with the statutory Medicare price updates. Given these uncertainties, it will be important for policymakers to monitor the adequacy of Medicare payment rates over time to ensure beneficiary access to high-quality care.

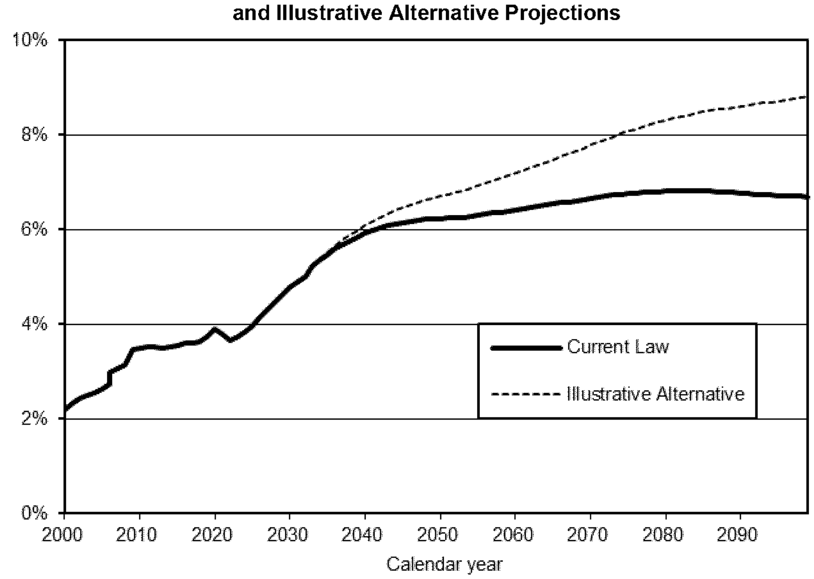
To help illustrate and quantify the potential magnitude of the cost understatement, a set of illustrative Medicare projections has been prepared under a hypothetical alternative.[107] The 2016–2017 Medicare Technical Review Panel recommended that the Trustees continue to prepare such a projection and that, under this illustrative alternative, Medicare spending reflect less than full implementation of the payment updates to providers specified under current law.[108]

There are multiple ways in which the law could be changed if these provider updates prove unsustainable. The illustrative scenario presented in this report is just one possibility among many that demonstrates the degree to which the current-law projections may be understated. While a particular set of illustrative alternative update assumptions for specific years is used, the transition from current law to the illustrative alternative ultimate assumptions over time is intended to reflect an increasing likelihood of modifications to current law rather than a specific forecast of when current law will cease to be

[107]The 2010–2011 Medicare Technical Review Panel supported the continued use of illustrative alternative projections for this purpose (Recommendation IV-3). In addition, the Panel recommended a graphical comparison of the current-law and alternative projections within the Medicare annual report, highlighting the potential effects of both the SGR system and productivity adjustments (Recommendation IV-4). The Panel's report, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections,* can be found at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf. The text summarizes the specific assumptions chosen by the Trustees for the illustrative alternative projections.
[108]See Recommendation 2-3 of the 2016–2017 Medicare Technical Review Panel report, available at https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf.

fully implemented. Figure V.C1 compares the illustrative alternative projection with the projections under current law.

Figure V.C1.—Medicare Expenditures as a Percentage of the Gross Domestic Product under Current Law and Illustrative Alternative Projections



Note: Percentages are affected by economic cycles.

The top curve in figure V.C1 shows the cost levels under the illustrative alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028–2042.[109] It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Under this alternative, the average long-range per beneficiary growth rate for all Medicare services would be similar to the long-range growth rate assumed for the overall health sector.

Under the illustrative alternative scenario, Medicare costs as a percentage of GDP continue to increase rapidly throughout the projection period, reaching 6.7 percent of GDP in 2049 and 8.8 percent in 2099—considerably higher than under current law (6.2 percent of GDP in 2049 and 6.7 percent of GDP in 2099).

[109]Section IV.D of this report describes the price component of health care cost increases for the overall health sector.

D. AVERAGE MEDICARE EXPENDITURES PER BENEFICIARY

Table V.D1 shows historical average per beneficiary expenditures for HI and SMI, as well as projected costs for calendar years 2025 through 2034 under the intermediate assumptions. Starting with the 2014 report, this section presents per beneficiary expenditures based on when the service is performed rather than when payment for the service is made.

For both HI and SMI Part B, costs increased very rapidly in the early years, in part because the availability of Medicare coverage enabled many beneficiaries to obtain the full range of health services they needed. The rapid inflation of the 1970s and early 1980s also contributed to rapid Medicare expenditure increases, and the cost-based reimbursement mechanisms in place provided relatively little incentive for efficiency in the provision of health care.

Growth in average HI expenditures moderated dramatically following the introduction of the inpatient hospital prospective payment system in fiscal year 1984, but it accelerated again in the late 1980s and early 1990s because of rapid growth in skilled nursing and home health expenditures. During this same period, SMI Part B average costs generally continued to increase at relatively fast rates, but cost growth slowed somewhat in the early 1990s with the implementation of physician fee reform legislation.

Expenditure growth moderated again during the late 1990s because of the effects of further legislation and efforts to control fraud and abuse. In addition, historically low levels of general and medical inflation helped reduce Medicare payment updates. The growth rates rebounded from 2001 through 2005 and then moderated somewhat for the remainder of the decade.

For 2010 through 2015, HI and Part B of SMI experienced the lowest 5-year per beneficiary growth rates in the program's history. This slow growth, which continued in 2016 and 2017 (and in 2018 for HI), was driven in part by legislated update reductions, low provider payment updates caused by the economic recession, and adjustments for documentation and coding that did not reflect changes in real case mix. In addition, increased enrollment resulting from eligibility of the baby boom generation has decreased the average age of Medicare beneficiaries, thereby reducing per beneficiary costs.

The growth rates also reflect the impact of the sequestration process, which is required under current law and reduces Medicare expenditures by 2 percent per year beginning April 1, 2013, through January 31, 2033, with two exceptions: May 1, 2020, through March 31, 2022, when it was suspended and April 1, 2022, through June 30, 2022, when the reduction was 1 percent. Finally, growth in the volume and intensity of the services delivered has also been relatively low, highlighted by reductions in the number of hospital admissions over this period.

Although SMI Part D began in 2004, full prescription drug coverage did not start until 2006. Accordingly, this discussion includes only the per beneficiary expenditures for 2006 and later. Spending growth occurred in 2011 but was negative in 2012 because of the patent expiration of certain high-cost drugs. The large amount of growth in 2014 and 2015 was due to utilization of the new, expensive specialty drugs used to treat hepatitis C. Lower utilization of these drugs contributed to the decline in average spending growth in 2016. In 2017, larger rebates caused average per beneficiary costs to drop, but growth in spending rebounded in 2018 and 2019. It slowed again in 2020 and 2021 because the plan bids assumed higher direct and indirect remuneration and slow reinsurance growth. The pattern of projected Part D expenditure growth reflects the impact of the provisions of the Inflation Reduction Act of 2022—specifically, the benefit enhancements, the phase-in of the drug manufacturer discount program for low-income beneficiaries for specific drugs, and the drug price negotiations that lower growth after 2026.

Table V.D1.—HI and SMI Average Incurred per Beneficiary Costs

Calendar year	Average per beneficiary costs: HI	SMI: Part B	SMI: Part D	Total[2]	Average percent change[1]: HI	SMI: Part B	SMI: Part D	Total
Historical data:								
1970	$270	$115	—	$385	13.8%	13.8%	—	13.8%
1975	472	205	—	677	11.8	12.3	—	12.0
1980	929	423	—	1,352	14.5	15.6	—	14.8
1985	1,579	795	—	2,373	11.2	13.4	—	11.9
1990	1,979	1,355	—	3,334	4.6	11.3	—	7.0
1995	3,194	1,867	—	5,061	10.0	6.6	—	8.7
2000	3,348	2,496	—	5,844	0.9	6.0	—	2.9
2005	4,439	3,839	—	8,278	5.8	9.0	—	7.2
2010	5,193	4,901	$1,808	11,902	3.2	5.0	—	7.5
2015	5,027	5,554	2,153	12,734	−0.6	2.5	3.6%	1.4
2016	5,094	5,672	2,156	12,922	1.3	2.1	0.2	1.5
2017	5,145	5,870	2,120	13,135	1.0	3.5	−1.7	1.6
2018	5,222	6,254	2,139	13,615	1.5	6.5	0.9	3.7
2019	5,413	6,651	2,175	14,239	3.7	6.3	1.7	4.6
2020	5,496	6,706	2,197	14,399	1.5	0.8	1.0	1.1
2021	5,620	7,345	2,206	15,171	2.3	9.5	0.4	5.4
2022	5,868	7,667	2,288	15,823	4.4	4.4	3.7	4.3
2023	6,121	8,274	2,431	16,826	4.3	7.9	6.2	6.3
2024	6,319	8,765	2,702	17,786	3.2	5.9	11.2	5.7
Intermediate estimates:								
2025	6,553	9,238	2,862	18,653	3.7	5.4	5.9	4.9
2026	6,915	10,050	2,903	19,868	5.5	8.8	1.4	6.5
2027	7,272	10,752	3,047	21,071	5.2	7.0	4.9	6.1
2028	7,649	11,354	3,187	22,189	5.2	5.6	4.6	5.3
2029	8,062	12,149	3,269	23,481	5.4	7.0	2.6	5.8
2030	8,436	13,018	3,341	24,796	4.6	7.2	2.2	5.6
2031	8,851	13,858	3,371	26,080	4.9	6.4	0.9	5.2
2032	9,294	14,752	3,369	27,416	5.0	6.5	0.0	5.1
2033	9,916	16,050	3,447	29,413	6.7	8.8	2.3	7.3
2034	10,388	17,111	3,528	31,027	4.8	6.6	2.4	5.5

[1]Percent changes for 1970 represent the average annual increases from 1967 (the first full year of trust fund operations) through 1970. Similarly, percent changes shown for 1975, 1980, 1985, 1990, 1995, 2000, 2005, and 2010 represent the average annual increase over the 5-year period ending in the indicated year.
[2]Represents the sum of the HI and SMI per beneficiary costs.

On average, annual increases in per beneficiary costs have been greater for SMI Part B than for HI during the previous five decades—by approximately 1.0 percent, 4.5 percent, 1.0 percent, 2.5 percent, and 2.6 percent per year in the 1970s, 1980s, 1990s, 2000s, and 2010s, respectively. The HI increase remains lower than the SMI Part B increase for all of the next 10 years because of lower utilization growth of HI services.

Note that the rapid growth rates in the 1970s and 1980s are not expected to recur for either HI or SMI Part B because of more moderate inflation rates and the conversion of Medicare's remaining cost-based reimbursement mechanisms to prospective payment systems. In addition, the reduction in Medicare price updates for most categories of providers that affected the growth rates over the last several years will continue to reduce growth rates throughout the projection period.

E. MEDICARE COST-SHARING AND PREMIUM AMOUNTS

HI beneficiaries who use covered services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the HI trust fund to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each of days 61–90 in the hospital. After 90 days in a spell of illness, each individual has 60 lifetime reserve days of coverage, for which the coinsurance amount is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each of days 21–100 of skilled nursing facility services furnished during a spell of illness. No cost sharing is required for home health or hospice services.

Most persons aged 65 and older and many disabled individuals under age 65 are insured for HI benefits without payment of any premium. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, subject to the payment of a monthly premium. In addition, since 1994, voluntary enrollees may qualify for a reduced premium if they have at least 30 quarters of covered employment.

Table V.E1 shows the historical levels of the HI deductible, coinsurance amounts, and premiums, as well as projected values for future years based on the intermediate set of assumptions used in estimating the operations of the trust funds. The values listed in the table for future years are estimates, and the actual amounts are likely to be somewhat different as experience emerges.

Table V.E1.—HI Cost-Sharing and Premium Amounts

Year	Inpatient hospital deductible[1]	Inpatient daily coinsurance[1] Days 61–90	Inpatient daily coinsurance[1] Lifetime reserve days	SNF daily coinsurance[1]	Monthly premium Standard[2]	Monthly premium Reduced[1]
Historical data:						
1970	$52	$13	$26	$6.50	—	—
1975	92	23	46	11.50	$40	—
1980	180	45	90	22.50	78	—
1985	400	100	200	50.00	174	—
1990	592	148	296	74.00	175	—
1995	716	179	358	89.50	261	$183
2000	776	194	388	97.00	301	166
2005	912	228	456	114.00	375	206
2010	1,100	275	550	137.50	461	254
2015	1,260	315	630	157.50	407	224
2016	1,288	322	644	161.00	411	226
2017	1,316	329	658	164.50	413	227
2018	1,340	335	670	167.50	422	232
2019	1,364	341	682	170.50	437	240
2020	1,408	352	704	176.00	458	252
2021	1,484	371	742	185.50	471	259
2022	1,556	389	778	194.50	499	274
2023	1,600	400	800	200.00	506	278
2024	1,632	408	816	204.00	505	278
2025	1,676	419	838	209.50	518	285
Intermediate estimates:						
2026	1,716	429	858	214.50	563	310
2027	1,768	442	884	221.00	592	326
2028	1,828	457	914	228.50	623	343
2029	1,888	472	944	236.00	657	361
2030	1,948	487	974	243.50	688	378
2031	2,012	503	1,006	251.50	722	397
2032	2,076	519	1,038	259.50	758	417
2033	2,144	536	1,072	268.00	809	445
2034	2,212	553	1,106	276.50	848	466

[1]Amounts shown are effective for calendar years.
[2]Amounts shown for 1970–1980 are for the 12-month periods ending June 30; amounts shown for 1985 and later are for calendar years.

The *Federal Register* notice[110] announcing the HI deductible and coinsurance amounts for 2025 included an estimate of the aggregate cost to HI beneficiaries for the changes in the deductible and coinsurance amounts from 2024 to 2025. At the time of the notice's publication, it was estimated that in 2025 there would be 4.91 million inpatient deductibles paid at $1,676 each, 1.21 million inpatient days subject to coinsurance at $419 per day (for hospital days 61 through 90), 0.61 million lifetime reserve days subject to coinsurance at $838 per day, and 24.46 million extended care days subject to coinsurance at $209.50 per day. Similarly, it was estimated that in 2024 there would be 5.00 million deductibles paid at $1,632 each, 1.23 million days subject to coinsurance at $408 per day (for hospital days 61 through 90), 0.62 million lifetime reserve days subject to coinsurance at $816 per day, and 24.66 million extended care days subject to coinsurance at $204.00 per day. The total increase in cost to

[110]See https://www.govinfo.gov/content/pkg/FR-2024-11-14/pdf/2024-26472.pdf.

beneficiaries was estimated to be $170 million as a result of the increase in the inpatient deductible and coinsurance amounts and the change in the number of deductibles and daily coinsurance amounts paid.

Table V.E2 displays the SMI cost-sharing and premium amounts for Parts B and D. The projected values for future years are based on the intermediate set of assumptions used in estimating the operations of the Part B and Part D accounts. As a result, these values are estimates, and the actual amounts are likely to be somewhat different as experience emerges.

The Part B premiums for 2010 and 2017 also reflect significant additional increases designed to offset the loss of revenues attributable to the hold-harmless provision, as described later in this appendix.

Table V.E2.—SMI Cost-Sharing and Premium Amounts

	Part B		Part D			
Calendar year	Standard monthly premium[1]	Annual deductible[2]	Base beneficiary premium	Deductible	Initial benefit limit[3]	Catastrophic threshold[3]
Historical data:						
1970	$4.00	$50	—	—	—	—
1975	6.70	60	—	—	—	—
1980	8.70	60	—	—	—	—
1985	15.50	75	—	—	—	—
1990	28.60	75	—	—	—	—
1995	46.10	100	—	—	—	—
2000	45.50	100	—	—	—	—
2005	78.20	110	—	—	—	—
2010	110.50	155	$31.94	$310	$2,830	$4,550
2015	104.90	147	33.13	320	2,960	4,700
2016	121.80	166	34.10	360	3,310	4,850
2017	134.00	183	35.63	400	3,700	4,950
2018	134.00	183	35.02	405	3,750	5,000
2019	135.50	185	33.19	415	3,820	5,100
2020	144.60	198	32.74	435	4,020	6,350
2021	148.50	203	33.06	445	4,130	6,550
2022	170.10	233	33.37	480	4,430	7,050
2023	164.90	226	32.74	505	4,660	7,400
2024	174.70	240	34.70	545	5,030	8,000
2025	185.00	257	36.78	590	—	2,000
Intermediate estimates:						
2026	206.50	288	38.99	615[4]	—	2,100[4]
2027	218.60	305	41.33	595	—	2,050
2028	231.30	323	43.81	570	—	1,950
2029	247.40	346	46.44	575	—	1,950
2030	264.70	370	49.26	575	—	1,950
2031	281.60	394	49.73	590	—	2,000
2032	300.80	421	49.56	605	—	2,050
2033	325.90	456	50.19	605	—	2,050
2034	347.50	486	51.25	605	—	2,050

[1]Amounts shown for 1970–1980 are for the 12-month periods ending June 30; amounts shown for 1985 and later are for calendar years.

[2]The Part B deductible was fixed by statute through 2005 and is to be indexed by average per beneficiary Part B expenditures thereafter.
[3]As required by the provisions of the Inflation Reduction Act 2022, the initial benefit limit will end at the catastrophic threshold beginning in 2025, and the catastrophic threshold will be reduced to $2,000 in that year. Thereafter, the catastrophic threshold will be indexed by program growth.
[4]This amount has already been finalized.

The Part B monthly premiums displayed in table V.E2 are the standard premium rates paid by most Part B enrollees. However, there are three provisions that alter the premium rate for certain Part B enrollees. First, there is a premium surcharge for those beneficiaries who enroll after their initial enrollment period.

Second, beginning in 2007, there is a higher income-related premium for those individuals whose modified adjusted gross income exceeds a specified threshold. Table V.E3 displays, for 2007 through 2034, the income-related premium adjustment amounts, the number of beneficiaries affected, and the aggregate additional premium amounts collected, based on the intermediate set of assumptions. In 2024, approximately 4.8 million beneficiaries paid a Part B income-related premium.

Table V.E3.—Part B Income-Related Premium Information

Calendar year	Income-related monthly adjustment amount[1]					Beneficiaries affected (millions)	Aggregate premiums[2] (billions)
	35%	50%	65%	80%	85%		
Historical data:							
2007	$12.30	$30.90	$49.40	$67.90	—	1.7	$0.7
2008	25.80	64.50	103.30	142.00	—	2.0	1.8
2009	38.50	96.30	154.10	211.90	—	2.2	2.9
2010	44.20	110.50	176.80	243.10	—	1.9	2.7
2011	46.10	115.30	184.50	253.70	—	1.6	2.3
2012	40.00	99.90	159.80	219.80	—	1.9	2.4
2013	42.00	104.90	167.80	230.80	—	2.2	2.9
2014	42.00	104.90	167.80	230.80	—	2.6	3.4
2015	42.00	104.90	167.80	230.80	—	2.9	3.8
2016	48.70	121.80	194.90	268.00	—	3.3	5.2
2017	53.50	133.90	214.30	294.60	—	3.5	6.0
2018	53.50	133.90	214.30	294.60	—	3.7	7.0
2019	54.10	135.40	216.70	297.90	$325.00	4.3	8.4
2020	57.80	144.60	231.40	318.10	347.00	4.7	10.0
2021	59.40	148.50	237.60	326.70	356.40	4.8	10.5
2022	68.00	170.10	272.20	374.20	408.20	4.4	11.1
2023	65.90	164.80	263.70	362.60	395.60	5.3	13.4
2024	69.90	174.70	279.50	384.30	419.30	4.8	12.8
2025	74.00	184.90	295.80	406.90	443.90	5.1	14.1
Intermediate estimates:							
2026	82.60	206.50	330.40	454.30	495.60	5.7	17.5
2027	87.40	218.60	349.80	480.90	524.60	6.0	19.6
2028	92.50	231.20	370.00	508.70	555.00	6.4	22.0
2029	99.00	247.40	395.80	544.30	593.80	6.8	25.0
2030	105.80	264.60	423.40	582.20	635.10	7.2	28.1
2031	112.60	281.50	450.40	619.40	675.70	7.5	31.4
2032	120.30	300.70	481.20	661.60	721.80	7.9	35.3
2033	130.30	325.80	521.30	716.80	782.00	8.2	39.9
2034	139.00	347.50	556.00	764.50	834.00	8.6	44.5

[1]Amount is based on the applicable percentage of program cost represented by the premium and also reflects the impact of the 3-year transition in 2007 and 2008. The Bipartisan Budget Act of 2018 created an additional premium level for 2019 and later.
[2]Represents the total amount paid by affected beneficiaries in excess of the Part B standard premium.

In 2025 the initial threshold is $106,000 for an individual tax return and $212,000 for a joint return. The thresholds were not indexed to inflation in the years 2011 through 2019 but are indexed thereafter. Individuals exceeding the threshold will pay premiums covering 35, 50, 65, 80, or, beginning in 2019, 85 percent of the average program cost for aged beneficiaries, depending on their income level, compared with the standard premium covering 25 percent.

Effective in 2018, the Medicare Access and CHIP Reauthorization Act of 2015 lowered certain income thresholds used for determining the income-related monthly adjustment amounts to be paid by beneficiaries, resulting in a greater number of beneficiaries paying the higher amounts. In addition, beginning in 2020, the legislation adjusted the methodology used to index the thresholds, and accordingly more beneficiaries will be subject to the income-related premiums. The Bipartisan Budget Act of 2018 (BBA 2018) established an additional premium level beginning in 2019 for individuals with incomes at or above $500,000 (and couples with incomes at or above $750,000), and they will pay a premium covering 85 percent of the average program cost. These new thresholds will not be indexed until 2028 and later.

The third provision that may cause Part B premiums to vary from the standard rate is a hold-harmless provision that can lower the premium rate for individuals who have their premiums deducted from their Social Security benefits. On an individual basis, this provision limits the dollar increase in the Part B premium to the dollar increase in the individual's Social Security benefit. As a result, the person affected pays a lower Part B premium, and the net amount of the individual's Social Security benefit does not decrease despite the greater increase in the premium.

Most services under Part B are subject to an annual deductible and coinsurance. The annual deductible was set by statute through 2005. Thereafter, it increases with the increase in the Part B aged actuarial rate to approximate the growth in per capita Part B expenditures.[111] After meeting the deductible, the beneficiary pays an amount equal to the product of the coinsurance percentage and the remaining allowed charges.

The coinsurance percentage is 20 percent for most services. However, since the coinsurance payment for a service paid under the outpatient hospital prospective payment system is capped at the inpatient hospital deductible amount, the average coinsurance percentage for these services was about 18 percent in 2018 and is expected to gradually decline in the projection period. For those services not subject to the deductible or coinsurance (clinical laboratory tests, home health agency services, and most preventive care services), the beneficiary pays nothing.

The Part D average premiums displayed in table V.E2 are the estimated base beneficiary premiums. Starting in 2009, the national average monthly bid amount is based on the enrollment-weighted average. The actual premium that a beneficiary pays varies according to the plan in which the beneficiary enrolls. The average paid premium has always been lower than the base beneficiary premium. Since beneficiaries may switch plans each year once the premium rates become known, the Trustees assume that the estimated average premium rate paid by beneficiaries will continue to be somewhat less than the base beneficiary premium in future years. In 2024, the average paid premium was $33.59, and it is projected to be $24.06 in 2025. (The substantial decrease in 2025 is due to the 3-year voluntary Part D premium stabilization demonstration for prescription drug plans.)

Similar to Part B, there are two provisions that affect the premium rate for certain Part D beneficiaries. First, there is a Part D late enrollment penalty for those beneficiaries enrolling after their initial enrollment period. Second, starting in 2011, individuals whose modified adjusted gross income exceeds the same thresholds applicable to the Part B premium pay an income-related premium in addition to the premium charged by the plan in which the individual enrolled. The amount of the income-related premium adjustment is dependent on the individual's income level, and the extra premium amount is the

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[111]The current mechanism to index the Part B deductible has technical computational issues that are mainly attributable to the timing of the calculation. The Part B deductible for any given year is indexed by the increase in the monthly aged actuarial rate for that same year, which represents estimated monthly per capita expenditures. However, these expenditures are dependent on the Part B deductible, which is not known until the actuarial rate is determined. The result is circularity in the modeling process.

difference between 35, 50, 65, 80, or 85 percent and 25.5 percent,[112] applied to the national average monthly bid amount adjusted for reinsurance. In addition, the changes to the income ranges and threshold methodology that were previously described for Part B also apply to Part D.

Table V.E4 displays, for 2011 through 2034, the Part D income-related premium adjustment amounts, the number of beneficiaries affected, and the aggregate additional premium amounts collected, based on the intermediate set of assumptions. In 2024, approximately 4.2 million beneficiaries paid a Part D income-related premium.

Table V.E4.—Part D Income-Related Premium Information

Calendar year	Income-related monthly adjustment amount[1] 35%	50%	65%	80%	85%	Beneficiaries affected (millions)	Aggregate premiums[2] (billions)
Historical data:							
2011	$12.00	$31.10	$50.10	$69.10	—	0.9	$0.3
2012	11.60	29.90	48.10	66.40	—	1.1	0.4
2013	11.60	29.90	48.30	66.60	—	1.5	0.5
2014	12.10	31.10	50.20	69.30	—	1.8	0.7
2015	12.30	31.80	51.30	70.80	—	2.1	0.9
2016	12.70	32.80	52.80	72.90	—	2.5	1.0
2017	13.30	34.20	55.20	76.20	—	2.7	1.2
2018	13.00	33.60	54.20	74.80	—	2.9	1.4
2019	12.40	31.90	51.40	70.90	$77.40	3.4	1.6
2020	12.20	31.50	50.70	70.00	76.40	3.8	1.8
2021	12.30	31.80	51.20	70.70	77.10	3.9	1.8
2022	12.40	32.10	51.70	71.30	77.90	3.6	1.7
2023	12.20	31.50	50.70	70.00	76.40	4.4	2.2
2024	12.90	33.30	53.80	74.20	81.00	4.2	2.2
2025	13.70	35.30	57.00	78.60	85.80	4.4	2.3
Intermediate estimates:							
2026	14.50	37.50	60.40	83.30	91.00	5.0	2.9
2027	15.40	39.70	64.00	88.30	96.40	5.3	3.1
2028	16.30	42.10	67.90	93.60	102.20	5.7	3.6
2029	17.30	44.60	71.90	99.30	108.40	6.0	4.1
2030	36.90	73.90	110.80	147.80	160.10	6.4	6.8
2031	37.30	74.60	111.90	149.20	161.60	6.7	7.2[3]
2032	37.20	74.30	111.50	148.70	161.10	7.0	7.6
2033	37.60	75.30	112.90	150.60	163.10	7.3	8.0
2034	38.40	76.90	115.30	153.80	166.60	7.7	8.6

[1]Amount is based on the applicable percentage of program cost represented by the premium. The Bipartisan Budget Act of 2018 created an additional premium level for 2019 and later.
[2]Represents the total amount paid by affected beneficiaries in excess of the Part D plan premium.
[3]The income-related monthly adjustment amounts will increase more rapidly beginning in 2030 because of the new base beneficiary premium percentage specified by the Inflation Reduction Act of 2022.

In addition, there are Part D premium and cost-sharing subsidies for those beneficiaries with incomes less than 150 percent of the Federal poverty level and with assets, including burial expenses, in 2025 that amount to less than $17,600 for an individual and $35,130 for a couple. The asset thresholds are indexed in subsequent years by the Consumer

[112]Beginning in 2030, the base beneficiary premium percentage will be reset according to the specifications of the Inflation Reduction Act of 2022.

Price Index (CPI-U). Under the current statutory adjustment formula, the asset figures for 2025 increase for both an individual and a couple as a result of increases in the CPI-U.

Under standard Part D coverage, there is an initial deductible. After meeting the deductible, beneficiaries pay 25 percent of the remaining costs up to the initial benefit limit. Beyond this limit, prior to 2011, beneficiaries paid all the drug costs until their total out-of-pocket expenditures reached the catastrophic threshold. (This total includes the deductible and coinsurance payments for expenses up to the initial benefit limit.) The coverage gap was to be gradually closed beginning in 2011 until 2020, and then BBA 2018 required the coverage gap for brand-name drugs to close 1 year earlier, in 2019. Starting in 2020, for all drugs, beneficiaries pay 25 percent of the costs between the deductible and the catastrophic threshold under the standard coverage. Beginning in 2024, under the Inflation Reduction Act of 2022, there is no cost sharing for beneficiaries after they reach the catastrophic threshold.

The initial deductible amount from 2025 is indexed annually by per enrollee Part D average costs. The catastrophic threshold will be set at $2,100 in 2026 and will also be indexed annually. Beneficiaries qualifying for the Part D low-income subsidy pay substantially reduced premium and cost-sharing amounts. Many Part D plans offer alternative coverage that differs from the standard coverage described above. The majority of beneficiaries have not enrolled in the standard benefit design but rather in plans with low or no deductibles or flat copayments for covered drugs.

F. MEDICARE AND SOCIAL SECURITY TRUST FUNDS AND THE FEDERAL BUDGET

One can view the financial operations of Medicare and Social Security in the context of the programs' trust funds or in the context of the overall Federal budget. The financial status of the trust funds differs fundamentally from the impact of these programs on the budget, and people often misunderstand the relationship between these two perspectives. Each perspective is appropriate and important for its intended purpose; this appendix attempts to clarify their roles and relationship.

By law, the annual reports of the Medicare and Social Security Boards of Trustees to Congress include a statement of the financial status of the programs' trust funds—that is, whether these funds have sufficient revenues and assets to enable the payment of benefits and administrative expenses. This trust fund perspective is important because the existence of trust fund assets provides the statutory authority to make such payments without the need for an appropriation from Congress. Under current law, Medicare and Social Security benefits can be paid only if the relevant trust fund has sufficient income or assets.

The trust fund perspective does not encompass the interrelationship between the Medicare and Social Security trust funds and the overall Federal budget. The budget is a comprehensive display of all Federal activities, whether financed through trust funds or from the general fund of the Treasury. This broader focus may appropriately be termed the budget perspective or government-wide perspective and is officially presented in the *Budget of the United States Government*[113] and in the *Financial Report of the United States Government*.[114]

Payroll taxes, income taxes on Social Security benefits, Medicare premiums, and special State payments to Medicare finance the majority of Medicare and Social Security costs. In addition to these earmarked receipts from workers, employers, beneficiaries, and States, and interest payments on their accumulated assets, the trust funds (principally the SMI trust fund) rely on Federal general fund revenues for some of their financing. The financial status of a trust fund appropriately considers all sources of financing provided for that fund,

[113]https://www.whitehouse.gov/wp-content/uploads/2024/03/budget_fy2025.pdf
[114]https://www.fiscal.treasury.gov/files/reports-statements/financial-report/2024/01-16-2025-FR-(Final).pdf

including the availability of trust fund assets that Medicare or Social Security can use to meet program expenditures.

From a budget perspective, however, general fund transfers represent a draw on other Federal resources for which there is no earmarked source of revenue from the public. For this appendix, interest payments to the trust funds and asset redemptions, both of which occur because of the postponed use of earmarked revenues, are classified as draws on other Federal resources, since they require payments from the Treasury general fund. The budget perspective does not reflect that publicly held debt and interest payments to the public are both lower because the trust funds hold some of the debt.

At the beginning of the Medicare program, general fund and interest payments were relatively small. These amounts have been increasing, and the expected future growth of Medicare and Social Security will make their interaction with the Federal budget increasingly important. As the difference between earmarked and total trust fund revenues grows, the financial operations of Social Security and Medicare can appear markedly different depending on which of the two perspectives one uses.[115]

Illustration with Actual Data for 2024

Table V.F1 illustrates the trust fund and budget perspectives using actual data on Federal financial operations for fiscal year (FY) 2024. The first three columns show revenues and expenditures for HI, SMI, and OASDI, respectively, and the fourth ("Combined") column is the sum of these three columns. The sixth ("Total") column shows total revenues and expenditures for the total Federal budget, and the fifth ("Other") column presents all other Federal programs (including the general fund account of the Treasury) and is calculated as the difference between the amounts in the "Total" column and the amounts in the "Combined" column. The table shows earmarked revenues from the public separately from revenues from other government accounts (general revenue transfers and interest credits). Note that the

[115]A more complete treatment of this topic appears in a May 2009 Treasury report titled "Social Security and Medicare Trust Funds and the Federal Budget" at https://home.treasury.gov/system/files/226/ep_budget_trust_fund_perspectives_2009.pdf. Additional information is available in a *Health Care Financing Review* article titled "Medicare Financial Status, Budget Impact, and Sustainability: Which Concept Is Which?" at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/05-06Winpg127.pdf and in a *Social Security Bulletin* article titled "Social Security Trust Fund Cash Flows and Reserves" at https://www.ssa.gov/policy/docs/ssb/v75n1/v75n1p1.html.

transfers and interest credits received by the trust funds are the key differences between the two perspectives.

Table V.F1.—Annual Revenues and Expenditures for Medicare and Social Security Trust Funds and the Total Federal Budget, Fiscal Year 2024[1]
[In billions]

Revenue and expenditures categories	Trust funds: HI	Trust funds: SMI	Trust funds: OASDI	Trust funds: Combined	Other	Total
Revenues from public:						
Payroll and benefit taxes	$431.7	—	$1,337.0	$1,768.7	—	$1,768.7
Premiums[2]	5.0	$157.1	—	162.1	—	162.1
Other taxes, fees, and payments[3]	1.6	21.1	—	22.8	$3,128.0	3,150.8
Total	438.3	178.3	1,337.0	1,953.6	3,128.0	5,081.5
Total expenditures to public[4]	402.6	652.4	1,460.9	2,516.0	4,425.0	6,940.9
Net Results for Budget Perspective	**35.7**	**−474.2**	**−123.9**	**−562.4**	**−1,297.0**	**−1,859.4**
Revenues from other government accounts:						
Transfers	1.2	476.1	0.0	477.2	n/a	n/a
Interest credits	6.1	4.0	67.4	77.5	n/a	n/a
Total	7.2	480.1	67.4	554.7	n/a	n/a
Net Results for Trust Fund Perspective	**43.0**	**5.9**	**−56.5**	**−7.6**	**n/a**	**n/a**

[1]The "Total" column presents estimated revenues and expenditures for the total Federal budget in fiscal year 2024. The total revenue and expenditure amounts can be found in Historical Table 1.1 of the FY 2025 President's Budget, and the figure $1,859.4 billion is the difference between these amounts and represents the estimated total Federal budget deficit for fiscal year 2024. Amounts reported for the "Trust funds" columns represent actual operations based on information in the Monthly Treasury Statement and are presented throughout the Trustees Reports. "Other" amounts are calculated as the difference between the amounts in the "Total" column and the amounts in the "Combined" column under "Trust funds."
[2]Includes Part D premiums paid directly to plans, which are not displayed on Treasury statements and are estimated.
[3]Includes Part D State payments, Part B drug fees, and other miscellaneous items.
[4]The OASDI figure includes $5.9 billion transferred to the Railroad Retirement Board.

Notes: 1. For comparison, HI taxable payroll, OASDI taxable payroll, and GDP were $12,710 billion, $10,124 billion, and $29,170 billion, respectively, in 2024.
2. Totals do not necessarily equal the sums of rounded components.
3. n/a indicates not applicable.

The trust fund perspective reflects both categories of revenues for each trust fund. For HI, revenues from the public plus transfers/credits from other government accounts were $43.0 billion more than total expenditures in FY 2024, as shown at the bottom of the first column.[116] For the SMI trust fund, the statutory revenues from beneficiary premiums, State payments, general revenue transfers, and interest earnings collectively were $5.9 billion more than expenditures in FY 2024. Note that it is appropriate to view the general revenue transfers from other government accounts as financial resources from

[116]The Department of the Treasury invests surplus revenues from the public over expenditures to the public in special Treasury securities, which thereby represent a loan from the trust funds to the general fund of the Federal Government. These loans reduce the amount that the general fund has to borrow from the public to finance a deficit (or likewise increase the amount of debt paid off if there is a surplus). Interest is credited to the trust funds while the securities are being held. Trust fund securities can be redeemed at any time if needed to help meet program expenditures.

the trust fund perspective since they are available to help meet trust fund expenditures. For OASDI, total trust fund revenues from all sources (including $67.4 billion in interest payments and $0.0 billion in general fund reimbursements) were $56.5 billion less than expenditures.

From the government-wide or budget perspective, only earmarked revenues received from the public—principally taxes on payroll and benefits, plus premiums—and expenditures made to the public are important for the final balance.[117] For HI, the difference between such revenues ($438.3 billion) and total expenditures made to the public ($402.6 billion) was $35.7 billion in FY 2024, indicating that HI had a positive effect on the overall budget in FY 2024. For SMI, beneficiary premiums, fees on brand-name prescription drugs to Part B, and State payments to Part D of Medicare were the only sources of revenues from the public in FY 2024 and represented only about 27 percent of total expenditures. The remaining $474.2 billion in FY 2024 expenditures represented a substantial net draw on the Federal budget in that year.[118]

For OASDI, the difference between revenues from the public ($1,337.0 billion) and total expenditures ($1,460.9 billion) was $123.9 billion, indicating that OASDI also had a negative effect on the overall budget last year if the effects of past trust fund cash flows on interest payments from the Federal Government to the public are not taken into account.

Thus, from the trust fund perspective, HI and SMI both had an annual surplus in FY 2024, and OASDI had a deficit. From the budget perspective, HI had a surplus, and SMI and OASDI each required a net draw on the budget. HI, SMI, and OASDI collectively had a trust fund deficit of $7.6 billion in FY 2024 and a net draw of $562.4 billion on the budget.

It is important to recognize that each viewpoint is appropriate for its intended purpose but that one perspective cannot be used to answer questions related to the other. In the case of SMI, the trust fund will always be in balance and there will always be a net draw on the Federal

[117]For this purpose, the public includes State governments since they are outside of the Federal Government.

[118]Three types of trust fund transactions constituted this net budget obligation: $476.1 billion was drawn in the form of general revenue transfers, and another $4.0 billion in interest payments, while $5.9 billion was transferred to the general fund from the trust fund through the redemption of special-issue Treasury securities in an amount equal to the trust fund deficit for the year.

budget. In the case of HI, trust fund surpluses in a given year may occur with either a positive or negative direct impact on the budget for that year. Conversely, a positive or negative budget impact from HI offers minimal insight into whether its trust fund has sufficient total revenues and assets to permit payment of benefits.

The next section illustrates the magnitude of the long-range difference between projected expenditures and revenues for Medicare and Social Security from both the trust fund and budget perspectives.

Future Obligations of the Trust Funds and the Budget

Table V.F2 collects from the Medicare and OASDI Trustees Reports the present values of projected future revenues and expenditures over the next 75 years. For HI and OASDI, tax revenues from the public are projected to fall short of statutory expenditures by \$3.3 trillion and \$27.9 trillion, respectively, in present value terms.[119]

Table V.F2.—Present Values of Projected Revenue and Cost Components of 75-Year Open-Group Obligations for HI, SMI, and OASDI
[In trillions, as of January 1, 2025]

Revenue and expenditure categories	HI	SMI	OASDI	Combined
Revenues from public:				
Payroll and benefit taxes	\$32.6	—	\$92.4	\$124.9
Premiums	0.5	\$21.2	—	21.6
Other taxes and fees[1]	0.1	1.1	—	1.2
Total	33.1	22.2	92.4	147.7
Total expenditures to public	36.4	79.3	120.2	235.9
Net Results for Budget Perspective	**−3.3**	**−57.0**	**−27.9**	**−88.2**
Revenues from other government accounts:				
Transfers	0.0	56.9	0.0	57.0
Interest credits	n/a	n/a	n/a	n/a
Total	0.0	56.9	0.0	57.0
Trust fund assets on January 1, 2025	0.2	0.2	2.7	3.1
Net Results for Trust Fund Perspective	**−3.1**	**0.1**	**−25.1**	**−28.1**

[1]Includes Part B revenues from fees on manufacturers and importers of brand-name prescription drugs and Part D State payments.

Notes:
1. For comparison, the present values of HI taxable payroll, OASDI taxable payroll, and GDP are \$813.0 trillion, \$689.6 trillion, and \$1,882.3 trillion, respectively, over the next 75 years. This present value of GDP is calculated using HI-specific interest discount factors and differs slightly from the corresponding amount shown in the OASDI Trustees Report.
2. Medicare present values are calculated using HI-specific discount factors, while OASDI amounts use OASDI-specific discount factors.
3. Totals do not necessarily equal the sums of rounded components.
4. n/a indicates not applicable.
5. 0.0 indicates an amount of less than \$50 billion.

[119]Interest income is not a factor in this table, as dollar amounts are in present value terms.

From the budget perspective, these are the additional amounts that would be necessary in order to pay HI and OASDI benefits and other costs at the level scheduled over the next 75 years. From the trust fund perspective, the amounts needed are smaller by the value of the accumulated assets in the respective trust funds—$0.2 trillion for HI and $2.7 trillion for OASDI—that could be drawn down to cover a part of the projected shortfall in tax revenues. Three points about this comparison in table V.F2 are important to note:

- The trust fund and budget perspectives differ in the treatment of the starting trust fund assets. Those accumulated reserves are credited to the trust fund programs under the trust fund perspective but are not under the budget perspective.

- The amounts shown in table V.F2 assume payment of full scheduled benefits, which is not permissible under current law after trust fund depletion. For both the budget and trust fund perspectives, the 75-year HI and OASDI deficits reflect the financial imbalance after trust fund depletion. By law, however, once assets are depleted, expenditures cannot be made except to the extent covered by ongoing tax receipts and other trust fund income.

- In practice, the long-range HI and OASDI deficits would likely be addressed by future legislation to reduce expenditures, increase payroll or other earmarked tax revenues, or some combination of such measures. For Medicare, in particular, lawmakers have frequently enacted legislation to slow the growth of expenditures.

The situation for SMI is somewhat different. SMI expenditures for Part B and Part D are projected to exceed premium and other dedicated revenues by $57.0 trillion. To keep the SMI trust fund solvent for the next 75 years will require general fund transfers of this amount, and these transfers represent a formal budget requirement. From the trust fund perspective, the present value of projected total premiums and general revenues is about equal to the present value of future expenditures.

From the 75-year budget perspective, the present value of the additional resources that would be necessary to meet projected expenditures, for the three programs combined, is $88.2 trillion.[120] To

[120]As noted previously, the long-range HI and OASDI financial imbalances could instead be partially addressed by expenditure reductions, thereby reducing the need for additional revenues. Similarly, SMI expenditure reductions would reduce the need for general fund transfers.

put this very large figure in perspective, it would represent 4.7 percent of the present value of projected GDP over the same period ($1,882 trillion). The components of the $88.2 trillion total are as follows:

Unfunded Medicare and OASDI obligations (trust fund perspective)[121]	$28.1 trillion	(1.5% of GDP)
HI, SMI, and OASDI asset redemptions	3.1 trillion	(0.2% of GDP)
SMI general revenue financing	57.0 trillion	(3.0% of GDP)

These resource needs would be in addition to the payroll taxes, benefit taxes, and premium payments. As noted, the asset redemptions and SMI general revenue transfers represent formal budget commitments, but no provision exists for covering the HI and OASDI trust fund deficits once assets are depleted.

As discussed throughout this report, the Medicare projections shown here could be substantially understated as a result of other potentially unsustainable elements of current law. Although this issue does not affect the nature of the budget and trust fund perspectives described in this appendix, it is important to note that actual long-range present values for HI expenditures and SMI expenditures and revenues could exceed the amounts shown in table V.F2 by a substantial margin.

[121]Additional revenues and/or expenditure reductions totaling $28.1 trillion, together with $3.1 trillion in asset redemptions, would cover the projected financial imbalance but would leave the HI and OASDI trust funds depleted at the end of the 75-year period. The long-range actuarial deficits for HI and OASDI include a cost factor to allow for a normal level of fund assets. See section III.B3 in this report, and section IV.B4 in the OASDI Trustees Report, for the numerical relationship between the actuarial deficit and the unfunded obligations of each program.

G. INFINITE HORIZON PROJECTIONS

Consistent with the practice of previous reports, this report focuses on the 75-year period 2025–2099 for the evaluation of the long-range financial status of the Medicare program. The estimates are for the open-group population—all persons, some of whom are not yet born, who will participate during the period as either taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 75 years.

Experts have noted that limiting the projections to 75 years understates the magnitude of the long-range unfunded obligations because summary measures (such as the actuarial balance and *open-group unfunded obligations*) reflect the full amount of taxes paid by the next two or three generations of workers, but not the full amount of their benefits. One approach to addressing the limitations of 75-year summary measures is to extend the projection horizon indefinitely, so that the overall results reflect the projected costs and revenues after the first 75 years.[122] Such extended projections can also help indicate whether the financial imbalance would be improving or continuing to worsen beyond the normal 75-year period.

Table V.G1 presents estimates of HI unfunded obligations that extend to the infinite horizon. The extension assumes that the HI program and the demographic and economic trends used for the 75-year projection continue indefinitely except that average HI expenditures per beneficiary increase at the same rate as GDP per capita less the productivity adjustments after 2099. If the slower HI price updates under current law were able to continue indefinitely, then the HI financial imbalance would actually improve beyond the 75-year period.[123] Specifically, under these assumptions, extending the calculations beyond 2099 *subtracts* \$18.3 trillion in unfunded obligations from the amount estimated through 2099. Over the infinite horizon, the HI program thus has a projected surplus of \$15.2 trillion.

[122]The calculation of present values, in effect, applies successively less weight to future amounts over time, through the process of interest discounting. For example, the weights associated with the 25th, 75th, and 200th years of the projection would be about 35.1 percent, 3.5 percent, and 0.01133 percent, respectively, of the weight for the first year. In this way, it is possible to calculate a finite summary measure for an infinite projection period.

[123]It is important to note that the actual future costs for Medicare may exceed the projections shown in this report, possibly by substantial amounts. See section V.C for details on the illustrative alternative projections.

Table V.G1.—Unfunded HI Obligations from Program Inception through the Infinite Horizon

[Present values as of January 1, 2025; dollar amounts in trillions]

		As a percentage of:	
	Present value	HI taxable payroll	GDP
Unfunded obligations through the infinite horizon[1]	−$15.2	−0.9%	−0.3%
Unfunded obligations from program inception through 2099[1]	3.1	0.4	0.2

[1]Present value of future expenditures less income, reduced by the amount of trust fund assets at the beginning of the period.

Notes: 1. The present values of future HI taxable payroll for 2025–2099 and for 2025 through the infinite horizon are $813.0 trillion and $1,711.1 trillion, respectively.

2. The present values of GDP for 2025–2099 and for 2025 through the infinite horizon are $1,882.3 trillion and $4,431.4 trillion, respectively. (These present values differ slightly from the corresponding amounts shown in the OASDI Trustees Report because of the use of HI-specific interest discount factors.)

It is possible to separate the projected HI unfunded obligation over the infinite horizon into the portions associated with current participants versus future participants. The first line of table V.G2 shows the present value of future expenditures less future taxes for current participants, including both beneficiaries and covered workers. Subtracting the current value of the HI trust fund (the accumulated value of past HI taxes less expenditures) results in a closed-group unfunded obligation of $14.2 trillion. In contrast, the projected difference between taxes and expenditures for future participants is a surplus of $29.4 trillion.

The year-by-year HI deficits described in section III.B have shown that HI taxes will not be adequate to finance the program on a pay-as-you-go basis (whereby payroll taxes from today's workers provide benefits to today's beneficiaries).[124] The unfunded obligations shown in table V.G2 for current participants further indicate that their HI taxes are not adequate to cover their own future costs when they become eligible for HI benefits—and that this situation has also occurred for workers in the past. For future workers, however, the compounding effects of the lower HI price updates would, if they were able to continue indefinitely, lower costs to the point that scheduled HI taxes would be more than sufficient.

In practice, lawmakers could address the projected aggregate HI deficits by raising additional revenue or reducing benefits (or some combination of these actions). The impact of such changes on the unfunded obligation amounts for current versus future participants would depend on the specific policies selected.

[124]As noted previously, the HI trust fund also receives small amounts of income in the form of income taxes on OASDI benefits, interest, and general fund reimbursements for certain uninsured beneficiaries.

Table V.G2.—Unfunded HI Obligations for Current and Future Program Participants through the Infinite Horizon
[Present values as of January 1, 2025; dollar amounts in trillions]

		As a percentage of:	
	Present value	HI taxable payroll	GDP
Future expenditures less income for current participants	$14.4	0.8%	0.3%
Less current trust fund (income minus expenditures to date for past and current participants)	0.2	0.0	0.0
Equals unfunded obligations for past and current participants[1]	14.2	0.8	0.3
Plus expenditures less income for future participants for the infinite horizon	−29.4	−1.7	−0.7
Equals unfunded obligations for all participants for the infinite future	−15.2	−0.9	−0.3

[1]This concept is also referred to as the closed-group unfunded obligation.

Notes: 1. The estimated present value of future HI taxable payroll for 2025 through the infinite horizon is $1,711.1 trillion.
2. The estimated present value of GDP for 2025 through the infinite horizon is $4,431.4 trillion. See note 2 in table V.G1.
3. Totals do not necessarily equal the sums of rounded components.

Tables V.G3 and V.G4 show the infinite horizon estimates for Part B. The extension assumes that the demographic and economic trends used for the 75-year projection continue indefinitely and that the productivity adjustments to payment updates for some providers remain unchanged. To simplify and stabilize the modeling for the infinite horizon, the Trustees project that average Part B expenditures per beneficiary will increase at about the same rate as GDP per capita minus 0.3 percentage point in every year, reflecting the mix of costs by provider category after 2099 and the payment rate updates applicable to each category.

Table V.G3 shows an estimated present value of Part B expenditures through the infinite horizon of $157.5 trillion, of which $68.5 trillion would occur during the first 75 years. Because such amounts, calculated over extremely long horizons, can be difficult to interpret, they are also shown as percentages of the present value of future GDP. So expressed, for both time periods, the corresponding figure is 3.6 percent. The table also indicates that beneficiary premiums will finance approximately 28 percent of expenditures for each time period and that fees related to brand-name prescription drugs will finance about 0.1 percent. Government contributions pay for the remaining 72 percent.

Table V.G3.—Unfunded Part B Obligations from Program Inception through the Infinite Horizon

[Present values as of January 1, 2025; dollar amounts in trillions]

	Present value	As a percentage of GDP
Unfunded obligations through the infinite horizon[1]	$0.0	0.0%
Expenditures	157.5	3.6
Income	157.5	3.6
Beneficiary premiums	44.4	1.0
Government contributions	113.1	2.6
Fees related to brand-name prescription drugs	0.1	0.0
Unfunded obligations from program inception through 2099[1]	0.0	0.0
Expenditures	68.5	3.6
Income	68.5	3.6
Beneficiary premiums	19.2	1.0
Government contributions	49.3	2.6
Fees related to brand-name prescription drugs	0.1	0.0

[1]Present value of future expenditures less income, reduced by the amount of trust fund assets at the beginning of the period.

Notes: 1. The present values of GDP for 2025–2099 and for 2025 through the infinite horizon are $1,882.3 trillion and $4,431.4 trillion, respectively. See note 2 of table V.G1.
2. Totals do not necessarily equal the sums of rounded components.

Table V.G4 shows corresponding present values separately for current versus future beneficiaries. As indicated, about 36 percent of the projected total, infinite-horizon cost is attributable to current beneficiaries, with the remaining 64 percent attributable to beneficiaries becoming eligible for Part B benefits after January 1, 2025.

Table V.G4.—Unfunded Part B Obligations for Current and Future Program Participants through the Infinite Horizon
[Present values as of January 1, 2025; dollar amounts in trillions]

	Present value	As a percentage of GDP
Future expenditures less income for current participants	$0.1	0.0%
Expenditures	56.8	1.3
Income	56.7	1.3
Beneficiary premiums	16.0	0.4
Government contributions	40.7	0.9
Fees related to brand-name prescription drugs	0.0	0.0
Less current trust fund (Income minus expenditures to date for past and current participants)	0.2	0.0
Equals unfunded obligations for past and current participants[1]	0.0	0.0
Expenditures	56.7	1.3
Income	56.5	1.3
Beneficiary premiums	15.8	0.4
Government contributions	40.5	0.9
Fees related to brand-name prescription drugs	−0.1	0.0
Plus expenditures less income for future participants for the infinite horizon	−0.1	0.0
Expenditures	100.7	2.3
Income	100.9	2.3
Beneficiary premiums	28.4	0.6
Government contributions	72.4	1.6
Fees related to brand-name prescription drugs	0.0	0.0
Equals unfunded obligations for all participants for the infinite future	−0.2	0.0
Expenditures	157.4	3.6
Income	157.4	3.6
Beneficiary premiums	44.2	1.0
Government contributions	113.0	2.5
Fees related to brand-name prescription drugs	−0.1	0.0

[1]This concept is also referred to as the closed-group unfunded obligation.

Notes: 1. The estimated present value of GDP for 2025 through the infinite horizon is $4,431.4 trillion. See note 2 of table V.G1.
2 Totals do not necessarily equal the sums of rounded components.

Tables V.G5 and V.G6 present revenue and expenditure estimates for Part D that extend to the infinite horizon. The extension assumes that the demographic and economic trends used for the 75-year projection continue indefinitely except that average Part D expenditures per beneficiary would increase at the same rate as GDP per capita minus 0.1 percentage point in every year after 2099.

Table V.G5 shows an estimated present value of Part D expenditures through the infinite horizon of $27.6 trillion, of which $10.7 trillion would occur during the first 75 years. To put the estimates in perspective, they are also shown as percentages of the present value of future GDP. Expressed in this way, for both time periods, the corresponding figure is 0.6 percent of GDP. The table also indicates that, for each time period, beneficiary premiums would finance approximately 18 percent of expenditures and State payments would finance about 9 percent, with government contributions paying for the remaining 73 percent.

Table V.G5.—Unfunded Part D Obligations from Program Inception through the Infinite Horizon
[Present values as of January 1, 2025; dollar amounts in trillions]

	Present value	As a percentage of GDP
Unfunded obligations through the infinite horizon[1]	$0.0	0.0%
Expenditures	27.6	0.6
Income	27.6	0.6
Beneficiary premiums	5.1	0.1
State payments	2.6	0.1
Government contributions	20.0	0.5
Unfunded obligations from program inception through 2099[1]	0.0	0.0
Expenditures	10.7	0.6
Income	10.7	0.6
Beneficiary premiums	2.0	0.1
State payments	1.0	0.1
Government contributions	7.8	0.4

[1]Present value of future expenditures less income, reduced by the amount of trust fund assets at the beginning of the period.

Notes: 1. The present values of GDP for 2025–2099 and for 2025 through the infinite horizon are $1,882.3 trillion and $4,431.4 trillion, respectively. See note 2 of table V.G1.
2 Totals do not necessarily equal the sums of rounded components.

Table V.G6 shows corresponding projections separately for current versus future beneficiaries. As indicated, about 31 percent of the projected total, infinite-horizon cost is attributable to current beneficiaries, with the remaining 69 percent attributable to beneficiaries becoming eligible for Part D benefits after January 1, 2025.

Table V.G6.—Unfunded Part D Obligations for Current and Future Program Participants through the Infinite Horizon
[Present values as of January 1, 2025; dollar amounts in trillions]

	Present value	As a percentage of GDP
Future expenditures less income for current participants	$0.0	0.0%
Expenditures	8.5	0.2
Income	8.5	0.2
Beneficiary premiums	1.6	0.0
State payments	0.8	0.0
Government contributions	6.1	0.1
Less current trust fund (Income minus expenditures to date for past and current participants)	0.0	0.0
Equals unfunded obligations for past and current participants[1]	0.0	0.0
Expenditures	8.5	0.2
Income	8.5	0.2
Beneficiary premiums	1.6	0.0
State payments	0.8	0.0
Government contributions	6.1	0.1
Plus expenditures less income for future participants for the infinite horizon	0.0	0.0
Expenditures	19.1	0.4
Income	19.1	0.4
Beneficiary premiums	3.5	0.1
State payments	1.8	0.0
Government contributions	13.8	0.3
Equals unfunded obligations for all participants for the infinite future	0.0	0.0
Expenditures	27.6	0.6
Income	27.6	0.6
Beneficiary premiums	5.1	0.1
State payments	2.5	0.1
Government contributions	19.9	0.5

[1]This concept is also referred to as the closed-group unfunded obligation.

Notes: 1. The estimated present value of GDP for 2025 through the infinite horizon is $4,431.4 trillion. See note 2 of table V.G1.
2. Totals do not necessarily equal the sums of rounded components.

H. FISCAL YEAR HISTORICAL DATA AND PROJECTIONS THROUGH 2034

Tables V.H1, V.H2, and V.H3 present detailed operations of the HI trust fund, along with Part B and Part D of the SMI trust fund, for fiscal year 2024. These tables are similar to the calendar-year operation tables displayed in sections III.B, III.C, and III.D.

Table V.H1.—Statement of Operations of the HI Trust Fund during Fiscal Year 2024
[In thousands]

Total assets of the trust fund, beginning of period	$191,742,580
Revenue:	
Payroll taxes	$391,904,447
Income from taxation of OASDI benefits	39,794,000
Interest on investments	6,052,980
Premiums collected from voluntary participants	4,737,346
Premiums collected from Medicare Advantage participants	227,972
ACA Medicare shared savings program receipts	379,355
Transfer from Railroad Retirement account	645,200
Reimbursement, transitional uninsured coverage	44,000
Interfund interest payments to OASDI[1]	−3,499
Interest on reimbursements, Railroad Retirement	25,303
Other	125
Reimbursement, union activity	1,340
General fund transfer, program management	574,372
Fraud and abuse control receipts:	
Criminal fines	1,932
Civil monetary penalties	43,797
Civil penalties and damages, Department of Justice	362,202
Asset forfeitures, Department of Justice	193,473
3% administrative expense reimbursement, Department of Justice	18,584
General fund appropriation fraud and abuse, FBI	168,347
General fund transfer, discretionary	367,892
Total revenue	$445,539,169
Expenditures:	
Net benefit payments	$396,633,083
Administrative expenses:	
Treasury administrative expenses	141,751
Salaries and expenses, SSA[2]	1,301,225
Salaries and expenses, CMS[3]	1,636,321
Salaries and expenses, Office of the Secretary, HHS	108,089
Medicare Payment Advisory Commission	8,294
Medicare Access Children's Health Insurance Program (CHIP)	49
Administration for Community Living State Health Insurance Program	49,763
Fraud and abuse control expenses:	
HHS Medicare integrity program	1,028,777
HHS Office of Inspector General	345,796
Department of Justice	28,119
FBI	119,570
HCFAC Discretionary, CMS	856,822
HCFAC Other HHS Discretionary, CMS	528
HCFAC Department of Justice Discretionary, CMS	214,435
HCFAC Office of Inspector General Discretionary, CMS	115,521
Total administrative expenses	5,955,060
Total expenditures	$402,588,143
Net addition to the trust fund	42,951,026
Total assets of the trust fund, end of period	$234,693,606

[1]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds and then are reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the HI trust fund from the other trust funds. A negative figure represents a transfer from the HI trust fund to the other funds.
[2]For facilities, goods, and services provided by SSA.
[3]Includes expenses of the Medicare Administrative Contractors.

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H2.—Statement of Operations of the Part B Account in the SMI Trust Fund during Fiscal Year 2024
[In thousands]

Total assets of the Part B account in the trust fund, beginning of period		$157,903,092
Revenue:		
Premiums from enrollees:		
Enrollees aged 65 and over	$124,091,614	
Disabled enrollees under age 65	13,639,973	
Total premiums		137,731,587
Premiums collected from Medicare Advantage participants		334,261
Government contributions:		
Enrollees aged 65 and over	329,796,499	
Disabled enrollees under age 65	53,019,083	
Repayment amount[1]	−2,214,052	
Adjustment for exempted amounts[2]	−6,848,422	
Repayment of the Medicare Accelerated and Advance Payments (AAP) Program transfer[3]	−36,174	
Union activity	1,874	
Total government contributions		373,718,809
Other		108
Interest on investments		3,796,340
Interfund interest receipts & payments[4]		−4,177
Annual fees—branded Rx manufacturers and importers		2,788,862
ACA Medicare shared savings program receipts		489,652
Total revenue		$518,855,443
Expenditures:		
Net Part B benefit payments		$516,633,105
Administrative expenses:		
Transfer to Medicaid[5]	1,319,549	
Treasury administrative expenses	345	
Salaries and expenses, CMS[6]	2,287,507	
Salaries and expenses, Office of the Secretary, HHS	108,089	
Salaries and expenses, SSA	1,780,060	
Medicare Payment Advisory Commission	5,530	
Railroad Retirement administrative expenses	11,014	
Railroad Retirement administrative expenses, OIG	2,217	
Railroad Retirement administrative expenses, SMAC	19,685	
ACL State Health Ins Program, OBRA	49,763	
MACRA[7]	5,211	
Total administrative expenses		5,588,969
Total expenditures		$522,222,073
Net addition to the trust fund		−3,366,630
Total assets of the Part B account in the trust fund, end of period		$154,536,461

[1]Represents transfers from Part B to the general fund of the Treasury of amounts collected from beneficiaries for repayment of (i) the 2016 and 2021 transfers for the premium income lost and (ii) the forgone income-related premium income in those years as a result of the specification of the aged actuarial rate. The repayment amounts reflect the $3.00 that is added to the Part B premium otherwise determined. This addition will continue until the total amount of the forgone income-related premium income plus transfers is fully repaid.
[2]The additional premium repayment amounts (footnote 1 repayment amounts) are not to be matched by general revenue contributions; however, since CMS is not able to separate the additional repayment premium amounts from the standard premium amounts, the additional repayment premium amounts are

matched. An adjustment for exempted amounts is therefore necessary to transfer these erroneous Federal matching amounts back to the general fund.
[3]Represents transfers from Part B to the general fund of the Treasury of amounts recovered from providers for repayment of AAP program payments.
[4]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds and then are reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the Part B account of the SMI trust fund from the other trust funds. A negative figure represents a transfer from the Part B account in the SMI trust fund to the other funds.
[5]Represents amount transferred from the Part B account in the SMI trust fund to Medicaid to pay the Part B premium for certain qualified individuals.
[6]Includes expenses of the Medicare Administrative Contractors.
[7]Represents amounts transferred from the Part B account of the SMI trust fund for administration of provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H3—Statement of Operations of the Part D Account in the SMI Trust Fund during Fiscal Year 2024
[In thousands]

Total assets of the Part D account in the trust fund, beginning of period		$3,279,175
Revenue:		
Premiums from enrollees		
Premiums deducted from Social Security benefits	$5,785,266	
Premiums paid directly to plans[1]	13,255,921	
Total premiums		19,041,187
Government contributions:		
Prescription drug benefits	101,860,622	
Prescription drug administrative expenses	493,000	
Total government contributions		102,353,622
Payments from States		17,757,893
Interest on investments		222,836
DOJ/OIG/MA settlements[2]		109,927
Total revenue		$139,485,464
Expenditures:		
Part D benefit payments[1]		$129,720,739
Part D administrative expenses		491,334
Total expenditures		$130,212,073
Net addition to the trust fund		9,273,391
Total assets of the Part D account in the trust fund, end of period		$12,552,567

[1]Premiums paid directly to plans are not displayed on Treasury statements and are estimated. These premiums have been added to the benefit payments reported on the Treasury statement to obtain an estimate of total Part D benefits. Direct data on such benefit amounts are not yet available.
[2]Reflects amounts transferred to the Part D account for settlements related to Department of Justice (DOJ) civil and criminal court cases, Office of the Inspector General (OIG) civil monetary penalties, and Medicare Advantage (MA) civil monetary penalties.

Note: Totals do not necessarily equal the sums of rounded components.

Tables V.H4, V.H5, V.H6, V.H7, and V.H8 present estimates of the fiscal-year operations of total Medicare, the HI trust fund, the SMI trust fund, the Part B account in the SMI trust fund, and the Part D account in the SMI trust fund, respectively. These tables correspond to the calendar-year trust fund operation tables shown in section V.B and in section III.

Table V.H4.—Total Medicare Income, Expenditures, and Trust Fund Assets during Fiscal Years 1970–2034
[In billions]

Fiscal year	Total income	Total expenditures	Net change in assets	Assets at end of year
Historical data:				
1970	$7.5	$7.1	$0.3	$2.7
1975	16.9	14.8	2.1	11.3
1980	35.7	35.0	0.7	19.0
1985	75.5	71.4	4.1	31.9
1990	125.7	109.7	16.0	110.2
1995	173.0	180.1	−7.1	143.4
2000	248.9	219.3	29.6	214.0
2005	349.4	336.9	12.5	294.6
2010	500.7	521.2	−20.5	350.9
2015	629.9	638.1	−8.3	265.3
2016	687.7	694.5	−6.8	258.6
2017	721.0	707.4	13.6	272.1
2018	744.4	711.3	33.1	305.3
2019	782.8	782.1	0.7	306.0
2020	833.7	915.4[1]	−81.7	224.3
2021	928.6[2]	843.0[1]	85.6	309.9
2022	957.4[2]	918.2[1]	39.2	349.1
2023	1,021.5[2]	1,017.7[1]	3.8	352.9
2024	1,103.9	1,055.0	48.9	401.8
Intermediate estimates:				
2025	1,206.1	1,182.4	23.7	425.5
2026	1,301.9	1,281.1	20.8	446.3
2027	1,405.9	1,388.6	17.3	463.6
2028	1,505.0	1,574.1	−69.2	394.4
2029	1,625.5	1,552.7	72.8	467.2
2030	1,733.7	1,750.8	−17.1	450.1
2031	1,841.8	1,871.4	−29.6	420.6
2032	1,951.4	1,991.2	−39.9	380.7
2033	2,086.2	2,255.2	−169.0	211.7
2034	2,226.8	2,312.5	−85.7	126.0

[1]Includes net payments of $103.8 billion made through the Medicare Accelerated and Advance Payments (AAP) Program in fiscal year 2020 and subsequent net repayments of $36.4 billion, $62.4 billion, and $4.8 billion in fiscal years 2021 through 2023, respectively.
[2]Includes (i) a transfer of $37.8 billion in fiscal year 2021 from the general fund of the Treasury to Part B, which occurred in November 2020 for the outstanding balance of the AAP program, as required by the Continuing Appropriations Act, 2021 and Other Extensions Act, and (ii) subsequent recoveries from providers that were transferred from Part B to the general fund of the Treasury in the amounts of $8.5 billion, $26.5 billion, and $2.7 billion in fiscal years 2021 through 2023, respectively.

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H5.—Operations of the HI Trust Fund during Fiscal Years 1970–2034

[In billions]

	Income								Expenditures			Trust fund	
Fiscal year[1]	Payroll taxes	Income from taxation of benefits	Railroad Retirement account transfers	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other[2,3]	Total	Benefit payments[3,4]	Administrative expenses[5]	Total	Net change	Balance at end of year
Historical data:													
1970	$4.8	—	$0.1	$0.6	—	$0.0	$0.1	$5.6	$4.8	$0.1	$5.0	$0.7	$2.7
1975	11.3	—	0.1	0.5	$0.0	0.0	0.6	12.6	10.4	0.3	10.6	2.0	9.9
1980	23.2	—	0.2	0.7	0.0	0.1	1.1	25.4	23.8	0.5	24.3	1.1	14.5
1985	46.5	—	0.4	0.8	0.0	0.1	3.2	50.9	47.8	0.8	48.7	4.1[6]	21.3
1990	70.7	—	0.4	0.4	0.1	0.1	7.9	79.6	65.9	0.8	66.7	12.9	95.6
1995	98.1	$3.9	0.4	0.5	1.0	0.1	11.0	114.8	113.6	1.3	114.9	0.0	129.5
2000	137.7	8.8	0.5	0.5	1.4	0.0	10.8	159.7	127.9[7]	2.4	130.3	29.4	168.1
2005	169.0	8.8	0.4	0.3	2.3	0.0	16.2	196.9	181.3	2.9	184.1	12.8	277.7
2010	183.6	13.8	0.5	−0.1	3.3	0.0	16.9	218.0	245.6	3.3	249.0	−31.0	278.9
2015	237.7	20.2	0.6	0.2	3.3	0.0	10.4	272.4	273.2	5.5	278.7	−6.4	195.9
2016	250.5	23.0	0.7	0.2	3.2	0.0	9.6	287.1	285.6	5.1	290.6	−3.5	192.4
2017	259.7	24.2	0.6	0.1	3.5	0.0	10.3	298.5	290.3	3.0[8]	293.3	5.3	197.6
2018	264.6	24.2	0.6	0.1	3.5	0.0	9.8	302.8	292.1	5.1	297.2	5.7	203.3
2019	281.4	23.8	0.6	0.1	3.8	0.0	9.5	319.3	318.4	5.4	323.7	−4.5	198.8
2020	295.9	26.9	0.6	0.1	4.0	0.0	8.6	336.1	395.8[9]	4.8	400.6	−64.5	134.3
2021	299.1	25.0	0.6	0.1	4.1	0.0	4.8	333.7	326.8[9]	5.1	331.9	1.8	136.1
2022	343.7	32.8	0.5	0.1	4.5	0.0	5.1	386.6	339.6[9]	5.2	344.7	41.9	178.0
2023	362.5	35.0	0.6	0.1	4.7	0.0	7.3	410.1	390.7[9]	5.6	396.3	13.8	191.7
2024	391.9	39.8	0.7	0.0	4.7	0.0	8.4	445.5	396.6	6.0	402.6	43.0	234.7
Intermediate estimates:													
2025	397.0	40.7	0.7	0.0	5.2	0.0	10.0	453.6	433.7	6.4	440.1	13.5	248.2
2026	417.7	52.2	0.7	0.0	5.8	0.0	10.9	487.3	470.1	6.7	476.8	10.5	258.7
2027	437.8	60.6	0.7	0.0	6.2	0.0	11.5	516.8	506.7	7.0	513.7	3.1	261.8
2028	461.5	65.6	0.7	0.0	6.7	0.0	12.0	546.5	568.6	7.3	575.8	−29.3	232.5
2029	481.7	70.8	0.7	0.0	7.1	0.0	12.1	572.4	563.5	7.6	571.1	1.3	233.8
2030	503.2	76.6	0.7	0.0	7.6	0.0	11.5	599.6	626.1	7.8	634.0	−34.4	199.4
2031	524.8	83.0	0.7	0.0	8.1	0.0	10.2	626.9	665.7	8.1	673.8	−46.9	152.6
2032	546.8	89.9	0.8	0.0	8.6	0.0	8.1	654.2	706.7	8.4	715.1	−60.9	91.6
2033[10]	576.8	97.0	0.8	0.0	9.3	0.0	5.4	689.4	791.2	9.1	800.4	−111.0	−19.3
2034[10]	599.0	104.5	0.8	0.0	9.9	0.0	2.7	717.1	808.7	9.7	818.3	−101.2	−120.6

[1]Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.
[2]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income.
[3]See footnote 2 of table III.B4.
[4]Includes costs of Peer Review Organizations from 1983 through 2001 (beginning with the implementation of the prospective payment system on October 1, 1983) and costs of Quality Improvement Organizations beginning in 2002.
[5]Includes costs of experiments and demonstration projects. Beginning in 1997, includes fraud and abuse control expenses.
[6]Includes repayment of loan principal, from the OASI trust fund, of $1.8 billion.
[7]For 1998 through 2003, includes monies transferred to the SMI trust fund for home health agency costs.
[8]Reflects a larger-than-usual downward adjustment of $1.8 billion for prior-year allocations among Part A, Part B, and Part D.
[9]Includes net payments of $65.5 billion made through the Medicare Accelerated and Advance Payments Program in fiscal year 2020 and subsequent net repayments of $21.9 billion, $40.4 billion, and $3.0 billion in fiscal years 2021 through 2023, respectively.
[10]Estimates for 2033 and later are hypothetical since the HI trust fund would be depleted in those years.

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H6.—Operations of the SMI Trust Fund (Cash Basis) during Fiscal Years 1970–2034

[In billions]

	Income					Expenditures			Trust fund	
Fiscal year[1]	Premium income	Government contribution[2]	Payments from States	Interest and other[3,4]	Total	Benefit payments[4,5]	Administrative expense	Total	Net change	Balance at end of year[6]
Historical data:										
1970	$0.9	$0.9	—	$0.0	$1.9	$2.0	$0.2	$2.2	−$0.3	$0.1
1975	1.9	2.3	—	0.1	4.3	3.8	0.4	4.2	0.2	1.4
1980	2.9	6.9	—	0.4	10.3	10.1	0.6	10.7	−0.5	4.5
1985	5.5	17.9	—	1.2	24.6	21.8	0.9	22.7	1.8	10.6
1990	11.5[7]	33.2	—	1.4[7]	46.1[7]	41.5	1.5[7]	43.0[7]	3.1[7]	14.5[7]
1995	19.2	37.0	—	1.9	58.2	63.5	1.7	65.2	−7.0	13.9
2000	20.5	65.6	—	3.2	89.2	87.2[8]	1.8	89.0	0.2	45.9
2005	35.9	115.2	—	1.4	152.5	149.8	2.9	152.7	−0.2	16.9
2010	61.4	213.7	$4.5	3.2	282.7	268.7	3.5	272.2	10.5	72.0
2015	79.4	263.5	8.8	5.9	357.5	355.8	3.6	359.4	−1.9	69.4
2016	86.1	299.5	9.8	5.3	400.6	399.5	4.4	403.9	−3.3	66.2
2017	94.8	309.6	11.1	6.9	422.4	409.3	4.9[9]	414.1	8.3	74.5
2018	106.2	316.7	11.7	7.0	441.6	409.4	4.7	414.1	27.5	102.0
2019	113.5	331.8	12.2	6.1	463.6	453.5	4.9	458.4	5.2	107.2
2020	122.0	357.5	11.7	6.4	497.6	509.6[10]	5.2	514.8	−17.2	90.0
2021	129.2	448.2[11]	11.9	5.7	594.9	505.7[10]	5.3	511.1	83.8	173.8
2022	144.3	406.4[11]	13.3	6.8	570.8	567.8[10]	5.7	573.4	−2.6	171.2
2023	149.1	439.0[11]	15.1	8.2	611.4	615.4[10]	5.9	621.4	−10.0	161.2
2024	156.8	476.1	17.8	7.7	658.3	646.4	6.1	652.4	5.9	167.1
Intermediate estimates:										
2025	167.9	558.5	18.2	7.8	752.5	735.7	6.5	742.3	10.2	177.3
2026	192.5	594.6	18.9	8.6	814.6	797.2	7.0	804.3	10.3	187.6
2027	216.4	644.2	19.2	9.3	889.1	867.5	7.5	874.9	14.2	201.8
2028	237.7	691.7	19.0	10.0	958.5	990.4	7.9	998.3	−39.8	161.9
2029	260.6	762.4	19.2	10.9	1,053.1	973.2	8.4	981.6	71.5	233.4
2030	286.6	815.9	19.7	11.9	1,134.1	1,108.0	8.8	1,116.8	17.3	250.7
2031	310.1	871.3	20.4	13.0	1,214.8	1,188.3	9.3	1,197.5	17.3	268.0
2032	334.1	927.6	21.2	14.2	1,297.2	1,266.3	9.8	1,276.1	21.0	289.0
2033	363.6	995.9	21.7	15.6	1,396.8	1,444.5	10.3	1,454.9	−58.0	231.0
2034	393.2	1,077.7	21.9	16.9	1,509.8	1,483.0	11.2	1,494.2	15.6	246.6

[1]Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.
[2]Includes Part B general fund matching payments, Part D subsidy costs, and certain interest-adjustment items.
[3]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income. In 2008, includes an adjustment of $0.8 billion for interest inadvertently earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.
[4]See footnote 2 of table III.B4.
[5]See footnote 3 of table III.B4.
[6]The financial status of SMI depends on both the assets and the liabilities of the trust fund (see table III.C8).
[7]Includes the impact of the Medicare Catastrophic Coverage Act of 1988.
[8]Benefit payments less monies transferred from the HI trust fund for home health agency costs.
[9]Reflects a larger-than-usual upward adjustment of $1.4 billion for prior-year allocations among Part A, Part B, and Part D.
[10]Includes net Part B payments of $38.3 billion made through the Medicare Accelerated and Advance Payments (AAP) Program in fiscal year 2020 and subsequent net repayments of $14.5 billion, $22.0 billion, and $1.7 billion in fiscal years 2021–2023, respectively.
[11]Includes (i) a transfer of $37.8 billion in fiscal year 2021 from the general fund of the Treasury to Part B, which occurred in November 2020 for the outstanding balance of the AAP program, as required by the Continuing Appropriations Act, 2021 and Other Extensions Act, and (ii) subsequent recoveries from providers that were transferred from Part B to the general fund of the Treasury in the amounts of $8.5 billion, $26.5 billion, and $2.7 billion in fiscal years 2021–2023, respectively.

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H7.—Operations of the Part B Account in the SMI Trust Fund (Cash Basis) during Fiscal Years 1970–2034

[In billions]

	Income				Expenditures			Account	
Fiscal year[1]	Premium income	Government contribution[2]	Interest and other[3,4]	Total	Benefit payments[4,5]	Administrative expense	Total	Net change	Balance at end of year[6]
Historical data:									
1970	$0.9	$0.9	$0.0	$1.9	$2.0	$0.2	$2.2	−$0.3	$0.1
1975	1.9	2.3	0.1	4.3	3.8	0.4	4.2	0.2	1.4
1980	2.9	6.9	0.4	10.3	10.1	0.6	10.7	−0.5	4.5
1985	5.5	17.9	1.2	24.6	21.8	0.9	22.7	1.8	10.6
1990	11.5[7]	33.2	1.4[7]	46.1[7]	41.5	1.5[7]	43.0[7]	3.1[7]	14.5[7]
1995	19.2	37.0	1.9	58.2	63.5	1.7	65.2	−7.0	13.9
2000	20.5	65.6	3.2	89.2	87.2[8]	1.8	89.0	0.2	45.9
2005	35.9	114.0	1.4	151.3	148.6	2.9	151.5	−0.2	16.9
2010	54.8	161.1	3.2	219.0	205.1	3.3	208.4	10.7	71.3
2015	67.1	195.8	5.8	268.8	272.0	3.2	275.2	−6.4	63.9
2016	72.5	223.1	5.3	300.8	295.1	4.0	299.1	1.7	65.6
2017	79.7	231.0	6.9	317.5	304.1	5.0[9]	309.1	8.5	74.1
2018	90.4	244.3	6.9	341.7	316.8	4.2	321.0	20.7	94.8
2019	97.8	263.9	5.7	367.4	358.2	4.4	362.6	4.7	99.5
2020	106.3	285.2	5.9	397.3	409.9[10]	4.8	414.6	−17.3	82.2
2021	112.4	366.1[11]	5.4	483.9	396.1[10]	4.8	400.9	82.9	165.1
2022	126.8	313.7[11]	6.4	447.0	438.3[10]	5.2	443.4	3.5	168.7
2023	131.0	342.8[11]	7.5	481.2	486.6[10]	5.4	492.0	−10.8	157.9
2024	137.7	373.7	7.4	518.9	516.6	5.6	522.2	−3.4	154.5
Intermediate estimates:									
2025	151.9	413.6	7.4	572.8	562.0	5.9	568.0	4.8	159.3
2026	172.4	465.5	8.1	646.0	628.9	6.4	635.3	10.7	170.0
2027	190.6	512.5	8.8	711.9	691.6	6.8	698.4	13.4	183.5
2028	207.5	555.7	9.5	772.7	789.6	7.2	796.8	−24.1	159.3
2029	227.2	605.2	10.3	842.7	780.6	7.6	788.3	54.4	213.8
2030	248.6	658.7	11.3	918.6	894.1	8.1	902.2	16.5	230.3
2031	269.9	711.5	12.5	993.9	968.6	8.5	977.1	16.8	247.0
2032	293.0	768.1	13.7	1,074.8	1,044.9	9.0	1,053.9	20.9	267.9
2033	321.5	838.0	15.0	1,174.5	1,204.6	9.5	1,214.2	−39.7	228.2
2034	349.5	905.9	16.3	1,271.7	1,245.8	10.3	1,256.1	15.6	243.8

[1]Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.
[2]General fund matching payments, plus certain interest-adjustment items.
[3]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income. In 2008, includes an adjustment of $0.8 billion for interest earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.
[4]See footnote 2 of table III.B4.
[5]See footnote 3 of table III.B4.
[6]The financial status of Part B depends on both the assets and the liabilities of the trust fund (see table III.C8).
[7]Includes the impact of the Medicare Catastrophic Coverage Act of 1988.
[8]Benefit payments less monies transferred from the HI trust fund for home health agency costs.
[9]Reflects a larger-than-usual upward adjustment of $1.7 billion for prior-year allocations among Part A, Part B, and Part D.
[10]See footnote 10 of table V.H6.
[11]See footnote 11 of table V.H6.

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H8.—Operations of the Part D Account in the SMI Trust Fund (Cash Basis) during Fiscal Years 2004–2034

[In billions]

	Income					Expenditures			Account	
Fiscal year	Premium income	Government contribution[1]	Payments from States[2]	Interest and other	Total	Benefit payments[3]	Administrative expense	Total	Net change	Balance at end of year[4]
Historical data:										
2004	—	$0.2	—	—	$0.2	$0.2	—	$0.2	—	—
2005	—	1.2	—	—	1.2	1.2	—	1.2	—	—
2006	$2.6	28.3	$3.6	$0.0	34.6	33.7	$0.2	33.9	$0.7	$0.7
2007	3.9	41.4	7.0	0.0	52.3	51.4	1.0	52.4	−0.1	0.6
2008	4.8	35.5	7.0	0.0	47.4	46.8	0.4	47.2	0.2	0.8
2009	5.8	43.5	7.5	0.0	56.9	56.6	0.2	56.8	0.0	0.9
2010	6.6	52.6	4.5	0.0	63.7	63.6	0.3	63.8	−0.2	0.7
2011	7.5	56.3	6.5	0.0	70.4	70.6	0.4	71.0	−0.7	0.0
2012	8.2	45.3	8.3	0.0	61.8	60.6	0.4	61.0	0.8	0.8
2013	9.5	50.3	8.7	0.0	68.5	68.0	0.4	68.3	0.1	1.0
2014	11.0	52.9	8.7	0.0	72.7	72.2	0.4	72.6	0.1	1.1
2015	12.3	67.6	8.8	0.0	88.7	83.8	0.4	84.2	4.5	5.6
2016	13.6	76.4	9.8	0.0	99.8	104.4	0.4	104.8	−5.0	0.6
2017	15.1	78.7	11.1	0.1	104.9	105.2	−0.1[5]	105.1	−0.2	0.4
2018	15.8	72.4	11.7	0.1	99.9	92.6	0.5	93.1	6.8	7.2
2019	15.7	67.9	12.2	0.4	96.2	95.3	0.5	95.7	0.5	7.7
2020	15.7	72.3	11.7	0.6	100.3	99.7	0.4	100.2	0.1	7.8
2021	16.8	82.1	11.9	0.3	111.0	109.6	0.5	110.2	0.9	8.7
2022	17.5	92.7	13.3	0.3	123.8	129.5	0.5	130.0	−6.2	2.5
2023	18.1	96.2	15.1	0.8	130.2	128.8	0.5	129.4	0.8	3.3
2024	19.0	102.4	17.8	0.3	139.5	129.7	0.5	130.2	9.3	12.6
Intermediate estimates:										
2025	16.0	145.0	18.2	0.5	179.7	173.7	0.6	174.3	5.4	18.0
2026	20.1	129.1	18.9	0.5	168.6	168.4	0.6	169.0	−0.4	17.6
2027	25.8	131.7	19.2	0.5	177.2	175.8	0.7	176.5	0.7	18.3
2028	30.3	136.0	19.0	0.5	185.8	200.9	0.7	201.5	−15.7	2.6
2029	33.4	157.2	19.2	0.5	210.4	192.6	0.7	193.3	17.0	19.6
2030	38.0	157.2	19.7	0.6	215.5	213.9	0.7	214.7	0.8	20.4
2031	40.2	159.8	20.4	0.6	221.0	219.7	0.8	220.4	0.5	21.0
2032	41.0	159.5	21.2	0.6	222.3	221.4	0.8	222.2	0.1	21.1
2033	42.1	157.9	21.7	0.6	222.4	239.9	0.8	240.7	−18.3	2.8
2034	43.7	171.8	21.9	0.6	238.1	237.2	0.9	238.1	0.0	2.8

[1]Includes, net of payments from States, all government transfers required to fund benefit payments, inflation rebates as specified under the Inflation Reduction Act of 2022, administrative expenses, and State expenses for making low-income eligibility determinations.

[2]Payments from States with respect to the Federal assumption of Medicaid responsibility for drug expenditures for full-benefit dually eligible individuals.

[3]Includes payments to Part D plans, government subsidies under the Inflation Reduction Act, payments to retiree drug subsidy plans, payments to States for making low-income eligibility determinations, Part D drug premiums collected from beneficiaries, and transfers to Medicare Advantage plans and private drug plans. Includes amounts for the Transitional Assistance program of $0.2, $1.1, and $0.2 billion in 2004–2006, respectively.

[4]As noted in section III.D2, a new policy was developed in 2015 under which amounts from the Treasury are transferred into the Part D account 5 business days before the benefit payments to the plans, rather than on the day the benefit payments are due—typically the first business day of a month—as had previously been the case. Accordingly, for any year in which October 1 does not occur on a weekend, the Part D account includes a balance at the end of the previous fiscal year that is more substantial than it would have been prior to implementation of the new policy. In addition, the balances since 2019 have also included an accumulated reserve for the administrative costs incurred by the Social Security Administration on behalf of Medicare.

[5]Reflects a larger-than-usual downward adjustment of $0.3 billion for prior-year allocations among Part A, Part B, and Part D.

Note: Totals do not necessarily equal the sums of rounded components.

Table V.H9 shows the total assets of the HI trust fund and their distribution by interest rate and maturity date at the end of fiscal years 2023 and 2024. The assets at the end of fiscal year 2024 totaled \$234.7 billion: \$235.0 billion in the form of U.S. Government obligations and an undisbursed balance of −\$0.3 billion.

Table V.H9.—Assets of the HI Trust Fund, by Type, at the End of Fiscal Years 2023 and 2024[1]

	September 30, 2023	September 30, 2024
Investments in public-debt obligations sold only to the trust funds (special issues):		
Certificates of indebtedness:		
4.000 percent, 2025	——	\$26,962,033,000.00
4.250 percent, 2024	\$20,882,089,000.00	——
Bonds:		
1.875 percent, 2025	11,410,932,000.00	——
1.875 percent, 2026	11,968,532,000.00	278,171,000.00
2.000 percent, 2025	8,357,018,000.00	——
2.250 percent, 2026–2029	45,482,280,000.00	45,482,280,000.00
2.875 percent, 2027–2028	17,524,027,000.00	17,524,027,000.00
3.000 percent, 2025	2,120,770,000.00	——
3.000 percent, 2029–2031	46,145,100,000.00	46,145,100,000.00
3.875 percent, 2031-2032	30,470,818,000.00	30,470,818,000.00
4.625 percent, 2032–2036	——	68,097,148,000.00
Total investments	\$194,361,566,000.00	\$234,959,577,000.00
Undisbursed balance[2]	−2,618,986,348.43	−265,970,920.80
Total assets	\$191,742,579,651.57	\$234,693,606,079.20

[1]Certificates of indebtedness and bonds are carried at par value, which is the same as book value.
[2]Negative figures represent an extension of credit against securities to be redeemed within the following few days.

The effective annual rate of interest earned by the assets of the HI trust fund during the 12 months ending on December 31, 2024, was 3.3 percent. Interest on special issues is paid semiannually on June 30 and December 31. The interest rate on public-debt obligations issued for purchase by the trust fund in June 2024 was 4.625 percent, payable semiannually.

Table V.H10 shows a comparison of the total assets of the SMI trust fund, Parts B and D combined, and their distribution at the end of fiscal years 2023 and 2024. At the end of 2024, assets totaled \$167.1 billion: \$164.4 billion in the form of U.S. Government obligations and an undisbursed balance of \$2.7 billion.

Table V.H10.—Assets of the SMI Trust Fund, by Type, at the End of Fiscal Years 2023 and 2024[1]

	September 30, 2023	September 30, 2024
Investments in public-debt obligations sold only to the trust funds (special issues):		
Certificates of indebtedness:		
4.000 percent, 2025	——	$30,726,291.000.00
4.125 percent, 2025	——	1,016,723,000.00
4.250 percent, 2024	$3,128,642,000.00	——
4.625 percent, 2025	——	2,737,286.000.00
Bonds:		
1.500 percent, 2025–2027	11,942,590,000.00	——
1.500 percent, 2028–2036	54,508,024,000.00	54,508,024,000.00
1.875 percent, 2029–2031	13,543,136,000.00	13,543,136,000.00
2.250 percent, 2026	1,132,720,000.00	——
2.250 percent, 2027–2034	31,527,523,000.00	27,519,069,000.00
2.500 percent, 2026	5,305,162,000.00	——
2.875 percent, 2025–2026	1,981,628,000.00	——
2.875 percent, 2027–2033	7,289,354,000.00	7,289,354,000.00
3.000 percent, 2025–2026	2,774,066,000.00	——
3.000 percent, 2027–2037	26,404,358,000.00	26,404,358,000.00
4.625 percent, 2028–2038	——	667,977,000.00
Total investments	$159,537,203,000.00	$164,412,218,000.00
Undisbursed balance	1,645,064,303.25	2,676,810,210.39
Total assets	$161,182,267,303.25	$167,089,028,210.39

[1]Certificates of indebtedness and bonds are carried at par value, which is the same as book value.

The effective annual rate of interest earned by the assets of the SMI trust fund for the 12 months ending on December 31, 2024, was 2.0 percent. Interest on special issues is paid semiannually on June 30 and December 31. The interest rate on special issues purchased by the account in June 2024 was 4.625 percent, payable semiannually.

I. GLOSSARY

Accelerated and Advance Payments (AAP) Program. A Medicare loan program that allows the Centers for Medicare & Medicaid Services (CMS) to make accelerated payments to Part A and Part B providers, and advance payments to Part B suppliers, when there is a disruption in claims submission and/or claims processing. CMS can also offer these payments in circumstances such as national emergencies or natural disasters in order to accelerate cash flow to the affected health care providers and suppliers.

Accountable care organizations (ACOs). Groups of clinicians, hospitals, and other health care providers that choose to come together to deliver coordinated, high-quality care to the Medicare patients they serve.

Actuarial balance. The difference between the summarized income rate and the summarized cost rate over a given valuation period.

Actuarial deficit. A negative actuarial balance.

Actuarial rates. One-half of the Part B expected monthly benefit and administrative costs for each aged enrollee adjusted for interest earned on the Part B account assets attributable to aged enrollees and a contingency margin (for the aged actuarial rate), and one-half of the expected monthly benefit and administrative costs for each disabled enrollee adjusted for interest earned on the Part B account assets attributable to disabled enrollees and a contingency margin (for the disabled actuarial rate), for the duration the rate is in effect.

Actuarial status. A measure of the adequacy of the financing as determined by the difference between assets and liabilities at the end of the periods for which financing was established.

Administrative expenses. Expenses incurred by the Department of Health and Human Services and the Department of the Treasury in administering HI and SMI and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses, which are paid from the HI and SMI trust funds, include expenditures for contractors to determine costs of, and make payments to, providers, as well as salaries and expenses of CMS.

Advanced alternative payment model (advanced APM). An APM that meets certain standards for risk-bearing, use of health information technology, and quality.

Aged enrollee. An individual, aged 65 or over, who is enrolled in HI or SMI.

Allowed charge. Individual charge determined by a Medicare Administrative Contractor for a covered Part B medical service or supply.

Alternative payment model (APM). A program or model (except for a health care innovation award model) implemented by the Center for Medicare and Medicaid Innovation at CMS; a demonstration under the Health Care Quality Demonstration Program; an ACO model participating in the Medicare shared savings program; or a Medicare demonstration required by law.

Annual out-of-pocket threshold. The amount of out-of-pocket expenses that must be paid for prescription drugs before significantly reduced Part D beneficiary cost sharing is effective. Amounts paid by a third-party insurer are not included in testing this threshold, but amounts paid by State or Federal assistance programs are included.

Assets. Treasury notes and bonds guaranteed by the Federal Government, and cash held by the trust funds for investment purposes.

Assumptions. Values relating to future trends in certain key factors that affect the balance in the trust funds. Demographic assumptions include fertility, mortality, net immigration, marriage, divorce, retirement patterns, disability incidence and termination rates, and changes in the labor force. Economic assumptions include unemployment, average earnings, inflation, interest rates, and productivity. Three sets of economic assumptions are presented in the Trustees Report:

(1) The low-cost alternative, with relatively rapid economic growth, low inflation, and favorable (from the standpoint of program financing) demographic conditions;
(2) The intermediate assumptions, which represent the Trustees' best estimates of likely future economic and demographic conditions; and
(3) The high-cost alternative, with slow economic growth, more rapid inflation, and financially disadvantageous demographic conditions.

See also *Hospital assumptions*.

Average market yield. A computation that is made on all marketable interest-bearing obligations of the United States. It is computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue.

Baby boom. The period from the end of World War II through the mid-1960s marked by unusually high birth rates.

Base estimate. The updated estimate of the most recent historical year.

Beneficiary. A person enrolled in HI or SMI. See also *Aged enrollee* and *Disabled enrollee.*

Benefit payments. The amounts disbursed for covered services after the deductible and coinsurance amounts have been deducted.

Benefit period. An alternate name for spell of illness.

Board of Trustees. A Board established by the Social Security Act to oversee the financial operations of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The Board comprises six members, four of whom serve automatically by virtue of their positions in the Federal Government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. Two other members are public representatives whom the President appoints and the Senate confirms. These positions are currently vacant. The Administrator of CMS serves as Secretary of the Board of Trustees.

Bond. A certificate of ownership of a specified portion of a debt due by the Federal Government to holders, bearing a fixed rate of interest.

Callable. Subject to redemption upon notice, as is a bond.

Capitated payment. A predetermined amount paid to a health care provider or organization to provide specified services to enrollees over a period of time.

Case mix index. A relative weight that captures the average complexity of certain Medicare services.

Cash basis. The costs of the service when payment was made rather than when the service was performed.

Certificate of indebtedness. A short-term certificate of ownership (12 months or less) of a specified portion of a debt due by the Federal Government to individual holders, bearing a fixed rate of interest.

Closed-group population. Includes all persons currently participating in the program as either taxpayers or beneficiaries, or both. See also *Open-group population*.

Coinsurance. Portion of the costs for covered services paid by the beneficiary after meeting the annual deductible. See also *Hospital coinsurance* and *SNF coinsurance*.

Consumer Price Index (CPI). A measure of the average change in prices over time in a fixed group of goods and services. In this report, references to the CPI relate to the CPI for Urban Wage Earners and Clerical Workers (CPI-W), except for those cases in which the CPI for All Urban Consumers—all items (CPI-U) is indicated.

Contingency. Funds included in the SMI Part B trust fund account to serve as a cushion in case actual expenditures are higher than those projected at the time financing was established. Since the financing is set prospectively, actual experience may be different from the estimates used in setting the financing.

Contingency margin. An amount included in the actuarial rates to provide for changes in the contingency level in the SMI Part B trust fund account. Positive margins increase the contingency level, and negative margins decrease it.

Contribution base. See *Maximum tax base*.

Contributions. See *Payroll taxes*.

Cost rate. The ratio of HI cost (or expenditures) on an incurred basis during a given year to the taxable payroll for the year.

Covered earnings. Earnings in employment covered by HI.

Covered employment. All employment and self-employment creditable for Social Security purposes. Almost every kind of employment and self-employment is covered under HI. In a few employment situations—for example, religious orders under a vow of poverty, foreign affiliates of American employers, or State and local governments—coverage must be elected by the employer. However, effective July 1991, coverage is mandatory for State and local employees who are not participating in a public employee retirement system. All new State and local employees have been covered since April 1986. In a few situations—for instance, ministers or self-employed members of certain religious groups—workers can opt out of coverage. Covered employment for HI includes all Federal employees (whereas covered employment for OASDI includes some, but not all, Federal employees).

Covered Part D drugs. Prescription drugs covered under the Medicaid program plus insulin-related supplies and smoking cessation agents. Drugs covered in Parts A and B of Medicare will continue to be covered there, rather than in Part D.

Covered services. Services for which HI or SMI pays, as defined and limited by statute. Covered HI services are provided by hospitals (inpatient care), skilled nursing facilities, home health agencies, and hospices. Covered SMI Part B services include most physician services, care in outpatient departments of hospitals, diagnostic tests, durable medical equipment, ambulance services, and other health services that are not covered by HI. See *Covered Part D drugs* for SMI Part D.

Covered worker. A person who has earnings creditable for Social Security purposes on the basis of services for wages in covered employment and/or on the basis of income from covered self-employment. The number of HI covered workers is slightly larger than the number of OASDI covered workers because of different coverage status for Federal employment. See *Covered employment.*

Creditable prescription drug coverage. Prescription drug coverage that meets or exceeds the actuarial value of Part D coverage provided through a group health plan or otherwise.

Dedicated financing sources. The sum of HI payroll taxes, HI share of income taxes on Social Security benefits, Part D State payments, Part B drug fees, and beneficiary premiums. This amount is used in the test of excess general revenue Medicare funding.

Deductible. The annual amount payable by the beneficiary for covered services before Medicare makes reimbursement. See also *Inpatient hospital deductible.*

Deemed wage credit. See *Non-contributory or deemed wage credits.*

Demographic assumptions. See *Assumptions.*

Diagnosis-related groups (DRGs). A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the inpatient hospital prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Direct and indirect remuneration (DIR). Payments primarily consisting of drug manufacturer rebates and pharmacy rebates that Part D plans negotiate.

Direct subsidy. The amount paid to the prescription drug plans representing the difference between the plan's risk-adjusted bid and the beneficiary premium for basic coverage.

Disability. For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled-worker cash benefit. An additional 24 months is necessary to qualify for benefits under Medicare.

Disability Insurance (DI). See *Old-Age, Survivors, and Disability Insurance (OASDI).*

Disabled enrollee. An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in HI or SMI.

Disproportionate share hospital (DSH). A hospital that serves a significantly disproportionate number of low-income patients and receives payments from Medicare to cover the costs of providing care to uninsured patients.

DRG Coding. The DRG categories used by hospitals on discharge billing. See also *Diagnosis-related groups (DRGs).*

Dual beneficiary. An individual who is eligible for both Medicare and Medicaid.

Durable medical equipment (DME). Items such as iron lungs, oxygen tents, hospital beds, wheelchairs, and seat lift mechanisms that are used in the patient's home and are either purchased or rented.

Earnings. Unless otherwise qualified, all wages from employment and net earnings from self-employment, whether or not taxable or covered.

Economic assumptions. See *Assumptions*.

Economy-wide private nonfarm business total factor productivity. A measure of real output per combined unit of labor and capital, reflecting the contributions of all factors of production for the private nonfarm business sector of the economy.

End-stage renal disease (ESRD). Permanent kidney failure.

Excess general revenue Medicare funding. A determination that occurs when the difference between expenditures and dedicated funding sources exceeds or is projected to exceed 45 percent of expenditures.

Extended care services. In the context of this report, an alternate name for skilled nursing facility services.

Federal Insurance Contributions Act (FICA). Provision authorizing taxes on the wages of employed persons to provide for OASDI and HI. The tax is paid in equal amounts by covered workers and their employers.

Financial interchange. Provisions of the Railroad Retirement Act providing for transfers between the trust funds and the Social Security Equivalent Benefit Account of the Railroad Retirement program in order to place each trust fund in the same position as if railroad employment had always been covered under Social Security.

Fiscal year. The accounting year of the U.S. Government. Since 1976, each fiscal year has begun October 1 of the prior calendar year and ended the following September 30. For example, fiscal year 2025 began October 1, 2024 and will end September 30, 2025.

Fixed capital assets. The net worth of facilities and other resources.

Frequency distribution. An exhaustive list of possible outcomes for a variable, and the associated probability of each outcome. The sum of the probabilities of all possible outcomes from a frequency distribution is 100 percent.

General fund of the Treasury. Funds held by the U.S. Treasury, other than revenue collected for a specific trust fund (such as HI or SMI) and maintained in a separate account for that purpose. The majority of this fund is derived from individual and business income taxes.

General revenue. Income to the HI and SMI trust funds from the general fund of the Treasury. Only a very small percentage of total HI trust fund income each year is attributable to general revenue.

Government contributions. Contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury to the Part B and Part D accounts of the SMI trust fund. For both parts separately, beneficiary premiums and government contributions are established annually to cover the expected costs for the upcoming year, with both parts primarily financed by government contributions.

Gross Domestic Product (GDP). The total dollar value of all goods and services produced in a year in the United States, regardless of who supplies the labor or property.

High-cost alternative. See *Assumptions*.

Hold-harmless provision. A provision limiting the dollar increase in the Part B premium to the dollar increase in an individual's Social Security benefit. As a result, the person affected pays a lower Part B premium, and the net amount of the individual's Social Security benefit does not decrease despite the greater increase in the premium.

Home health agency (HHA). A public agency or private organization that is primarily engaged in providing the following services in the home: skilled nursing services, other therapeutic services (such as physical, occupational, or speech therapy), and home health aide services.

Hospice. A provider of care for the terminally ill; delivered services generally include home health care, nursing care, physician services, medical supplies, and short-term inpatient hospital care.

Hospital assumptions. These include differentials between hospital labor and non-labor indices compared with general economy labor and non-labor indices; rates of admission incidence; the trend toward treating less complicated cases in outpatient settings; and continued improvement in DRG coding.

Hospital coinsurance. For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see *Lifetime reserve days*).

Hospital input price index. An alternate name for hospital market basket.

Hospital Insurance (HI). The Medicare trust fund that covers specified inpatient hospital services, posthospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

Hospital market basket. The cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services.

Income rate. The ratio of HI income (including payroll taxes, income from taxation of Social Security benefits, premiums, general fund transfers for uninsured beneficiaries, and monies from fraud and abuse control activities, but excluding interest income) to taxable payroll for the year.

Incurred basis. The costs based on when the service was performed rather than when the payment was made.

Infinite horizon. The period extending into the indefinite future.

Independent laboratory. A free-standing clinical laboratory meeting conditions for participation in the Medicare program.

Initial coverage limit. The amount up to which the coinsurance applies under the standard prescription drug benefit.

Inpatient hospital deductible. An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.

Inpatient hospital services. These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Interest. A payment for the use of money during a specified period.

Intermediate assumptions. See *Assumptions*.

Late enrollment penalty. Additional beneficiary premium amounts for those who either do not enroll in Part D at the first opportunity or fail to maintain other creditable coverage for more than 63 days.

Lifetime reserve days. Under HI, each beneficiary has 60 lifetime reserve days that he or she may opt to use when regular inpatient hospital benefits are exhausted. The beneficiary pays one-half of the inpatient hospital deductible for each lifetime reserve day used.

Long range. The next 75 years.

Low-cost alternative. See *Assumptions*.

Low-income beneficiaries. Individuals meeting income and assets tests who are eligible for prescription drug coverage subsidies to help finance premiums and out-of-pocket payments.

Managed care. See *Private Health Plans*.

Market basket. See *Hospital market basket*.

Maximum tax base. Annual dollar amount above which earnings in employment covered under HI are not taxable. In 1994, the maximum tax base was eliminated under HI.

Maximum taxable amount of annual earnings. See *Maximum tax base*.

Medicare. A nationwide, federally administered health insurance program authorized in 1965 under Title XVIII of the Social Security Act to cover the cost of hospitalization, medical care, and some related services for most people aged 65 and over. In 1972, lawmakers extended coverage to people receiving Social Security Disability Insurance payments for 2 years and people with end-stage renal disease. (For beneficiaries whose primary or secondary diagnosis is Amyotrophic Lateral Sclerosis, the 2-year waiting period is waived.) In 2010, people exposed to environmental health hazards within areas under a corresponding emergency declaration became Medicare-eligible. In 2006, prescription drug coverage was added as well. Medicare consists of two separate but coordinated trust funds: Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI). The SMI trust fund comprises two separate accounts: the Part B account and the Part D account. Almost all persons who are aged 65 and over or disabled and who are entitled to HI are eligible to enroll in Part B and Part D on a voluntary basis by paying monthly premiums.

Medicare Administrative Contractor (MAC). A private health care insurer that processes Part A and Part B medical claims or DME claims for fee-for-service beneficiaries.

Medicare Advantage (formerly called Medicare+Choice). An expanded set of options, established in 2006, for the delivery of health care under Medicare. Most Medicare beneficiaries can choose to receive benefits through the original fee-for-service program or through one of the following Medicare Advantage plans: (i) coordinated care plans (such as health maintenance organizations, provider-sponsored organizations, and preferred provider organizations); (ii) medical savings account (MSA)/high-deductible plans; (iii) private fee-for-service plans; or (iv) special needs plans.

Medicare Advantage Prescription Drug Plan (MA-PD). Prescription drug coverage provided by Medicare Advantage plans.

Medicare Advantage ratebook. A set of statutory capitation payment rates, by county, originally used directly to establish payments to private health insurance plans contracting with Medicare. Under current law, the ratebook amounts are used as benchmarks, against which plan costs are compared in the calculation of plan payments.

Medicare Economic Index (MEI). An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

Medicare funding warning. A warning triggered when a determination of excess general revenue Medicare funding has occurred in 2 consecutive years. Such a warning requires the President to submit to Congress, within 15 days after the date of the Budget submission for the succeeding year, proposed legislation to respond to the warning. The law also requires Congress to consider the legislation proposed in response to Medicare funding warnings on an expedited basis. See also *Excess general revenue Medicare funding*.

Medicare Payment Advisory Commission (MedPAC). A commission established by Congress in 1997 to replace the Prospective Payment Assessment Commission and the Physician Payment Review Commission. MedPAC is directed to provide the Congress with advice and recommendations on policies affecting the Medicare program.

Medicare Prescription Drug Account. The separate account within the SMI trust fund to manage revenues and expenditures of the Part D drug benefit.

Medicare severity diagnosis-related groups (MS-DRGs). A refinement of the diagnosis-related group classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the inpatient hospital prospective payment system, hospitals are paid a set fee for treating patients in a single MS-DRG category, regardless of the actual cost of care for the individual.

Merit-based incentive payment system (MIPS). A system for adjusting payments under the Medicare physician fee schedule to non-advanced APM providers based on metrics assessing provider quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities.

Military service wage credits. Credits recognizing that military personnel receive other cash payments and wages in kind (such as food and shelter) in addition to their basic pay. Noncontributory wage credits of $160 were provided for each month of active military service from September 16, 1940 through December 31, 1956. For years after 1956, the basic pay of military personnel is covered under the Social Security program on a contributory basis. In addition to contributory credits for basic pay, noncontributory wage credits of $300 were granted for each calendar quarter in which a person received pay for military service from January 1957 through December 1977. Deemed wage credits of $100 were granted for each $300 of military wages, up to a maximum of $1,200 per calendar year, from January 1978 through December 2001. See also *Quinquennial military service determinations and adjustments*.

National average monthly bid. The weighted average of all Part D drug bids including all of the bids from Prescription Drug Plans (PDPs) and the drug portion of bids from MA-PDs.

Noncontributory or deemed wage credits. Wages and wages in kind that were not subject to the HI tax but are deemed as having been. Deemed wage credits exist for the purposes of (i) determining HI eligibility for individuals who might not be eligible for HI coverage without payment of a premium were it not for the deemed wage credits and (ii) calculating reimbursement due the HI trust fund from the general fund of the Treasury. The first purpose applies in the case of providing coverage to persons during the transitional periods when HI began and when it was expanded to cover Federal employees; both purposes apply in the cases of military service wage credits and deemed wage credits granted for the internment of persons of Japanese ancestry during World War II.

Old-Age, Survivors, and Disability Insurance (OASDI). The Social Security programs that pay for (i) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (ii) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).

Open-group population. Includes all persons who will ever participate in the program as either taxpayers or beneficiaries, or both. See also *Closed-group population.*

Open-group unfunded obligation. See *Unfunded obligation.*

Outpatient hospital. Part of the hospital providing services covered by SMI Part B, including, for example, services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies such as splints, and laboratory tests billed by the hospital.

Part A. The Medicare Hospital Insurance trust fund.

Part A premium. A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in Medicare HI. These individuals are those who are aged 65 and older, are uninsured for Social Security or Railroad Retirement, and do not otherwise meet the requirements for entitlement to Part A. Disabled individuals who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Social Security Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Social Security Act).

Part B. The account within the Medicare Supplementary Medical Insurance trust fund that pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals.

Part B premium. The monthly amount paid by those individuals who have voluntarily enrolled in Part B. Most enrollees pay the standard premium amount, which currently represents approximately

25 percent of the average program costs for an aged beneficiary. Beneficiaries with high income are also required to pay an income-related monthly adjustment amount starting in 2007, and those individuals who meet the definition of a late enrollee are required to pay a penalty. In addition, beneficiaries who are affected by the hold-harmless provision pay a lower premium. See section V.E for more details about the Part B premium.

Part C. See *Private health plans*.

Part D. The account within the Medicare Supplementary Medical Insurance trust fund that pays private plans to provide prescription drug coverage.

Part D premium. The monthly amount paid by those individuals who have voluntarily enrolled in Part D. Premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The actual premium that a beneficiary pays varies according to the plan in which the beneficiary enrolls. Beneficiaries with high income are also required to pay an income-related monthly adjustment amount starting in 2011, and those who enroll late may be required to pay a penalty. In addition, there are premium subsidies for those beneficiaries with income and resources under specified amounts. See section V.E for more details about the Part D premium.

Pay-as-you-go financing. A financing scheme in which taxes are scheduled to produce just as much income as required to pay current benefits, with trust fund assets built up only to the extent needed to prevent depletion of the fund by random fluctuations.

Payroll taxes. Taxes levied on the gross wages of employees and net earnings of self-employed workers.

Peer Review Organization (PRO). A group of practicing physicians and other health care professionals paid by the Federal Government to review the care given to Medicare patients. Starting in 2002, these organizations are called Quality Improvement Organizations.

Percentile. A number that corresponds to one of the equal divisions of the range of a variable in a given sample and that characterizes a value of the variable as not exceeded by a specified percentage of all the values in the sample. For example, a score higher than 97 percent of those attained is said to be in the 97th percentile.

Prescription Drug Plans (PDPs). Stand-alone prescription drug plans offered to beneficiaries in traditional fee-for-service Medicare and to beneficiaries in Medicare Advantage plans that do not offer a prescription drug benefit.

Present value. The present value of a future stream of payments is the lump-sum amount that, if invested today, together with interest earnings would be just enough to meet each of the payments as it fell due. At the time of the last payment, the invested fund would be exactly zero.

Private health plans. Plans offered by private companies that contract with Medicare to provide coverage for Part A and Part B services. Medicare Advantage plans, cost plans, and Program of All-Inclusive Care for the Elderly (PACE) plans are all private health plans.

Projection error. Degree of variation between estimated and actual amounts.

Prospective payment system (PPS). A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Provider. Any organization, institution, or individual who provides health care services to Medicare beneficiaries. Hospitals (inpatient services), skilled nursing facilities, home health agencies, and hospices are the providers of services covered under Medicare Part A. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Quality Improvement Organization (QIO). See *Peer Review Organization.*

Quinquennial military service determination and adjustments. Prior to the Social Security Amendments of 1983, quinquennial determinations (that is, estimates made once every 5 years) were made of the costs arising from the granting of deemed wage credits for military service prior to 1957; annual reimbursements were made from the general fund of the Treasury to the HI trust fund for these costs. The Social Security Amendments of 1983 provided for (i) a lump-sum transfer in 1983 for (a) the costs arising from the pre-1957 wage credits and (b) amounts equivalent to the HI taxes that would have been paid on the deemed wage credits for military service for 1966 through 1983, inclusive, if such credits had been counted as covered earnings;

(ii) quinquennial adjustments to the pre-1957 portion of the 1983 lump-sum transfer; (iii) general fund transfers equivalent to HI taxes on military deemed wage credits for 1984 and later, to be credited to the fund on July 1 of each year; and (iv) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on military deemed wage credits.

Railroad Retirement. A Federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Ratebook. See *Medicare Advantage ratebook*.

Real-wage growth. The annual percentage change in average covered wages adjusted for the average percentage change in the CPI.

Reasonable-cost basis. The calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs that are unnecessary in the efficient delivery of services covered by a health insurance program.

Reinsurance subsidy. Payments to the prescription drug plans in the amount of 80 percent of drug expenses that exceed the annual out-of-pocket threshold.

Residual factors. Factors other than price, including volume of services, intensity of services, and age/sex changes.

Risk corridor. Triggers that are set to protect Part D prescription drug plans from unexpected losses and that allow the government to share in unexpected gains.

Self-employment. Operation of a trade or business by an individual or by a partnership in which an individual is a member.

Self-Employment Contributions Act (SECA). Provision authorizing taxes on the net income of most self-employed persons to provide for OASDI and HI.

Sequestration. The process of applying automatic reductions to certain Federal funding, which was required by the Budget Control Act of 2011.

Short range. The next 10 years.

Skilled nursing facility (SNF). An institution that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or that is engaged in the rehabilitation of injured, disabled, or sick persons.

SNF coinsurance. For the 21st through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-eighth of the inpatient hospital deductible.

Social Security Act. Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The HI and SMI trust funds are authorized by Title XVIII of the Social Security Act.

Special public-debt obligation. Securities of the U.S. Government issued exclusively to the OASI, DI, HI, and SMI trust funds and other Federal trust funds. Sections 1817(c) and 1841(a) of the Social Security Act provide that the public-debt obligations issued for purchase by the HI and SMI trust funds, respectively, shall have maturities fixed with due regard for the needs of the funds. The usual practice in the past has been to spread the holdings of special issues, as of every June 30, so that the amounts maturing in each of the next 15 years are approximately equal. Special public-debt obligations are redeemable at par at any time.

Spell of illness. A period of consecutive days, beginning with the first day on which a beneficiary is furnished inpatient hospital or extended care services, and ending with the close of the first period of 60 consecutive days thereafter in which the beneficiary is in neither a hospital nor a skilled nursing facility.

Standard prescription drug coverage. Part D prescription drug coverage that includes a deductible, coinsurance up to an initial coverage limit, and protection against high out-of-pocket expenditures by having reduced coinsurance provisions for individuals exceeding the out-of-pocket threshold.

Stochastic model. An analysis involving a random variable. For example, a stochastic model may include a frequency distribution for one assumption. From the frequency distribution, possible outcomes for the assumption are selected randomly for use in an illustration.

Summarized cost rate. The ratio of the present value of expenditures to the present value of the taxable payroll for the years in a given period. The summarized cost rate includes the cost of reaching and maintaining a target trust fund level, known as a contingency fund ratio. Because a trust fund level of about 1 year's expenditures is considered to be an adequate reserve for unforeseen contingencies, the targeted contingency fund ratio used in determining summarized cost rates is 100 percent of annual expenditures. Accordingly, the summarized cost rate is equal to the ratio of (i) the sum of the present value of the expenditures during the period, plus the present value of the targeted ending trust fund level, plus the beginning trust fund amount, to (ii) the present value of the taxable payroll during the period.

Summarized income rate. The ratio of the present value of HI income (including payroll taxes, income from taxation of Social Security benefits, premiums, general fund transfers for uninsured beneficiaries, and monies from fraud and abuse control activities, but excluding interest income) incurred during a given period to the present value of the taxable payroll for the years in the period.

Supplemental prescription drug coverage. Coverage in excess of the standard prescription drug coverage.

Supplementary Medical Insurance (SMI). The Medicare trust fund comprising the Part B account, the Part D account, and the Transitional Assistance Account. The Part B account pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals. The Part D account pays private plans to provide prescription drug coverage, beginning in 2006. The Transitional Assistance Account paid for transitional assistance under the prescription drug card program in 2004 and 2005.

Sustainable growth rate (SGR). A system for establishing goals for the rate of growth in Medicare Part B expenditures for physician services. The Medicare Access and CHIP Reauthorization Act of 2015 permanently repealed the SGR formula.

Tax rate. The percentage of taxable earnings, up to the maximum tax base, that is paid for the HI tax. Currently, the percentages are 1.45 for employees and employers, each. The self-employed pay 2.9 percent. There is an additional 0.9-percent tax on earnings above $200,000 (for those who file an individual tax return) or $250,000 (for those who file a joint income tax return).

Taxable earnings. Taxable wages and/or self-employment income under the prevailing annual maximum taxable limit.

Taxable payroll. A weighted average of taxable wages and taxable self-employment income. When multiplied by the combined employee-employer tax rate, it yields the total amount of taxes incurred by employees, employers, and the self-employed for work during the period.

Taxable self-employment income. Net earnings from self-employment—generally above $400 and below the annual maximum taxable amount for a calendar or other taxable year—less any taxable wages in the same taxable year.

Taxable wages. Wages paid for services rendered in covered employment up to the annual maximum taxable amount.

Taxation of benefits. Beginning in 1994, up to 85 percent of an individual's or a couple's OASDI benefits are potentially subject to Federal income taxation under certain circumstances. The revenue derived from taxation of benefits in excess of 50 percent, up to 85 percent, is allocated to the HI trust fund.

Taxes. See *Payroll taxes*.

Term insurance. A type of insurance that is in force for a specified period of time.

Test of Long-Range Close Actuarial Balance. The conditions required to meet this test are as follows: (i) The trust fund satisfies the short-range test of financial adequacy; and (ii) the trust fund ratios stay above zero throughout the 75-year projection period, such that benefits would be payable in a timely manner throughout the period. This test is applied to HI trust fund projections made under the intermediate assumptions.

Test of Short-Range Financial Adequacy. The conditions required to meet this test are as follows: (i) If the trust fund ratio for a fund exceeds 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10-year projection period; (ii) alternatively, if the fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within 5 years (and not be depleted at any time during this period), and then remain at or above 100 percent throughout the rest of the 10-year period. This test is applied to HI trust fund projections made under the intermediate assumptions.

Transitional assistance. An interim benefit for 2004 and 2005 that provided up to $600 per year to assist low-income beneficiaries who had no drug insurance coverage with prescription drug purchases. This benefit also paid the enrollment fee in the Medicare Prescription Drug Discount Card program.

Transitional Assistance Account. The separate account within the SMI trust fund that managed revenues and expenditures for the transitional assistance drug benefit in 2004 and 2005.

Trust fund. Separate accounts in the U.S. Treasury, mandated by Congress, whose assets may be used only for a specified purpose. For the HI and SMI trust funds, monies not withdrawn for current benefit payments and administrative expenses are invested in interest-bearing Federal securities, as required by law; the interest earned is also deposited in the trust funds.

Trust fund ratio. A short-range measure of the adequacy of the HI and SMI trust fund level; defined as the assets at the beginning of the year expressed as a percentage of the costs during the year.

Unfunded obligation. A measure of the shortfall of trust fund income to fully cover program cost over a specified time period after depletion of trust fund asset reserves. This measure can be expressed in present value dollars, discounted to the beginning of the valuation period, by computing the excess of the present value of the projected cost of the program over the sum of (i) the value of trust fund reserves at the beginning of the valuation period and (ii) the present value of the projected non-interest income of the program, assuming scheduled tax rates and benefit levels. This measure can apply for all participants over a specified time period—that is, the *open-group population*—or be limited to a specified subgroup of participants, referred to as the *closed-group population.*

Uninsured beneficiaries. HI beneficiaries who do not have 40 quarters of covered earnings but are entitled to HI coverage either because (i) they were deemed additional wage credits during the transitional periods when the HI program began or when it was expanded to cover Federal employees, or because (ii) they pay a monthly premium that is intended to cover their full cost. See *Part A premium.*

Unit input intensity allowance. The amount added to, or subtracted from, the hospital input price index to yield the prospective payment system update factor.

Valuation period. A period of years that is considered as a unit for purposes of calculating the status of a trust fund.

Voluntary enrollees. Certain individuals, aged 65 or older or disabled, who are not otherwise entitled to Medicare and who opt to obtain coverage under Part A by paying a monthly premium.

Year of depletion. The first year in which a trust fund is unable to pay full benefits when due because the assets of the fund are depleted.

TABLES

FIGURES

STATEMENT OF ACTUARIAL OPINION

It is my opinion that (1) the techniques and methodology used herein to evaluate the financial status of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund are based upon sound principles of actuarial practice and are generally accepted within the actuarial profession; and (2) with the important caveats noted below, the principal assumptions used and the resulting actuarial estimates are, individually and in the aggregate, reasonable for the purpose of evaluating the financial status of the trust funds under current law, taking into consideration the past experience and future expectations for the population, the economy, and the program. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

There remains continued uncertainty regarding adherence to current-law payment updates, particularly in the long range. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law in this report.

For more information, I encourage readers to review the illustrative alternative projection, which provides the potential magnitude of the understatement of Medicare costs relative to the current-law projections.[125]

Paul Spitalnic
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Member, American Academy of Actuaries
Chief Actuary, Centers for Medicare & Medicaid Services

[125]See https://www.cms.gov/files/document/illustrative-alternative-scenario-2025.pdf.

Exhibit C

PIPER EXHIBIT
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PART 4—SCHEDULE FOR RATING DISABILITIES

Subpart A—General Policy in Rating

Subpart B—Disability Ratings

The Musculoskeletal System

The Organs of Special Sense

Impairment of Auditory Acuity

Infectious Diseases, Immune Disorders and Nutritional Deficiencies

The Respiratory System

The Cardiovascular System

The Digestive System

AUTHORITY: 38 U.S.C. 1155, unless otherwise noted.

SOURCE: 29 FR 6718, May 22, 1964, unless otherwise noted.

Subpart A—General Policy in Rating

§ 4.1 Essentials of evaluative rating.

This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition. Over a period of many years, a veteran's disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, that each disability be viewed in relation to its history.

[41 FR 11292, Mar. 18, 1976]

§ 4.2 Interpretation of examination reports.

Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. Each disability must be considered from the point of view of the veteran working or seeking work. If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.

[41 FR 11292, Mar. 18, 1976]

§4.3 Resolution of reasonable doubt.

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant. See §3.102 of this chapter.

[40 FR 42535, Sept. 15, 1975]

§4.6 Evaluation of evidence.

The element of the weight to be accorded the character of the veteran's service is but one factor entering into the considerations of the rating boards in arriving at determinations of the evaluation of disability. Every element in any way affecting the probative value to be assigned to the evidence in each individual claim must be thoroughly and conscientiously studied by each member of the rating board in the light of the established policies of the Department of Veterans Affairs to the end that decisions will be equitable and just as contemplated by the requirements of the law.

§4.7 Higher of two evaluations.

Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned.

§4.9 Congenital or developmental defects.

Mere congenital or developmental defects, absent, displaced or supernumerary parts, refractive error of the eye, personality disorder and mental deficiency are not diseases or injuries in the meaning of applicable legislation for disability compensation purposes.

[41 FR 11292, Mar. 18, 1976]

§4.10 Functional impairment.

The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, evaluations are based upon lack of usefulness, of these parts or systems, especially in self-support. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person's ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.

[41 FR 11292, Mar. 18, 1976]

§4.13 Effect of change of diagnosis.

The repercussion upon a current rating of service connection when change is made of a previously assigned diagnosis or etiology must be kept in mind. The aim should be the reconciliation and continuance of the diagnosis or etiology upon which service connection for the disability had been granted. The relevant principle enunciated in §4.125, entitled "Diagnosis of mental disorders," should have careful attention in this connection. When any change in evaluation is to be made, the rating agency should assure itself that there has been an actual change in the conditions, for better or worse, and not merely a difference in thoroughness of the examination or in use of descriptive terms. This will not, of course, preclude the correction of erroneous ratings, nor will it preclude assignment of a rating in conformity with §4.7.

[29 FR 6718, May 22, 1964, as amended at 61 FR 52700, Oct. 8, 1996]

§ 4.14 Avoidance of pyramiding.

The evaluation of the same disability under various diagnoses is to be avoided. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, so that special rules are included in the appropriate bodily system for their evaluation. Dyspnea, tachycardia, nervousness, fatigability, etc., may result from many causes; some may be service connected, others, not. Both the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation, and the evaluation of the same manifestation under different diagnoses are to be avoided.

§ 4.15 Total disability ratings.

The ability to overcome the handicap of disability varies widely among individuals. The rating, however, is based primarily upon the average impairment in earning capacity, that is, upon the economic or industrial handicap which must be overcome and not from individual success in overcoming it. However, full consideration must be given to unusual physical or mental effects in individual cases, to peculiar effects of occupational activities, to defects in physical or mental endowment preventing the usual amount of success in overcoming the handicap of disability and to the effect of combinations of disability. Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation; *Provided*, That permanent total disability shall be taken to exist when the impairment is reasonably certain to continue throughout the life of the disabled person. The following will be considered to be permanent total disability: the permanent loss of the use of both hands, or of both feet, or of one hand and one foot, or of the sight of both eyes, or becoming permanently helpless or permanently bedridden. Other total disability ratings are scheduled in the various bodily systems of this schedule.

§ 4.16 Total disability ratings for compensation based on unemployability of the individual.

(a) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: *Provided* That, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more. For the above purpose of one 60 percent disability, or one 40 percent disability in combination, the following will be considered as one disability: (1) Disabilities of one or both upper extremities, or of one or both lower extremities, including the bilateral factor, if applicable, (2) disabilities resulting from common etiology or a single accident, (3) disabilities affecting a single body system, e.g. orthopedic, digestive, respiratory, cardiovascular-renal, neuropsychiatric, (4) multiple injuries incurred in action, or (5) multiple disabilities incurred as a prisoner of war. It is provided further that the existence or degree of nonservice-connected disabilities or previous unemployability status will be disregarded where the percentages referred to in this paragraph for the service-connected disability or disabilities are met and in the judgment of the rating agency such service-connected disabilities render the veteran unemployable. Marginal employment shall not be considered substantially gainful employment. For purposes of this section, marginal employment generally shall be deemed to exist when a veteran's earned annual income does not exceed the amount established by the U.S. Department of Commerce, Bureau of the Census, as the poverty threshold for one person. Marginal employment may also be held to exist, on a facts found basis (includes but is not limited to employment in a protected environment such as a family business or sheltered workshop), when earned annual income exceeds the poverty threshold. Consideration shall be given in all claims to the nature of the employment and the reason for termination.

(Authority: 38 U.S.C. 501)

(b) It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. Therefore, rating boards should submit to the Director, Compensation and Pension Service, for extra-schedular consideration all cases of veterans who are unemployable by reason of service-connected disabilities, but who fail to meet the percentage standards set forth in paragraph (a) of this section. The rating board will include a full statement as to the veteran's service-connected disabilities, employment history, educational and vocational attainment and all other factors having a bearing on the issue.

[40 FR 42535, Sept. 15, 1975, as amended at 54 FR 4281, Jan. 30, 1989; 55 FR 31580, Aug. 3, 1990; 58 FR 39664, July 26, 1993; 61 FR 52700, Oct. 8, 1996]

§4.17 Total disability ratings for pension based on unemployability and age of the individual.

All veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled. For the purpose of pension, the permanence of the percentage requirements of §4.16 is a requisite. When the percentage requirements are met, and the disabilities involved are of a permanent nature, a rating of permanent and total disability will be assigned if the veteran is found to be unable to secure and follow substantially gainful employment by reason of such disability. Prior employment or unemployment status is immaterial if in the judgment of the rating board the veteran's disabilities render him or her unemployable. In making such determinations, the following guidelines will be used:

(a) Marginal employment, for example, as a self-employed farmer or other person, while employed in his or her own business, or at odd jobs or while employed at less than half the usual remuneration will not be considered incompatible with a determination of unemployability, if the restriction, as to securing or retaining better employment, is due to disability.

(b) Claims of all veterans who fail to meet the percentage standards but who meet the basic entitlement criteria and are unemployable, will be referred by the rating board to the Veterans Service Center Manager or the Pension Management Center Manager under §3.321(b)(2) of this chapter.

(Authority: 38 U.S.C. 1155; 38 U.S.C. 3102)

[43 FR 45348, Oct. 2, 1978, as amended at 56 FR 57985, Nov. 15, 1991; 71 FR 28586, May 17, 2006; 74 FR 26959, June 5, 2009]

§4.17a Misconduct etiology.

A permanent and total disability rating under the provisions of §§4.15, 4.16 and 4.17 will not be precluded by reason of the coexistence of misconduct disability when:

(a) A veteran, regardless of employment status, also has innocently acquired 100 percent disability, or

(b) Where unemployable, the veteran has other disabilities innocently acquired which meet the percentage requirements of §§4.16 and 4.17 and would render, in the judgment of the rating agency, the average person unable to secure or follow a substantially gainful occupation.

[40 FR 42536, Sept. 15, 1975, as amended at 43 FR 45349, Oct. 2, 1978]

§4.18 Unemployability.

A veteran may be considered as unemployable upon termination of employment which was provided on account of disability, or in which special consideration was given on account of the same, when it is satisfactorily shown that he or she is unable to secure further employment. With amputations, sequelae of fractures and other residuals of traumatism shown to be of static character, a showing of continuous unemployability from date of incurrence, or the date the condition reached the stabilized level, is a general requirement in order to establish the fact that present unemployability is the result of the disability. However, consideration is to be given to the circumstances of employment in individual claims, and, if the employment was only occasional, intermittent, tryout or unsuccessful, or eventually terminated on account of the disability, present unemployability may be attributed to the static disability. Where unemployability for pension previously has been established on the basis of combined service-connected and nonservice-connected disabilities and the service-connected disability or disabilities have increased in severity, §4.16 is for consideration.

[40 FR 42536, Sept. 15, 1975, as amended at 43 FR 45349, Oct. 2, 1978]

§4.19 Age in service-connected claims.

Age may not be considered as a factor in evaluating service-connected disability; and unemployability, in service-connected claims, associated with advancing age or intercurrent disability, may not be used as a basis for a total disability rating. Age, as such, is a factor only in evaluations of disability not resulting from service, *i.e.*, for the purposes of pension.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978]

§4.20 Analogous ratings.

When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnosis, or for those not fully supported by clinical and laboratory findings. Nor will ratings assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.

§4.21 Application of rating schedule.

In view of the number of atypical instances it is not expected, especially with the more fully described grades of disabilities, that all cases will show all the findings specified. Findings sufficiently characteristic to identify the disease and the disability therefrom, and above all, coordination of rating with impairment of function will, however, be expected in all instances.

[41 FR 11293, Mar. 18, 1976]

§4.22 Rating of disabilities aggravated by active service.

In cases involving aggravation by active service, the rating will reflect only the degree of disability over and above the degree existing at the time of entrance into the active service, whether the particular condition was noted at the time of entrance into the active service, or it is determined upon the evidence of record to have existed at that time. It is necessary therefore, in all cases of this character to deduct from the present degree of disability the degree, if ascertainable, of the disability existing at the time of entrance into active service, in terms of the rating schedule, except that if the disability is total (100 percent) no deduction will be made. The resulting difference will be recorded on the rating sheet. If the degree of disability at the time of entrance into the service is not ascertainable in terms of the schedule, no deduction will be made.

§4.23 Attitude of rating officers.

It is to be remembered that the majority of applicants are disabled persons who are seeking benefits of law to which they believe themselves entitled. In the exercise of his or her functions, rating officers must not allow their personal feelings to intrude; an antagonistic, critical, or even abusive attitude on the part of a claimant should not in any instance influence the officers in the handling of the case. Fairness and courtesy must at all times be shown to applicants by all employees whose duties bring them in contact, directly or indirectly, with the Department's claimants.

[41 FR 11292, Mar. 18, 1976]

§4.24 Correspondence.

All correspondence relative to the interpretation of the schedule for rating disabilities, requests for advisory opinions, questions regarding lack of clarity or application to individual cases involving unusual difficulties, will be addressed to the Director, Compensation and Pension Service. A clear statement will be made of the point or points upon which information is desired, and the complete case file will be simultaneously forwarded to Central Office. Rating agencies will assure themselves that the recent report of physical examination presents an adequate picture of the claimant's condition. Claims in regard to which the schedule evaluations are considered inadequate or excessive, and errors in the schedule will be similarly brought to attention.

[41 FR 11292, Mar. 18, 1976]

§ 4.25 Combined ratings table.

Table I, Combined Ratings Table, results from the consideration of the efficiency of the individual as affected first by the most disabling condition, then by the less disabling condition, then by other less disabling conditions, if any, in the order of severity. Thus, a person having a 60 percent disability is considered 40 percent efficient. Proceeding from this 40 percent efficiency, the effect of a further 30 percent disability is to leave only 70 percent of the efficiency remaining after consideration of the first disability, or 28 percent efficiency altogether. The individual is thus 72 percent disabled, as shown in table I opposite 60 percent and under 30 percent.

(a) To use table I, the disabilities will first be arranged in the exact order of their severity, beginning with the greatest disability and then combined with use of table I as hereinafter indicated. For example, if there are two disabilities, the degree of one disability will be read in the left column and the degree of the other in the top row, whichever is appropriate. The figures appearing in the space where the column and row intersect will represent the combined value of the two. This combined value will then be converted to the nearest number divisible by 10, and combined values ending in 5 will be adjusted upward. Thus, with a 50 percent disability and a 30 percent disability, the combined value will be found to be 65 percent, but the 65 percent must be converted to 70 percent to represent the final degree of disability. Similarly, with a disability of 40 percent, and another disability of 20 percent, the combined value is found to be 52 percent, but the 52 percent must be converted to the nearest degree divisible by 10, which is 50 percent. If there are more than two disabilities, the disabilities will also be arranged in the exact order of their severity and the combined value for the first two will be found as previously described for two disabilities. The combined value, exactly as found in table I, will be combined with the degree of the third disability (in order of severity). The combined value for the three disabilities will be found in the space where the column and row intersect, and if there are only three disabilities will be converted to the nearest degree divisible by 10, adjusting final 5's upward. Thus, if there are three disabilities ratable at 60 percent, 40 percent, and 20 percent, respectively, the combined value for the first two will be found opposite 60 and under 40 and is 76 percent. This 76 will be combined with 20 and the combined value for the three is 81 percent. This combined value will be converted to the nearest degree divisible by 10 which is 80 percent. The same procedure will be employed when there are four or more disabilities. (See table I).

(b) Except as otherwise provided in this schedule, the disabilities arising from a single disease entity, e.g., arthritis, multiple sclerosis, cerebrovascular accident, etc., are to be rated separately as are all other disabling conditions, if any. All disabilities are then to be combined as described in paragraph (a) of this section. The conversion to the nearest degree divisible by 10 will be done only once per rating decision, will follow the combining of all disabilities, and will be the last procedure in determining the combined degree of disability.

TABLE I—COMBINED RATINGS TABLE

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
19	27	35	43	51	60	68	76	84	92
20	28	36	44	52	60	68	76	84	92

TABLE I—COMBINED RATINGS TABLE—Continued

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
21	29	37	45	53	61	68	76	84	92
22	30	38	45	53	61	69	77	84	92
23	31	38	46	54	62	69	77	85	92
24	32	39	47	54	62	70	77	85	92
25	33	40	48	55	63	70	78	85	93
26	33	41	48	56	63	70	78	85	93
27	34	42	49	56	64	71	78	85	93
28	35	42	50	57	64	71	78	86	93
29	36	43	50	57	65	72	79	86	93
30	37	44	51	58	65	72	79	86	93
31	38	45	52	59	66	72	79	86	93
32	39	46	52	59	66	73	80	86	93
33	40	46	53	60	67	73	80	87	93
34	41	47	54	60	67	74	80	87	93
35	42	48	55	61	68	74	81	87	94
36	42	49	55	62	68	74	81	87	94
37	43	50	56	62	69	75	81	87	94
38	44	50	57	63	69	75	81	88	94
39	45	51	57	63	70	76	82	88	94
40	46	52	58	64	70	76	82	88	94
41	47	53	59	65	71	76	82	88	94
42	48	54	59	65	71	77	83	88	94
43	49	54	60	66	72	77	83	89	94
44	50	55	61	66	72	78	83	89	94
45	51	56	62	67	73	78	84	89	95
46	51	57	62	68	73	78	84	89	95
47	52	58	63	68	74	79	84	89	95
48	53	58	64	69	74	79	84	90	95
49	54	59	64	69	75	80	85	90	95
50	55	60	65	70	75	80	85	90	95
51	56	61	66	71	76	80	85	90	95
52	57	62	66	71	76	81	86	90	95
53	58	62	67	72	77	81	86	91	95
54	59	63	68	72	77	82	86	91	95
55	60	64	69	73	78	82	87	91	96
56	60	65	69	74	78	82	87	91	96
57	61	66	70	74	79	83	87	91	96
58	62	66	71	75	79	83	87	92	96
59	63	67	71	75	80	84	88	92	96
60	64	68	72	76	80	84	88	92	96
61	65	69	73	77	81	84	88	92	96
62	66	70	73	77	81	85	89	92	96
63	67	70	74	78	82	85	89	93	96
64	68	71	75	78	82	86	89	93	96
65	69	72	76	79	83	86	90	93	97
66	69	73	76	80	83	86	90	93	97
67	70	74	77	80	84	87	90	93	97
68	71	74	78	81	84	87	90	94	97
69	72	75	78	81	85	88	91	94	97
70	73	76	79	82	85	88	91	94	97
71	74	77	80	83	86	88	91	94	97
72	75	78	80	83	86	89	92	94	97
73	76	78	81	84	87	89	92	95	97
74	77	79	82	84	87	90	92	95	97
75	78	80	83	85	88	90	93	95	98
76	78	81	83	86	88	90	93	95	98
77	79	82	84	86	89	91	93	95	98
78	80	82	85	87	89	91	93	96	98
79	81	83	85	87	90	92	94	96	98
80	82	84	86	88	90	92	94	96	98
81	83	85	87	89	91	92	94	96	98
82	84	86	87	89	91	93	95	96	98
83	85	86	88	90	92	93	95	97	98
84	86	87	89	90	92	94	95	97	98
85	87	88	90	91	93	94	96	97	99
86	87	89	90	92	93	94	96	97	99
87	88	90	91	92	94	95	96	97	99
88	89	90	92	93	94	95	96	98	99
89	90	91	92	93	95	96	87	38	99
90	91	92	93	94	95	96	97	98	99
91	92	93	94	95	96	96	97	98	99

TABLE I—COMBINED RATINGS TABLE—Continued

[10 combined with 10 is 19]

	10	20	30	40	50	60	70	80	90
92	93	94	94	95	96	97	98	98	99
93	94	94	95	96	97	97	98	99	99
94	95	95	96	96	97	98	98	99	99

(Authority: 38 U.S.C. 1155)

[41 FR 11293, Mar. 18, 1976, as amended at 54 FR 27161, June 28, 1989; 54 FR 36029, Aug. 31, 1989]

§4.26 Bilateral factor.

When a partial disability results from disease or injury of both arms, or of both legs, or of paired skeletal muscles, the ratings for the disabilities of the right and left sides will be combined as usual, and 10 percent of this value will be added (*i.e.*, not combined) before proceeding with further combinations, or converting to degree of disability. The bilateral factor will be applied to such bilateral disabilities before other combinations are carried out and the rating for such disabilities including the bilateral factor in this section will be treated as 1 disability for the purpose of arranging in order of severity and for all further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10's representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent, converted to 70 percent as the final degree of disability.

(a) The use of the terms ''arms'' and ''legs'' is not intended to distinguish between the arm, forearm and hand, or the thigh, leg, and foot, but relates to the upper extremities and lower extremities as a whole. Thus with a compensable disability of the right thigh, for example, amputation, and one of the left foot, for example, pes planus, the bilateral factor applies, and similarly whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment.

(b) The correct procedure when applying the bilateral factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the 4 extremities in the order of their individual severity and apply the bilateral factor by adding, not combining, 10 percent of the combined value thus attained.

(c) The bilateral factor is not applicable unless there is partial disability of compensable degree in each of 2 paired extremities, or paired skeletal muscles.

§4.27 Use of diagnostic code numbers.

The diagnostic code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis in the Department of Veterans Affairs, and as will be observed, extend from 5000 to a possible 9999. Great care will be exercised in the selection of the applicable code number and in its citation on the rating sheet. No other numbers than these listed or hereafter furnished are to be employed for rating purposes, with an exception as described in this section, as to unlisted conditions. When an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be ''built-up'' as follows: The first 2 digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the last 2 digits will be ''99'' for all unlisted conditions. This procedure will facilitate a close check of new and unlisted conditions, rated by analogy. In the selection of code numbers, injuries will generally be represented by the number assigned to the residual condition on the basis of which the rating is determined. With diseases, preference is to be given to the number assigned to the disease itself; if the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, rheumatoid (atrophic) arthritis rated as ankylosis of the lumbar spine should be coded ''5002–5240.'' In this way, the exact source of each rating can be easily identified. In the citation of disabilities on rating sheets, the diagnostic terminology will be that of the medical examiner, with no attempt to translate the terms into schedule nomenclature. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

[41 FR 11293, Mar. 18, 1976, as amended at 70 FR 75399, Dec. 20, 2005]

§ 4.28 Prestabilization rating from date of discharge from service.

The following ratings may be assigned, in lieu of ratings prescribed elsewhere, under the conditions stated for disability from any disease or injury. The prestabilization rating is not to be assigned in any case in which a total rating is immediately assignable under the regular provisions of the schedule or on the basis of individual unemployability. The prestabilization 50-percent rating is not to be used in any case in which a rating of 50 percent or more is immediately assignable under the regular provisions.

	Rating
Unstabilized condition with severe disability—	
Substantially gainful employment is not feasible or advisable	100
Unhealed or incompletely healed wounds or injuries—	
Material impairment of employability likely	50

NOTE (1): Department of Veterans Affairs examination is not required prior to assignment of prestabilization ratings; however, the fact that examination was accomplished will not preclude assignment of these benefits. Prestabilization ratings are for assignment in the immediate postdischarge period. They will continue for a 12-month period following discharge from service. However, prestabilization ratings may be changed to a regular schedular total rating or one authorizing a greater benefit at any time. In each prestabilization rating an examination will be requested to be accomplished not earlier than 6 months nor more than 12 months following discharge. In those prestabilization ratings in which following examination reduction in evaluation is found to be warranted, the higher evaluation will be continued to the end of the 12th month following discharge or to the end of the period provided under § 3.105(e) of this chapter, whichever is later. Special monthly compensation should be assigned concurrently in these cases whenever records are adequate to establish entitlement.

NOTE (2): Diagnosis of disease, injury, or residuals will be cited, with diagnostic code number assigned from this rating schedule for conditions listed therein.

[35 FR 11906, July 24, 1970]

§ 4.29 Ratings for service-connected disabilities requiring hospital treatment or observation.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established that a service-connected disability has required hospital treatment in a Department of Veterans Affairs or an approved hospital for a period in excess of 21 days or *hospital observation at Department of Veterans Affairs expense* for a service-connected disability for a period in excess of 21 days.

(a) Subject to the provisions of paragraphs (d), (e), and (f) of this section this increased rating will be effective the first day of continuous hospitalization and will be terminated effective the last day of the month of hospital discharge (regular discharge or release to non-bed care) or effective the last day of the month of termination of treatment or observation for the service-connected disability. A temporary release which is approved by an attending Department of Veterans Affairs physician as part of the treatment plan will not be considered an absence.

(1) An authorized absence in excess of 4 days which begins during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the first day of such authorized absence. An authorized absence of 4 days or less which results in a total of more than 8 days of authorized absence during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the ninth day of authorized absence.

(2) Following a period of hospitalization in excess of 21 days, an authorized absence in excess of 14 days or a third consecutive authorized absence of 14 days will be regarded as the equivalent

of hospital discharge and will interrupt hospitalization effective on the last day of the month in which either the authorized absence in excess of 14 days or the third 14 day period begins, except where there is a finding that convalescence is required as provided by paragraph (e) or (f) of this section. The termination of these total ratings will not be subject to § 3.105(e) of this chapter.

(b) Notwithstanding that hospital admission was for disability not connected with service, if during such hospitalization, hospital treatment for a service-connected disability is instituted and continued for a period in excess of 21 days, the increase to a total rating will be granted from the first day of such treatment. If service connection for the disability under treatment is granted after hospital admission, the rating will be from the first day of hospitalization if otherwise in order.

(c) The assignment of a total disability rating on the basis of hospital treatment or observation will not preclude the assignment of a total disability rating otherwise in order under other provisions of the rating schedule, and consideration will be given to the propriety of such a rating in all instances and to the propriety of its continuance after discharge. Particular attention, with a view to proper rating under the rating schedule, is to be given to the claims of veterans discharged from hospital, regardless of length of hospitalization, with indications on the final summary of expected confinement to bed or house, or to inability to work with requirement of frequent care of physician or nurse at home.

(d) On these total ratings Department of Veterans Affairs regulations governing effective dates for increased benefits will control.

(e) The total hospital rating if convalescence is required may be continued for periods of 1, 2, or 3 months in addition to the period provided in paragraph (a) of this section.

(f) Extension of periods of 1, 2 or 3 months beyond the initial 3 months may be made upon approval of the Veterans Service Center Manager.

(g) Meritorious claims of veterans who are discharged from the hospital with less than the required number of days but need post-hospital care and a prolonged period of convalescence will be referred to the Director, Compensation and Pension Service, under § 3.321(b)(1) of this chapter.

[29 FR 6718, May 22, 1964, as amended at 41 FR 11294, Mar. 18, 1976; 41 FR 34256, Aug. 13, 1976; 54 FR 4281, Jan. 30, 1989; 54 FR 34981, Aug. 23, 1989; 71 FR 28586, May 17, 2006]

§ 4.30 Convalescent ratings.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established by report at hospital discharge (regular discharge or release to non-bed care) or outpatient release that entitlement is warranted under paragraph (a) (1), (2) or (3) of this section effective the date of hospital admission or outpatient treatment and continuing for a period of 1, 2, or 3 months from the first day of the month following such hospital discharge or outpatient release. The termination of these total ratings will not be subject to § 3.105(e) of this chapter. Such total rating will be followed by appropriate schedular evaluations. When the evidence is inadequate to assign a schedular evaluation, a physical examination will be scheduled and considered prior to the termination of a total rating under this section.

(a) Total ratings will be assigned under this section if treatment of a service-connected disability resulted in:

(1) Surgery necessitating at least one month of convalescence (Effective as to outpatient surgery March 1, 1989.)

(2) Surgery with severe postoperative residuals such as incompletely healed surgical wounds, stumps of recent amputations, therapeutic immobilization of one major joint or more, application of a body cast, or the necessity for house confinement, or the necessity for continued use of a wheelchair or crutches (regular weight-bearing prohibited). (Effective as to outpatient surgery March 1, 1989.)

(3) Immobilization by cast, without surgery, of one major joint or more. (Effective as to outpatient treatment March 10, 1976.)

A reduction in the total rating will not be subject to § 3.105(e) of this chapter. The total rating will be followed by an open rating reflecting the appropriate schedular evaluation; where the evidence is inadequate to assign the schedular evaluation, a physcial examination will be scheduled prior to the end of the total rating period.

(b) A total rating under this section will require full justification on the rating sheet and may be extended as follows:

(1) Extensions of 1, 2 or 3 months beyond the initial 3 months may be made under paragraph (a) (1), (2) or (3) of this section.

(2) Extensions of 1 or more months up to 6 months beyond the initial 6 months period may be made under paragraph (a) (2) or (3) of this section upon approval of the Veterans Service Center Manager.

[41 FR 34256, Aug. 13, 1976, as amended at 54 FR 4281, Jan. 30, 1989; 71 FR 28586, May 17, 2006]

§ 4.31 Zero percent evaluations.

In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met.

[58 FR 52018, Oct. 6, 1993]

Subpart B—Disability Ratings

THE MUSCULOSKELETAL SYSTEM

§ 4.40 Functional loss.

Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. It is essential that the examination on which ratings are based adequately portray the anatomical damage, and the functional loss, with respect to all these elements. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled. A little used part of the musculoskeletal system may be expected to show evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like.

§ 4.41 History of injury.

In considering the residuals of injury, it is essential to trace the medical-industrial history of the disabled person from the original injury, considering the nature of the injury and the attendant circumstances, and the requirements for, and the effect of, treatment over past periods, and the course of the recovery to date. The duration of the initial, and any subsequent, period of total incapacity, especially periods reflecting delayed union, inflammation, swelling, drainage, or operative intervention, should be given close attention. This consideration, or the absence of clear cut evidence of injury, may result in classifying the disability as not of traumatic origin, either reflecting congenital or developmental etiology, or the effects of healed disease.

§ 4.42 Complete medical examination of injury cases.

The importance of complete medical examination of injury cases at the time of first medical examination by the Department of Veterans Affairs cannot be overemphasized. When possible, this should include complete neurological and psychiatric examination, and other special examinations indicated by the physical condition, in addition to the required general and orthopedic or surgical examinations. When complete examinations are not conducted covering all systems of the body affected by disease or injury, it is impossible to visualize the nature and extent of the service connected disability. Incomplete examination is a common cause of incorrect diagnosis, especially in the neurological and psychiatric fields, and frequently leaves the Department of Veterans Affairs in doubt as to the presence or absence of disabling conditions at the time of the examination.

§ 4.43 Osteomyelitis.

Chronic, or recurring, suppurative osteomyelitis, once clinically identified, including chronic inflammation of bone marrow, cortex, or periosteum, should be considered as a continuously disabling process, whether or not an actively discharging sinus or other obvious evidence of infection is manifest from time to time, and unless the focus is entirely removed by amputation will entitle to a permanent rating to be combined with other ratings for residual conditions, however, not exceeding amputation ratings at the site of election.

§ 4.44 The bones.

The osseous abnormalities incident to trauma or disease, such as malunion with deformity throwing abnormal stress upon, and causing malalignment of joint surfaces, should be depicted from study and observation of all available data, beginning with inception of injury or disease, its nature, degree of prostration, treatment and duration of convalescence, and progress of recovery with development of permanent residuals. With shortening of a long bone, some degree of angulation is to be expected; the extent and direction should be brought out by X-ray and observation. The direction of angulation and extent of deformity should be carefully related to strain on the neighboring joints, especially those connected with weight-bearing.

§ 4.45 The joints.

As regards the joints the factors of disability reside in reductions of their normal excursion of movements in different planes. Inquiry will be directed to these considerations:

(a) Less movement than normal (due to ankylosis, limitation or blocking, adhesions, tendon-tie-up, contracted scars, etc.).

(b) More movement than normal (from flail joint, resections, nonunion of fracture, relaxation of ligaments, etc.).

(c) Weakened movement (due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.).

(d) Excess fatigability.

(e) Incoordination, impaired ability to execute skilled movements smoothly.

(f) Pain on movement, swelling, deformity or atrophy of disuse. Instability of station, disturbance of locomotion, interference with sitting, standing and weight-bearing are related considerations. For the purpose of rating disability from arthritis, the shoulder, elbow, wrist, hip, knee, and ankle are considered major joints; multiple involvements of the interphalangeal, metacarpal and carpal joints of the upper extremities, the interphalangeal, metatarsal and tarsal joints of the lower extremities, the cervical vertebrae, the dorsal vertebrae, and the lumbar vertebrae, are considered groups of minor joints, ratable on a parity with major joints. The lumbosacral articulation and both sacroiliac joints are considered to be a group of minor joints, ratable on disturbance of lumbar spine functions.

§ 4.46 Accurate measurement.

Accurate measurement of the length of stumps, excursion of joints, dimensions and location of scars with respect to landmarks, should be insisted on. The use of a goniometer in the measurement of limitation of motion is indispensable in examinations conducted within the Department of Veterans Affairs. Muscle atrophy must also be accurately measured and reported.

[41 FR 11294, Mar. 18, 1976]

§§ 4.47–4.54 [Reserved]

§ 4.55 Principles of combined ratings for muscle injuries.

(a) A muscle injury rating will not be combined with a peripheral nerve paralysis rating of the same body part, unless the injuries affect entirely different functions.

(b) For rating purposes, the skeletal muscles of the body are divided into 23 muscle groups in 5 anatomical regions: 6 muscle groups for the shoulder girdle and arm (diagnostic codes 5301 through 5306); 3 muscle groups for the forearm and hand (diagnostic codes 5307 through 5309); 3 muscle groups for the foot and leg (diagnostic codes 5310 through 5312); 6 muscle groups for the pelvic girdle and thigh (diagnostic codes 5313 through 5318); and 5 muscle groups for the torso and neck (diagnostic codes 5319 through 5323).

(c) There will be no rating assigned for muscle groups which act upon an ankylosed joint, with the following exceptions:

(1) In the case of an ankylosed knee, if muscle group XIII is disabled, it will be rated, but at the next lower level than that which would otherwise be assigned.

(2) In the case of an ankylosed shoulder, if muscle groups I and II are severely disabled, the evaluation of the shoulder joint under diagnostic code 5200 will be elevated to the level for unfavorable ankylosis, if not already assigned, but the muscle groups themselves will not be rated.

(d) The combined evaluation of muscle groups acting upon a single unankylosed joint must be lower than the evaluation for unfavorable ankylosis of that joint, except in the case of muscle groups I and II acting upon the shoulder.

(e) For compensable muscle group injuries which are in the same anatomical region but do not act on the same joint, the evaluation for the most severely injured muscle group will be increased by one level and used as the combined evaluation for the affected muscle groups.

(f) For muscle group injuries in different anatomical regions which do not act upon ankylosed joints, each muscle group injury shall be separately rated and the ratings combined under the provisions of § 4.25.

(Authority: 38 U.S.C. 1155)

[62 FR 30237, June 3, 1997]

§ 4.56 Evaluation of muscle disabilities.

(a) An open comminuted fracture with muscle or tendon damage will be rated as a severe injury of the muscle group involved unless, for locations such as in the wrist or over the tibia, evidence establishes that the muscle damage is minimal.

(b) A through-and-through injury with muscle damage shall be evaluated as no less than a moderate injury for each group of muscles damaged.

(c) For VA rating purposes, the cardinal signs and symptoms of muscle disability are loss of power, weakness, lowered threshold of fatigue, fatigue-pain, impairment of coordination and uncertainty of movement.

(d) Under diagnostic codes 5301 through 5323, disabilities resulting from muscle injuries shall be classified as slight, moderate, moderately severe or severe as follows:

(1) *Slight disability of muscles*—(i) *Type of injury*. Simple wound of muscle without debridement or infection.

(ii) *History and complaint*. Service department record of superficial wound with brief treatment and return to duty. Healing with good functional results. No cardinal signs or symptoms of muscle disability as defined in paragraph (c) of this section.

(iii) *Objective findings*. Minimal scar. No evidence of fascial defect, atrophy, or impaired tonus. No impairment of function or metallic fragments retained in muscle tissue.

(2) *Moderate disability of muscles*—(i) *Type of injury*. Through and through or deep penetrating wound of short track from a single bullet, small shell or shrapnel fragment, without explosive effect of high velocity missile, residuals of debridement, or prolonged infection.

(ii) *History and complaint*. Service department record or other evidence of in-service treatment for the wound. Record of consistent complaint of one or more of the cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section, particularly lowered threshold of fatigue after average use, affecting the particular functions controlled by the injured muscles.

(iii) *Objective findings*. Entrance and (if present) exit scars, small or linear, indicating short track of missile through muscle tissue. Some loss of deep fascia or muscle substance or impairment of muscle tonus and loss of power or lowered threshold of fatigue when compared to the sound side.

(3) *Moderately severe disability of muscles*—(i) *Type of injury*. Through and through or deep penetrating wound by small high velocity missile or large

low-velocity missile, with debridement, prolonged infection, or sloughing of soft parts, and intermuscular scarring.

(ii) *History and complaint*. Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section and, if present, evidence of inability to keep up with work requirements.

(iii) *Objective findings*. Entrance and (if present) exit scars indicating track of missile through one or more muscle groups. Indications on palpation of loss of deep fascia, muscle substance, or normal firm resistance of muscles compared with sound side. Tests of strength and endurance compared with sound side demonstrate positive evidence of impairment.

(4) *Severe disability of muscles*—(i) *Type of injury*. Through and through or deep penetrating wound due to high-velocity missile, or large or multiple low velocity missiles, or with shattering bone fracture or open comminuted fracture with extensive debridement, prolonged infection, or sloughing of soft parts, intermuscular binding and scarring.

(ii) *History and complaint*. Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section, worse than those shown for moderately severe muscle injuries, and, if present, evidence of inability to keep up with work requirements.

(iii) *Objective findings*. Ragged, depressed and adherent scars indicating wide damage to muscle groups in missile track. Palpation shows loss of deep fascia or muscle substance, or soft flabby muscles in wound area. Muscles swell and harden abnormally in contraction. Tests of strength, endurance, or coordinated movements compared with the corresponding muscles of the uninjured side indicate severe impairment of function. If present, the following are also signs of severe muscle disability:

(A) X-ray evidence of minute multiple scattered foreign bodies indicating intermuscular trauma and explosive effect of the missile.

(B) Adhesion of scar to one of the long bones, scapula, pelvic bones, sacrum or vertebrae, with epithelial sealing over the bone rather than true skin covering in an area where bone is normally protected by muscle.

(C) Diminished muscle excitability to pulsed electrical current in electrodiagnostic tests.

(D) Visible or measurable atrophy.

(E) Adaptive contraction of an opposing group of muscles.

(F) Atrophy of muscle groups not in the track of the missile, particularly of the trapezius and serratus in wounds of the shoulder girdle.

(G) Induration or atrophy of an entire muscle following simple piercing by a projectile.

(Authority: 38 U.S.C. 1155

[62 FR 30238, June 3, 1997]

§4.57 Static foot deformities.

It is essential to make an initial distinction between bilateral flatfoot as a congenital or as an acquired condition. The congenital condition, with depression of the arch, but no evidence of abnormal callosities, areas of pressure, strain or demonstrable tenderness, is a congenital abnormality which is not compensable or pensionable. In the acquired condition, it is to be remembered that depression of the longitudinal arch, or the degree of depression, is not the essential feature. The attention should be given to anatomical changes, as compared to normal, in the relationship of the foot and leg, particularly to the inward rotation of the superior portion of the os calcis, medial deviation of the insertion of the Achilles tendon, the medial tilting of the upper border of the astragalus. This is an unfavorable mechanical relationship of the parts. A plumb line dropped from the middle of the patella falls inside of the normal point. The forepart of the foot is abducted, and the foot everted. The plantar surface of the foot is painful and shows demonstrable tenderness, and manipulation of the foot produces spasm of the Achilles tendon, peroneal spasm due to adhesion about the peroneal sheaths, and other evidence of pain and limited motion. The symptoms should be apparent without regard to exercise. In severe cases there is gaping of bones on the inner border of the foot, and rigid valgus position with loss of the power of inversion and adduction. Exercise with undeveloped or unbalanced musculature, producing chronic irritation, can be an aggravating factor. In the absence of trauma or other definite evidence of aggravation, service connection is not in order for pes cavus which is a typically congenital or juvenile disease.

§ 4.58 Arthritis due to strain.

With service incurred lower extremity amputation or shortening, a disabling arthritis, developing in the same extremity, or in both lower extremities, with indications of earlier, or more severe, arthritis in the injured extremity, including also arthritis of the lumbosacral joints and lumbar spine, if associated with the leg amputation or shortening, will be considered as service incurred, provided, however, that arthritis affecting joints not directly subject to strain as a result of the service incurred amputation will not be granted service connection. This will generally require separate evaluation of the arthritis in the joints directly subject to strain. Amputation, or injury to an upper extremity, is not considered as a causative factor with subsequently developing arthritis, except in joints subject to direct strain or actually injured.

§ 4.59 Painful motion.

With any form of arthritis, painful motion is an important factor of disability, the facial expression, wincing, etc., on pressure or manipulation, should be carefully noted and definitely related to affected joints. Muscle spasm will greatly assist the identification. Sciatic neuritis is not uncommonly caused by arthritis of the spine. The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or malaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint. Crepitation either in the soft tissues such as the tendons or ligaments, or crepitation within the joint structures should be noted carefully as points of contact which are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and nonweight-bearing and, if possible, with the range of the opposite undamaged joint.

§ 4.60 [Reserved]

§ 4.61 Examination.

With any form of arthritis (except traumatic arthritis) it is essential that the examination for rating purposes cover all major joints, with especial reference to Heberden's or Haygarth's nodes.

§ 4.62 Circulatory disturbances.

The circulatory disturbances, especially of the lower extremity following injury in the popliteal space, must not be overlooked, and require rating generally as phlebitis.

§ 4.63 Loss of use of hand or foot.

Loss of use of a hand or a foot, for the purpose of special monthly compensation, will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance. The determination will be made on the basis of the actual remaining function of the hand or foot, whether the acts of grasping, manipulation, etc., in the case of the hand, or of balance and propulsion, etc., in the case of the foot, could be accomplished equally well by an amputation stump with prosthesis.

(a) Extremely unfavorable complete ankylosis of the knee, or complete ankylosis of 2 major joints of an extremity, or shortening of the lower extremity of 3½ inches (8.9 cms.) or more, will be taken as loss of use of the hand or foot involved.

(b) Complete paralysis of the external popliteal nerve (common peroneal) and consequent, footdrop, accompanied by characteristic organic changes including trophic and circulatory disturbances and other concomitants confirmatory of complete paralysis of this nerve, will be taken as loss of use of the foot.

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978]

§ 4.64 Loss of use of both buttocks.

Loss of use of both buttocks shall be deemed to exist when there is severe damage to muscle Group XVII, bilateral (diagnostic code number 5317) and additional disability rendering it impossible for the disabled person, without assistance, to rise from a seated position and from a stooped position (fingers to toes position) and to maintain postural stability (the pelvis upon head of femur). The assistance may be rendered by the person's own hands or arms, and, in the matter of postural stability, by a special appliance.

§ 4.65 [Reserved]

§ 4.66 Sacroiliac joint.

The common cause of disability in this region is arthritis, to be identified in the usual manner. The lumbosacral and sacroiliac joints should be considered as one anatomical segment for rating purposes. X-ray changes from arthritis in this location are decrease or obliteration of the joint space, with the appearance of increased bone density of the sacrum and ilium and sharpening of the margins of the joint. Disability is manifest from erector spinae spasm (not accounted for by other pathology), tenderness on deep palpation and percussion over these joints, loss of normal quickness of motion and resiliency, and postural defects often accompanied by limitation of flexion and extension of the hip. Traumatism is a rare cause of disability in this connection, except when superimposed upon congenital defect or upon an existent arthritis; to permit assumption of pure traumatic origin, objective evidence of damage to the joint, and history of trauma sufficiently severe to injure this extremely strong and practically immovable joint is required. There should be careful consideration of lumbosacral sprain, and the various symptoms of pain and paralysis attributable to disease affecting the lumbar vertebrae and the intervertebral disc.

§ 4.67 Pelvic bones.

The variability of residuals following these fractures necessitates rating on specific residuals, faulty posture, limitation of motion, muscle injury, painful motion of the lumbar spine, manifest by muscle spasm, mild to moderate sciatic neuritis, peripheral nerve injury, or limitation of hip motion.

§ 4.68 Amputation rule.

The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not to exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

§ 4.69 Dominant hand.

Handedness for the purpose of a dominant rating will be determined by the evidence of record, or by testing on VA examination. Only one hand shall be considered dominant. The injured hand, or the most severely injured hand, of an ambidextrous individual will be considered the dominant hand for rating purposes.

(Authority: 38 U.S.C. 1155)

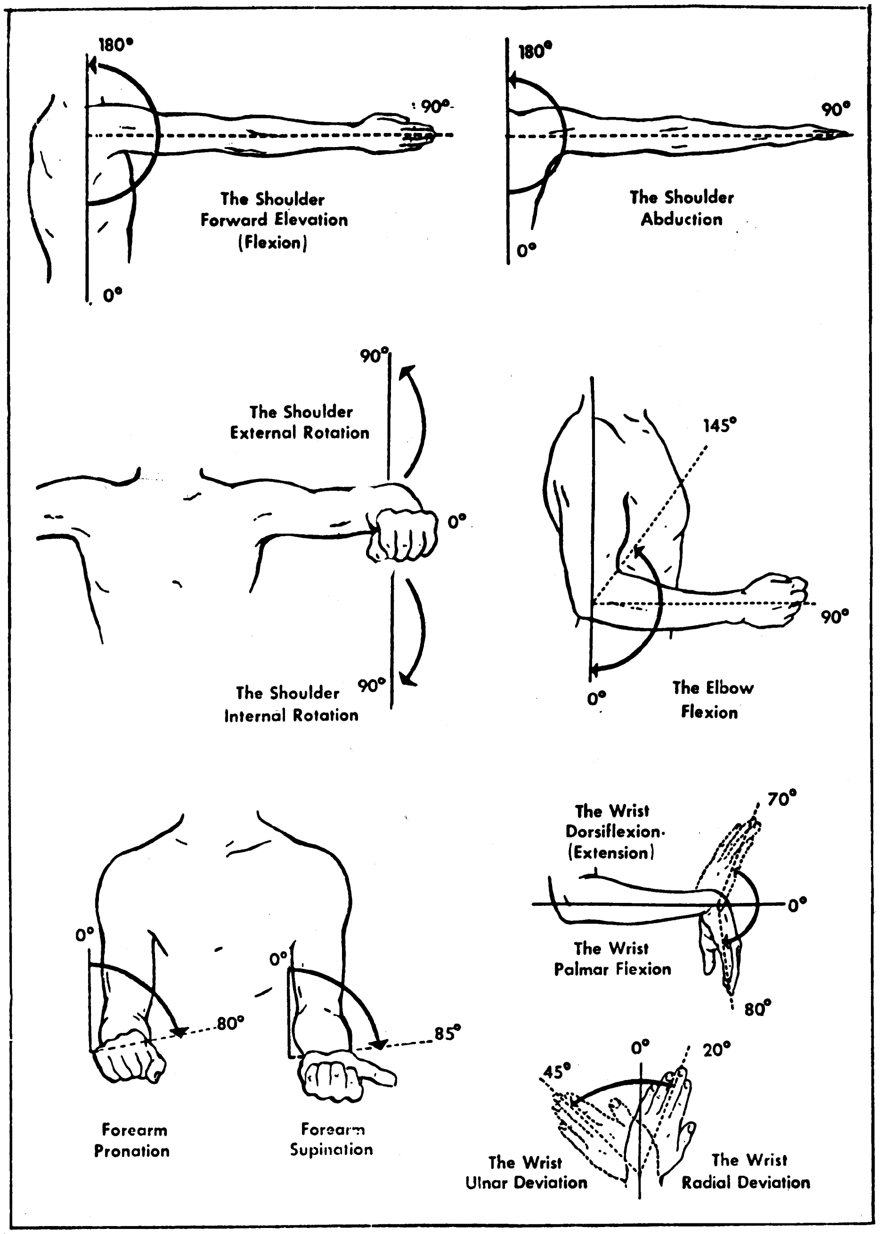
[62 FR 30239, June 3, 1997]

§ 4.70 Inadequate examinations.

If the report of examination is inadequate as a basis for the required consideration of service connection and evaluation, the rating agency may request a supplementary report from the examiner giving further details as to the limitations of the disabled person's ordinary activity imposed by the disease, injury, or residual condition, the prognosis for return to, or continuance of, useful work. When the best interests of the service will be advanced by personal conference with the examiner, such conference may be arranged through channels.

§4.71 Measurement of ankylosis and joint motion.

Plates I and II provide a standardized description of ankylosis and joint motion measurement. The anatomical position is considered as 0°, with two major exceptions: (a) Shoulder rotation—arm abducted to 90°, elbow flexed to 90° with the position of the forearm reflecting the midpoint 0° between internal and external rotation of the shoulder; and (b) supination and pronation—the arm next to the body, elbow flexed to 90°, and the forearm in midposition 0° between supination and pronation. Motion of the thumb and fingers should be described by appropriate reference to the joints (See Plate III) whose movement is limited, with a statement as to how near, in centimeters, the tip of the thumb can approximate the fingers, or how near the tips of the fingers can approximate the proximal transverse crease of palm.



180°
90°
0°
The Shoulder
Forward Elevation
(Flexion)
180°
90°
0°
The Shoulder
Abduction
90°
The Shoulder
External Rotation
0°
The Shoulder
Internal Rotation
90°
145°
90°
0°
The Elbow
Flexion
0°
80°
0°
85°
Forearm
Pronation
Forearm
Supination
The Wrist
Dorsiflexion
(Extension)
70°
0°
The Wrist
Palmar Flexion
80°
0°
20°
45°
The Wrist
Ulnar Deviation
The Wrist
Radial Deviation

PLATE I

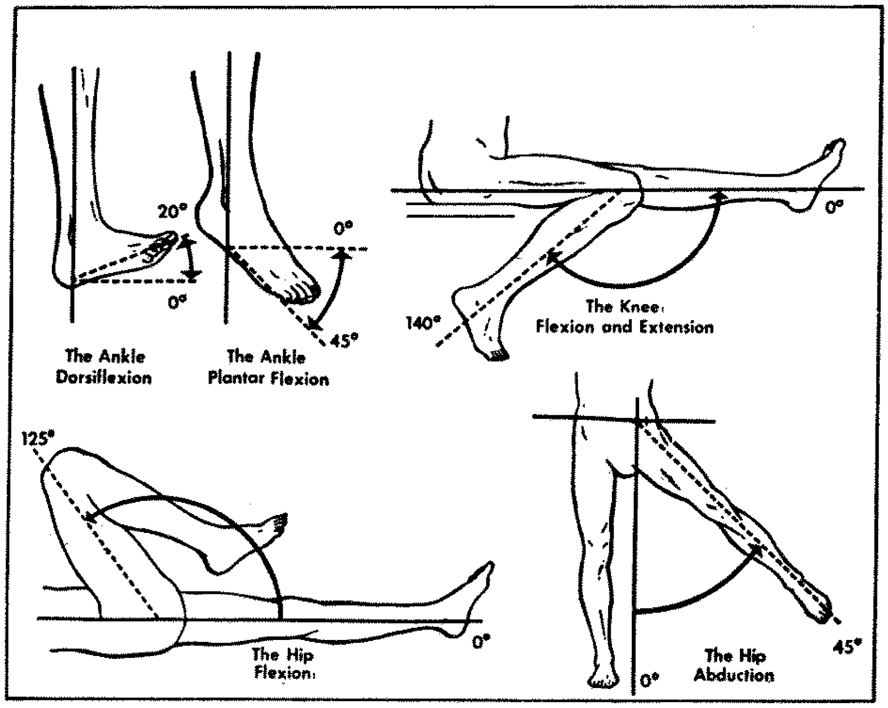


PLATE II

[29 FR 6718, May 22, 1964, as amended at 43 FR 45349, Oct. 2, 1978; 67 FR 48785, July 26, 2002]

§ 4.71a Schedule of ratings—musculoskeletal system.

ACUTE, SUBACUTE, OR CHRONIC DISEASES

	Rating
5000 Osteomyelitis, acute, subacute, or chronic:	
Of the pelvis, vertebrae, or extending into major joints, or with multiple localization or with long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms	100
Frequent episodes, with constitutional symptoms	60
With definite involucrum or sequestrum, with or without discharging sinus	30
With discharging sinus or other evidence of active infection within the past 5 years	20
Inactive, following repeated episodes, without evidence of active infection in past 5 years	10

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE (1): A rating of 10 percent, as an exception to the amputation rule, is to be assigned in any case of active osteomyelitis where the amputation rating for the affected part is no percent. This 10 percent rating and the other partial ratings of 30 percent or less are to be combined with ratings for ankylosis, limited motion, nonunion or malunion, shortening, etc., subject, of course, to the amputation rule. The 60 percent rating, as it is based on constitutional symptoms, is not subject to the amputation rule. A rating for osteomyelitis will not be applied following cure by removal or radical resection of the affected bone.	

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE (2): The 20 percent rating on the basis of activity within the past 5 years is not assignable following the initial infection of active osteomyelitis with no subsequent reactivation. The prerequisite for this historical rating is an established recurrent osteomyelitis. To qualify for the 10 percent rating, 2 or more episodes following the initial infection are required. This 20 percent rating or the 10 percent rating, when applicable, will be assigned once only to cover disability at all sites of previously active infection with a future ending date in the case of the 20 percent rating.	
5001 Bones and joints, tuberculosis of, active or inactive:	
Active	100
Inactive: See §§4.88b and 4.89.	
5002 Arthritis rheumatoid (atrophic) *As an active process:*	
With constitutional manifestations associated with active joint involvement, totally incapacitating	100
Less than criteria for 100% but with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods	60
Symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year	40
One or two exacerbations a year in a well-established diagnosis	20
For chronic residuals:	
For residuals such as limitation of motion or ankylosis, favorable or unfavorable, rate under the appropriate diagnostic codes for the specific joints involved. Where, however, the limitation of motion of the specific joint or joints involved is noncompensable under the codes a rating of 10 percent is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5002. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion.	
NOTE: The ratings for the active process will not be combined with the residual ratings for limitation of motion or ankylosis. Assign the higher evaluation.	
5003 Arthritis, degenerative (hypertrophic or osteoarthritis):	
Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. In the absence of limitation of motion, rate as below:	
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations	20
With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups	10
NOTE (1): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.	
NOTE (2): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be utilized in rating conditions listed under diagnostic codes 5013 to 5024, inclusive.	
5004 Arthritis, gonorrheal.	
5005 Arthritis, pneumococcic.	
5006 Arthritis, typhoid.	
5007 Arthritis, syphilitic.	
5008 Arthritis, streptococcic.	
5009 Arthritis, other types (specify).	
With the types of arthritis, diagnostic codes 5004 through 5009, rate the disability as rheumatoid arthritis.	
5010 Arthritis, due to trauma, substantiated by X-ray findings: Rate as arthritis, degenerative.	
5011 Bones, caisson disease of: Rate as arthritis, cord involvement, or deafness, depending on the severity of disabling manifestations.	
5012 Bones, new growths of, malignant	100
NOTE: The 100 percent rating will be continued for 1 year following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.	
5013 Osteoporosis, with joint manifestations.	
5014 Osteomalacia.	
5015 Bones, new growths of, benign.	
5016 Osteitis deformans.	
5017 Gout.	
5018 Hydrarthrosis, intermittent.	
5019 Bursitis.	
5020 Synovitis.	
5021 Myositis.	
5022 Periostitis.	
5023 Myositis ossificans.	
5024 Tenosynovitis.	
The diseases under diagnostic codes 5013 through 5024 will be rated on limitation of motion of affected parts, as arthritis, degenerative, except gout which will be rated under diagnostic code 5002.	
5025 Fibromyalgia (fibrositis, primary fibromyalgia syndrome)	
With widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms:	
That are constant, or nearly so, and refractory to therapy	40
That are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time	20
That require continuous medication for control	10

ACUTE, SUBACUTE, OR CHRONIC DISEASES—Continued

	Rating
NOTE: Widespread pain means pain in both the left and right sides of the body, that is both above and below the waist, and that affects both the axial skeleton (*i.e.*, cervical spine, anterior chest, thoracic spine, or low back) and the extremities.	

PROSTHETIC IMPLANTS

	Rating	
	Major	Minor
5051 Shoulder replacement (prosthesis).		
Prosthetic replacement of the shoulder joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	60	50
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic codes 5200 and 5203.		
Minimum rating	30	20
5052 Elbow replacement (prosthesis).		
Prosthetic replacement of the elbow joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity	50	40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5205 through 5208.		
Minimum evaluation	30	20
5053 Wrist replacement (prosthesis).		
Prosthetic replacement of wrist joint:		
For 1 year following implantation of prosthesis	100	100
With chronic residuals consisting of severe, painful motion or weakness in the affected extremity	40	30
With intermediate degrees of residual weakness, pain or limitation of motion, rate by analogy to diagnostic code 5214.		
Minimum rating	20	20
NOTE: The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.		
5054 Hip replacement (prosthesis).		
Prosthetic replacement of the head of the femur or of the acetabulum:		
For 1 year following implantation of prosthesis		100
Following implantation of prosthesis with painful motion or weakness such as to require the use of crutches		[1] 90
Markedly severe residual weakness, pain or limitation of motion following implantation of prosthesis		70
Moderately severe residuals of weakness, pain or limitation of motion		50
Minimum rating		30
5055 Knee replacement (prosthesis).		
Prosthetic replacement of knee joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness in the affected extremity		60
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to diagnostic codes 5256, 5261, or 5262.		
Minimum rating		30
5056 Ankle replacement (prosthesis).		
Prosthetic replacement of ankle joint:		
For 1 year following implantation of prosthesis		100
With chronic residuals consisting of severe painful motion or weakness		40
With intermediate degrees of residual weakness, pain or limitation of motion rate by analogy to 5270 or 5271.		
Minimum rating		20
NOTE (1): The 100 pct rating for 1 year following implantation of prosthesis will commence after initial grant of the 1-month total rating assigned under § 4.30 following hospital discharge.		
NOTE (2): Special monthly compensation is assignable during the 100 pct rating period the earliest date permanent use of crutches is established.		
COMBINATIONS OF DISABILITIES		
5104 Anatomical loss of one hand and loss of use of one foot		[1] 100
5105 Anatomical loss of one foot and loss of use of one hand		[1] 100
5106 Anatomical loss of both hands		[1] 100
5107 Anatomical loss of both feet		[1] 100
5108 Anatomical loss of one hand and one foot		[1] 100
5109 Loss of use of both hands		[1] 100
5110 Loss of use of both feet		[1] 100
5111 Loss of use of one hand and one foot		[1] 100

[1] Also entitled to special monthly compensation.

TABLE II—RATINGS FOR MULTIPLE LOSSES OF EXTREMITIES WITH DICTATOR'S RATING CODE AND 38 CFR CITATION

Impairment of one extremity	Impairment of other extremity					
	Anatomical loss or loss of use below elbow	Anatomical loss or loss of use below knee	Anatomical loss or loss of use above elbow (preventing use of prosthesis)	Anatomical loss or loss of use above knee (preventing use of prosthesis)	Anatomical loss near shoulder (preventing use of prosthesis)	Anatomical loss near hip (preventing use of prosthesis)
Anatomical loss or loss of use below elbow.	M Codes M–1 a, b, or c, 38 CFR 3.350 (c)(1)(i).	L Codes L–1 d, e, f, or g, 38 CFR 3.350(b).	M½ Code M–5, 38 CFR 3.350 (f)(1)(x).	L½ Code L–2 c, 38 CFR 3.350 (f)(1)(vi).	N Code N–3, 38 CFR 3.350 (f)(1)(xi).	M Code M–3 c, 38 CFR 3.350 (f)(1)(viii)
Anatomical loss or loss of use below knee.	....	L Codes L–1 a, b, or c, 38 CFR 3.350(b).	L½ Code L–2 b, 38 CFR 3.350 (f)(1)(iii).	L½ Code L–2 a, 38 CFR 3.350 (f)(1)(i).	M Code M–3 b, 38 CFR 3.350 (f)(1)(iv).	M Code M–3 a, 38 CFR 3.350 (f)(1)(ii)
Anatomical loss or loss of use above elbow (preventing use of prosthesis).	....	....	N Code N–1, 38 CFR 3.350 (d)(1).	M Code M–2 a, 38 CFR 3.350 (c)(1)(iii).	N½ Code N–4, 38 CFR 3.350 (f)(1)(ix).	M½ Code M–4 c, 38 CFR 3.350 (f)(1)(xi)
Anatomical loss or loss of use above knee (preventing use of prosthesis).	....	....	....	M Code M–2 a, 38 CFR 3.350 (c)(1)(ii).	M½ Code M–4 b, 38 CFR 3.350 (f)(1)(vii).	M½ Code M–4 a, 38 CFR 3.350 (f)(1)(v)
Anatomical loss near shoulder (preventing use of prosthesis).	....	....	....	....	O Code O–1, 38 CFR 3.350 (e)(1)(i).	N Code N–2 b, 38 CFR 3.350 (d)(3)
Anatomical loss near hip (preventing use of prosthesis).	....	....	....	....	....	N Code N–2 a, 38 CFR 3.350 (d)(2)

NOTE.—Need for aid attendance or permanently bedridden qualifies for subpar. L. Code L–1 h, i (38 CFR 3.350(b)). Paraplegia with loss of use of both lower extremities and loss of anal and bladder sphincter control qualifies for subpar. O. Code O–2 (38 CFR 3.350(e)(2)). Where there are additional disabilities rated 50% or 100%, or anatomical or loss of use of a third extremity see 38 CFR 3.350(f) (3), (4) or (5).

(Authority: 38 U.S.C. 1115)

AMPUTATIONS: UPPER EXTREMITY

	Rating Major	Rating Minor
Arm, amputation of:		
5120 Disarticulation	[1]90	[1]90
5121 Above insertion of deltoid	[1]90	[1]80
5122 Below insertion of deltoid	[1]80	[1]70
Forearm, amputation of:		
5123 Above insertion of pronator teres	[1]80	[1]70
5124 Below insertion of pronator teres	[1]70	[1]60
5125 Hand, loss of use of	[1]70	[1]60
MULTIPLE FINGER AMPUTATIONS		
5126 Five digits of one hand, amputation of	[1]70	[1]60
Four digits of one hand, amputation of:		
5127 Thumb, index, long and ring	[1]70	[1]60
5128 Thumb, index, long and little	[1]70	[1]60
5129 Thumb, index, ring and little	[1]70	[1]60
5130 Thumb, long, ring and little	[1]70	[1]60
5131 Index, long, ring and little	60	50
Three digits of one hand, amputation of:		
5132 Thumb, index and long	60	50
5133 Thumb, index and ring	60	50
5134 Thumb, index and little	60	50
5135 Thumb, long and ring	60	50
5136 Thumb, long and little	60	50

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating Major	Rating Minor
5137 Thumb, ring and little	60	50
5138 Index, long and ring	50	40
5139 Index, long and little	50	40
5140 Index, ring and little	50	40
5141 Long, ring and little	40	30
Two digits of one hand, amputation of:		
5142 Thumb and index	50	40
5143 Thumb and long	50	40
5144 Thumb and ring	50	40
5145 Thumb and little	50	40
5146 Index and long	40	30
5147 Index and ring	40	30
5148 Index and little	40	30
5149 Long and ring	30	20
5150 Long and little	30	20
5151 Ring and little	30	20
(a) The ratings for multiple finger amputations apply to amputations at the proximal interphalangeal joints or through proximal phalanges..		
(b) Amputation through middle phalanges will be rated as prescribed for unfavorable ankylosis of the fingers..		

AMPUTATIONS: UPPER EXTREMITY—Continued

	Rating	
	Major	Minor
(c) Amputations at distal joints, or through distal phalanges, other than negligible losses, will be rated as prescribed for favorable ankylosis of the fingers..		
(d) Amputation or resection of metacarpal bones (more than one-half the bone lost) in multiple fingers injuries will require a rating of 10 percent added to (not combined with) the ratings, multiple finger amputations, subject to the amputation rule applied to the forearm.		
(e) Combinations of finger amputations at various levels, or finger amputations with ankylosis or limitation of motion of the fingers will be rated on the basis of the grade of disability; *i.e.*, amputation, unfavorable ankylosis, most representative of the levels or combinations. With an even number of fingers involved, and adjacent grades of disability, select the higher of the two grades.		
(f) Loss of use of the hand will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump with a suitable prosthetic applicance.		
SINGLE FINGER AMPUTATIONS		
5152 Thumb, amputation of:		
With metacarpal resection	40	30
At metacarpophalangeal joint or through proximal phalanx	30	20
At distal joint or through distal phalanx	20	20
5153 Index finger, amputation of		
With metacarpal resection (more than one-half the bone lost)	30	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	20	20
Through middle phalanx or at distal joint	10	10
5154 Long finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5155 Ring finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
5156 Little finger, amputation of:		
With metacarpal resection (more than one-half the bone lost)	20	20
Without metacarpal resection, at proximal interphalangeal joint or proximal thereto	10	10
NOTE: The single finger amputation ratings are the only applicable ratings for amputations of whole or part of single fingers.		

[1] Entitled to special monthly compensation.

SINGLE FINGER AMPUTATIONS

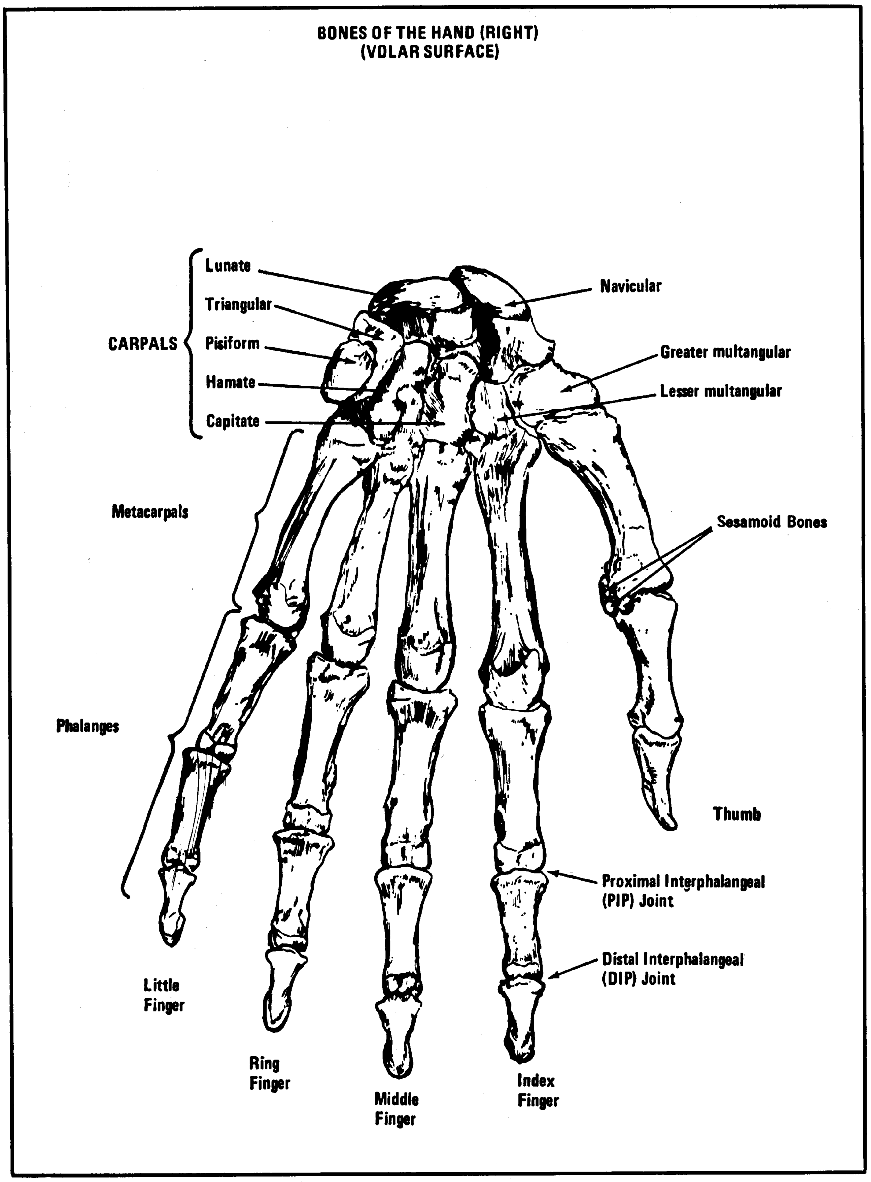


PLATE III

AMPUTATIONS: LOWER EXTREMITY

	Rating
Thigh, amputation of:	
5160 Disarticulation, with loss of extrinsic pelvic girdle muscles	[2] 90
5161 Upper third, one-third of the distance from perineum to knee joint measured from perineum	[2] 80
5162 Middle or lower thirds	[2] 60
Leg, amputation of:	
5163 With defective stump, thigh amputation recommended	[2] 60
5164 Amputation not improvable by prosthesis controlled by natural knee action	[2] 60
5165 At a lower level, permitting prosthesis	[2] 40
5166 Forefoot, amputation proximal to metatarsal bones (more than one-half of metatarsal loss)	[2] 40
5167 Foot, loss of use of	[2] 40

AMPUTATIONS: LOWER EXTREMITY—Continued

	Rating
5170 Toes, all, amputation of, without metatarsal loss	30
5171 Toe, great, amputation of:	
With removal of metatarsal head	30
Without metatarsal involvement	10
5172 Toes, other than great, amputation of, with removal of metatarsal head:	
One or two	20
Without metatarsal involvement	0
5173 Toes, three or four, amputation of, without metatarsal involvement:	
Including great toe	20
Not including great toe	10

[2] Also entitled to special monthly compensation.

AMPUTATIONS: LOWER EXTREMITY

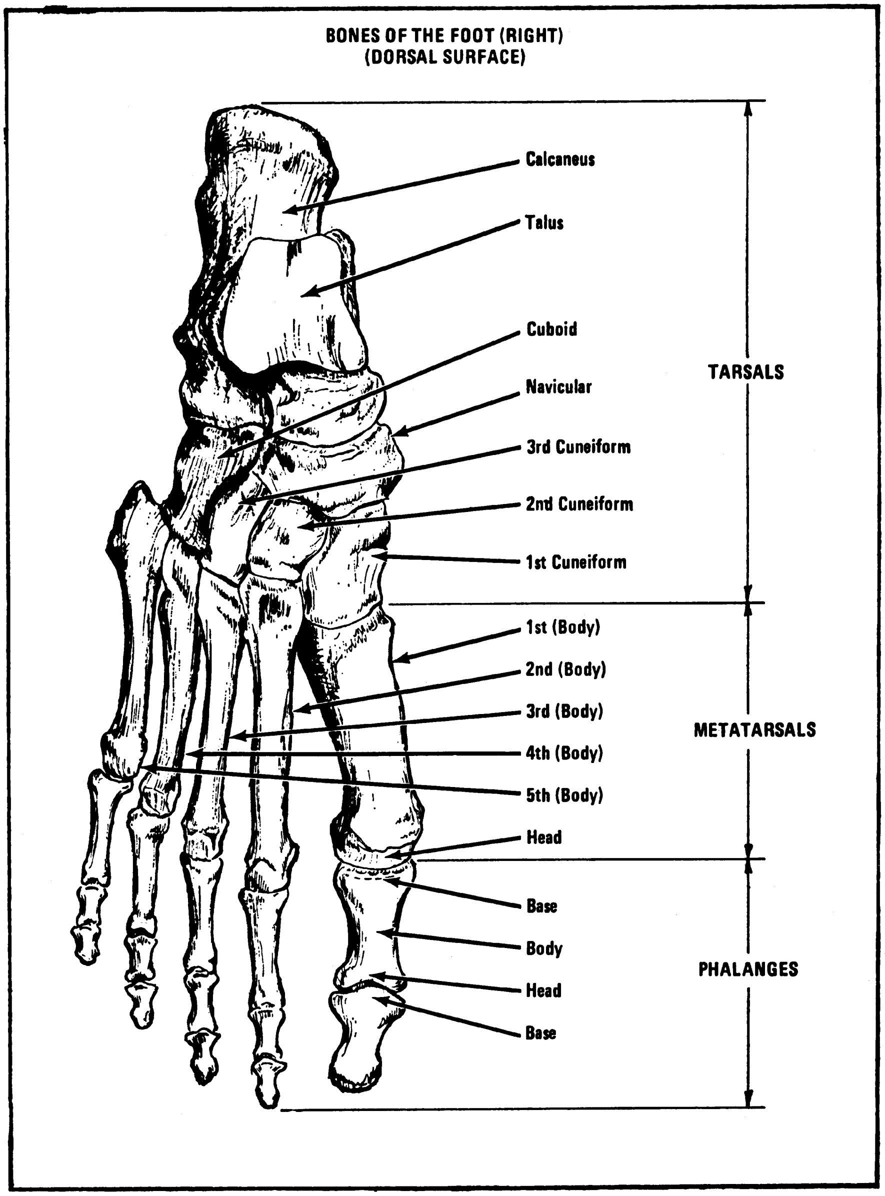


PLATE IV

THE SHOULDER AND ARM

	Rating Major	Rating Minor
5200 Scapulohumeral articulation, ankylosis of:		
NOTE: The scapula and humerus move as one piece.		
Unfavorable, abduction limited to 25° from side	50	40
Intermediate between favorable and unfavorable	40	30
Favorable, abduction to 60°, can reach mouth and head	30	20
5201 Arm, limitation of motion of:		
To 25° from side	40	30
Midway between side and shoulder level	30	20
At shoulder level	20	20
5202 Humerus, other impairment of:		
Loss of head of (flail shoulder)	80	70
Nonunion of (false flail joint)	60	50
Fibrous union of	50	40
Recurrent dislocation of at scapulohumeral joint.		
With frequent episodes and guarding of all arm movements	30	20
With infrequent episodes, and guarding of movement only at shoulder level	20	20
Malunion of:		
Marked deformity	30	20
Moderate deformity	20	20
5203 Clavicle or scapula, impairment of:		
Dislocation of	20	20
Nonunion of:		
With loose movement	20	20
Without loose movement	10	10
Malunion of	10	10
Or rate on impairment of function of contiguous joint.		

THE ELBOW AND FOREARM

	Rating Major	Rating Minor
5205 Elbow, ankylosis of:		
Unfavorable, at an angle of less than 50° or with complete loss of supination or pronation	60	50
Intermediate, at an angle of more than 90°, or between 70° and 50°	50	40
Favorable, at an angle between 90° and 70°	40	30
5206 Forearm, limitation of flexion of:		
Flexion limited to 45°	50	40
Flexion limited to 55°	40	30
Flexion limited to 70°	30	20
Flexion limited to 90°	20	20
Flexion limited to 100°	10	10
Flexion limited to 110°	0	0
5207 Forearm, limitation of extension of:		
Extension limited to 110°	50	40
Extension limited to 100°	40	30
Extension limited to 90°	30	20
Extension limited to 75°	20	20
Extension limited to 60°	10	10
Extension limited to 45°	10	10
5208 Forearm, flexion limited to 100° and extension to 45°	20	20
5209 Elbow, other impairment of Flail joint	60	50

THE ELBOW AND FOREARM—Continued

	Rating Major	Rating Minor
Joint fracture, with marked cubitus varus or cubitus valgus deformity or with ununited fracture of head of radius	20	20
5210 Radius and ulna, nonunion of, with flail false joint	50	40
5211 Ulna, impairment of:		
Nonunion in upper half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in lower half	20	20
Malunion of, with bad alignment	10	10
5212 Radius, impairment of:		
Nonunion in lower half, with false movement:		
With loss of bone substance (1 inch (2.5 cms.) or more) and marked deformity	40	30
Without loss of bone substance or deformity	30	20
Nonunion in upper half	20	20
Malunion of, with bad alignment	10	10
5213 Supination and pronation, impairment of:		
Loss of (bone fusion):		
The hand fixed in supination or hyperpronation	40	30
The hand fixed in full pronation	30	20
The hand fixed near the middle of the arc or moderate pronation	20	20
Limitation of pronation:		
Motion lost beyond middle of arc	30	20
Motion lost beyond last quarter of arc, the hand does not approach full pronation	20	20
Limitation of supination:		
To 30° or less	10	10
NOTE: In all the forearm and wrist injuries, codes 5205 through 5213, multiple impaired finger movements due to tendon tie-up, muscle or nerve injury, are to be separately rated and combined not to exceed rating for loss of use of hand.		

THE WRIST

	Rating Major	Rating Minor
5214 Wrist, ankylosis of:		
Unfavorable, in any degree of palmar flexion, or with ulnar or radial deviation	50	40
Any other position, except favorable	40	30
Favorable in 20° to 30° dorsiflexion	30	20
NOTE: Extremely unfavorable ankylosis will be rated as loss of use of hands under diagnostic code 5125.		
5215 Wrist, limitation of motion of:		
Dorsiflexion less than 15°	10	10
Palmar flexion limited in line with forearm	10	10

Evaluation of Ankylosis or Limitation of Motion of Single or Multiple Digits of the Hand

	Rating	
	Major	Minor
(1) For the index, long, ring, and little fingers (digits II, III, IV, and V), zero degrees of flexion represents the fingers fully extended, making a straight line with the rest of the hand. The position of function of the hand is with the wrist dorsiflexed 20 to 30 degrees, the metacarpophalangeal and proximal interphalangeal joints flexed to 30 degrees, and the thumb (digit I) abducted and rotated so that the thumb pad faces the finger pads. Only joints in these positions are considered to be in favorable position. For digits II through V, the metacarpophalangeal joint has a range of zero to 90 degrees of flexion, the proximal interphalangeal joint has a range of zero to 100 degrees of flexion, and the distal (terminal) interphalangeal joint has a range of zero to 70 or 80 degrees of flexion	....	....
(2) When two or more digits of the same hand are affected by any combination of amputation, ankylosis, or limitation of motion that is not otherwise specified in the rating schedule, the evaluation level assigned will be that which best represents the overall disability (*i.e.*, amputation, unfavorable or favorable ankylosis, or limitation of motion), assigning the higher level of evaluation when the level of disability is equally balanced between one level and the next higher level	....	....
(3) Evaluation of ankylosis of the index, long, ring, and little fingers:		
(i) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation without metacarpal resection, at proximal interphalangeal joint or proximal thereto	....	....
(ii) If both the metacarpophalangeal and proximal interphalangeal joints of a digit are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position.		
(iii) If only the metacarpophalangeal or proximal interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as unfavorable ankylosis	....	....
(iv) If only the metacarpophalangeal or proximal interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the fingertip(s) and the proximal transverse crease of the palm, with the finger(s) flexed to the extent possible, evaluate as favorable ankylosis	....	....
(4) Evaluation of ankylosis of the thumb:		
(i) If both the carpometacarpal and interphalangeal joints are ankylosed, and either is in extension or full flexion, or there is rotation or angulation of a bone, evaluate as amputation at metacarpophalangeal joint or through proximal phalanx	....	....
(ii) If both the carpometacarpal and interphalangeal joints are ankylosed, evaluate as unfavorable ankylosis, even if each joint is individually fixed in a favorable position	....	....
(iii) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as unfavorable ankylosis	....	....
(iv) If only the carpometacarpal or interphalangeal joint is ankylosed, and there is a gap of two inches (5.1 cm.) or less between the thumb pad and the fingers, with the thumb attempting to oppose the fingers, evaluate as favorable ankylosis	....	....
(5) If there is limitation of motion of two or more digits, evaluate each digit separately and combine the evaluations	....	....
I. Multiple Digits: Unfavorable Ankylosis		
5216 Five digits of one hand, unfavorable ankylosis of	60	50
Note: Also consider whether evaluation as amputation is warranted.		
5217 Four digits of one hand, unfavorable ankylosis of:		
Thumb and any three fingers	60	50
Index, long, ring, and little fingers	50	40
Note: Also consider whether evaluation as amputation is warranted.		
5218 Three digits of one hand, unfavorable ankylosis of:		
Thumb and any two fingers	50	40
Index, long, and ring; index, long, and little; or index, ring, and little fingers	40	30
Long, ring, and little fingers	30	20
Note: Also consider whether evaluation as amputation is warranted.		
5219 Two digits of one hand, unfavorable ankylosis of:		
Thumb and any finger	40	30

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating Major	Rating Minor
Index and long; index and ring; or index and little fingers	30	20
Long and ring; long and little; or ring and little fingers	20	20
Note: Also consider whether evaluation as amputation is warranted.		
II. Multiple Digits: Favorable Ankylosis		
5220 Five digits of one hand, favorable ankylosis of	50	40
5221 Four digits of one hand, favorable ankylosis of:		
Thumb and any three fingers	50	40
Index, long, ring, and little fingers	40	30
5222 Three digits of one hand, favorable ankylosis of:		
Thumb and any two fingers	40	30
Index, long, and ring; index, long, and little; or index, ring, and little fingers	30	20
Long, ring and little fingers	20	20
5223 Two digits of one hand, favorable ankylosis of:		
Thumb and any finger	30	20
Index and long; index and ring; or index and little fingers	20	20
Long and ring; long and little; or ring and little fingers	10	10
III. Ankylosis of Individual Digits		
5224 Thumb, ankylosis of:		
Unfavorable	20	20
Favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5225 Index finger, ankylosis of:		
Unfavorable or favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5226 Long finger, ankylosis of:		
Unfavorable or favorable	10	10
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
5227 Ring or little finger, ankylosis of:		
Unfavorable or favorable	0	0

EVALUATION OF ANKYLOSIS OR LIMITATION OF MOTION OF SINGLE OR MULTIPLE DIGITS OF THE HAND—Continued

	Rating Major	Rating Minor
Note: Also consider whether evaluation as amputation is warranted and whether an additional evaluation is warranted for resulting limitation of motion of other digits or interference with overall function of the hand.		
IV. Limitation of Motion of Individual Digits		
5228 Thumb, limitation of motion:		
With a gap of more than two inches (5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	20	20
With a gap of one to two inches (2.5 to 5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	10	10
With a gap of less than one inch (2.5 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers	0	0
5229 Index or long finger, limitation of motion:		
With a gap of one inch (2.5 cm.) or more between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, or; with extension limited by more than 30 degrees	10	10
With a gap of less than one inch (2.5 cm.) between the fingertip and the proximal transverse crease of the palm, with the finger flexed to the extent possible, and; extension is limited by no more than 30 degrees	0	0
5230 Ring or little finger, limitation of motion:		
Any limitation of motion	0	0

THE SPINE

	Rating
General Rating Formula for Diseases and Injuries of the Spine	
(For diagnostic codes 5235 to 5243 unless 5243 is evaluated under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes):	
With or without symptoms such as pain (whther or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease	
Unfavorable ankylosis of the entire spine	100
Unfavorable ankylosis of the entire thoracolumbar spine	50

THE SPINE—Continued

	Rating
Unfavorable ankylosis of the entire cervical spine; or, forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine	40
Forward flexion of the cervical spine 15 degrees or less; or, favorable ankylosis of the entire cervical spine	30
Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or, forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or, the combined range of motion of the thoracolumbar spine not greater than 120 degrees; or, the combined range of motion of the cervical spine not greater than 170 degrees; or, muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis	20
Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or, forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees; or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or, combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees; or, muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or, vertebral body fracture with loss of 50 percent or more of the height	10
Note (1): Evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, separately, under an appropriate diagnostic code.	

THE SPINE—Continued

	Rating
Note (2): (See also Plate V.) For VA compensation purposes, normal forward flexion of the cervical spine is zero to 45 degrees, extension is zero to 45 degrees, left and right lateral flexion are zero to 45 degrees, and left and right lateral rotation are zero to 80 degrees. Normal forward flexion of the thoracolumbar spine is zero to 90 degrees, extension is zero to 30 degrees, left and right lateral flexion are zero to 30 degrees, and left and right lateral rotation are zero to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation. The normal combined range of motion of the cervical spine is 340 degrees and of the thoracolumbar spine is 240 degrees. The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion.	
Note (3): In exceptional cases, an examiner may state that because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion stated in Note (2). Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted.	
Note (4): Round each range of motion measurement to the nearest five degrees.	
Note (5): For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.	
Note (6): Separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.	
5235 Vertebral fracture or dislocation	
5236 Sacroiliac injury and weakness	
5237 Lumbosacral or cervical strain	
5238 Spinal stenosis	
5239 Spondylolisthesis or segmental instability	
5240 Ankylosing spondylitis	
5241 Spinal fusion	
5242 Degenerative arthritis of the spine (see also diagnostic code 5003)	
5243 Intervertebral disc syndrome	
Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined under §4.25.	

THE SPINE—Continued

	Rating
Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months	20
With incapacitating episodes having a total duration of at least one week but less than 2 weeks during the past 12 months	10
Note (1): For purposes of evaluations under diagnostic code 5243, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician.	
Note (2): If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, evaluate each segment on the basis of incapacitating episodes or under the General Rating Formula for Diseases and Injuries of the Spine, whichever method results in a higher evaluation for that segment.	

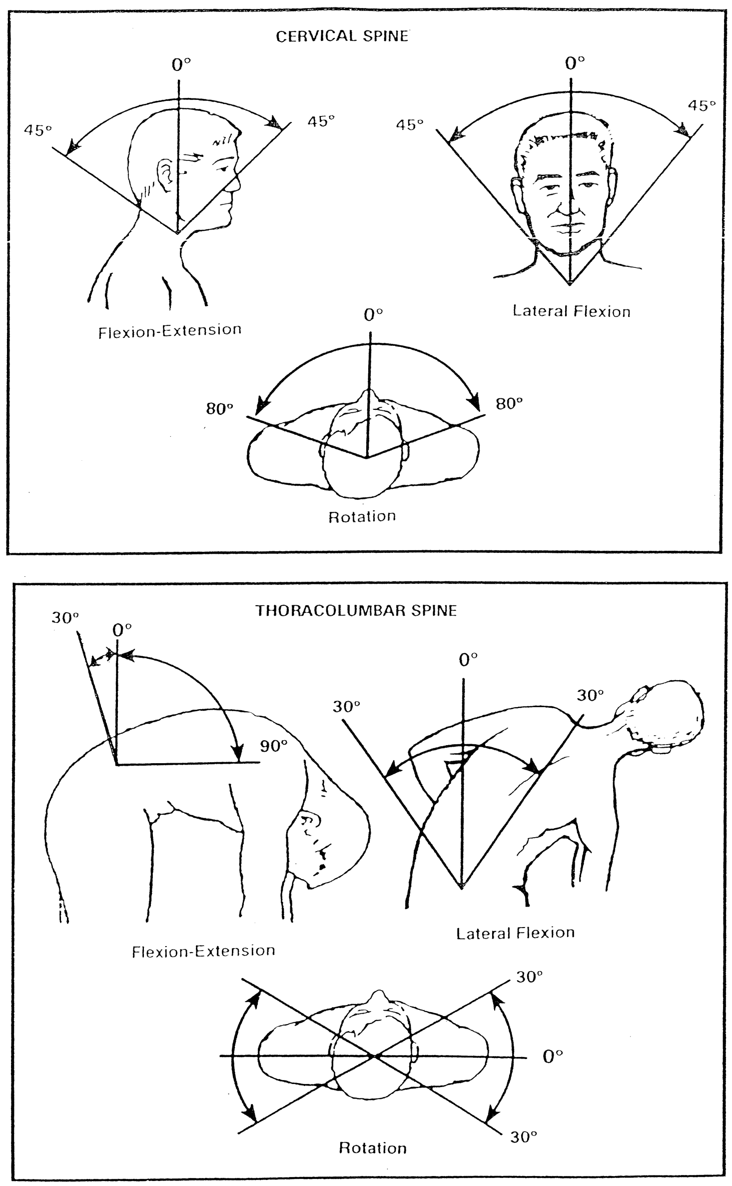


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

THE HIP AND THIGH

	Rating
5250 Hip, ankylosis of:	
Unfavorable, extremely unfavorable ankylosis, the foot not reaching ground, crutches necessitated	[3] 90
Intermediate	70
Favorable, in flexion at an angle between 20° and 40°, and slight adduction or abduction	60
5251 Thigh, limitation of extension of:	
Extension limited to 5°	10
5252 Thigh, limitation of flexion of:	
Flexion limited to 10°	40
Flexion limited to 20°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
5253 Thigh, impairment of:	
Limitation of abduction of, motion lost beyond 10°	20
Limitation of adduction of, cannot cross legs	10
Limitation of rotation of, cannot toe-out more than 15°, affected leg	10
5254 Hip, flail joint	80
5255 Femur, impairment of:	
Fracture of shaft or anatomical neck of:	
With nonunion, with loose motion (spiral or oblique fracture)	80
With nonunion, without loose motion, weightbearing preserved with aid of brace	60
Fracture of surgical neck of, with false joint	60
Malunion of:	
With marked knee or hip disability	30
With moderate knee or hip disability	20
With slight knee or hip disability	10

[3] Entitled to special monthly compensation.

THE KNEE AND LEG

	Rating
5256 Knee, ankylosis of:	
Extremely unfavorable, in flexion at an angle of 45° or more	60
In flexion between 20° and 45°	50
In flexion between 10° and 20°	40
Favorable angle in full extension, or in slight flexion between 0° and 10°	30
5257 Knee, other impairment of:	
Recurrent subluxation or lateral instability:	
Severe	30
Moderate	20
Slight	10
5258 Cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint	20
5259 Cartilage, semilunar, removal of, symptomatic	10
5260 Leg, limitation of flexion of:	
Flexion limited to 15°	30
Flexion limited to 30°	20
Flexion limited to 45°	10
Flexion limited to 60°	0
5261 Leg, limitation of extension of:	
Extension limited to 45°	50
Extension limited to 30°	40
Extension limited to 20°	30
Extension limited to 15°	20
Extension limited to 10°	10
Extension limited to 5°	0
5262 Tibia and fibula, impairment of:	
Nonunion of, with loose motion, requiring brace	40
Malunion of:	
With marked knee or ankle disability	30

THE KNEE AND LEG—Continued

	Rating
With moderate knee or ankle disability	20
With slight knee or ankle disability	10
5263 Genu recurvatum (acquired, traumatic, with weakness and insecurity in weight-bearing objectively demonstrated)	10

THE ANKLE

	Rating
5270 Ankle, ankylosis of:	
In plantar flexion at more than 40°, or in dorsiflexion at more than 10° or with abduction, adduction, inversion or eversion deformity	40
In plantar flexion, between 30° and 40°, or in dorsiflexion, between 0° and 10°	30
In plantar flexion, less than 30°	20
5271 Ankle, limited motion of:	
Marked	20
Moderate	10
5272 Subastragalar or tarsal joint, ankylosis of:	
In poor weight-bearing position	20
In good weight-bearing position	10
5273 Os calcis or astragalus, malunion of:	
Marked deformity	20
Moderate deformity	10
5274 Astragalectomy	20

SHORTENING OF THE LOWER EXTREMITY

	Rating
5275 Bones, of the lower extremity, shortening of:	
Over 4 inches (10.2 cms.)	[3] 60
3½ to 4 inches (8.9 cms. to 10.2 cms.)	[3] 50
3 to 3½ inches (7.6 cms. to 8.9 cms.)	40
2½ to 3 inches (6.4 cms. to 7.6 cms.)	30
2 to 2½ inches (5.1 cms. to 6.4 cms.)	20
1¼ to 2 inches (3.2 cms. to 5.1 cms.)	10
NOTE: Measure both lower extremities from anterior superior spine of the ilium to the internal malleolus of the tibia. Not to be combined with other ratings for fracture or faulty union in the same extremity.	

[3] Also entitled to special monthly compensation.

THE FOOT

	Rating
5276 Flatfoot, acquired:	
Pronounced; marked pronation, extreme tenderness of plantar surfaces of the feet, marked inward displacement and severe spasm of the tendo achillis on manipulation, not improved by orthopedic shoes or appliances.	
Bilateral	50
Unilateral	30
Severe; objective evidence of marked deformity (pronation, abduction, etc.), pain on manipulation and use accentuated, indication of swelling on use, characteristic callosities:	
Bilateral	30
Unilateral	20

THE FOOT—Continued

	Rating
Moderate; weight-bearing line over or medial to great toe, inward bowing of the tendo achillis, pain on manipulation and use of the feet, bilateral or unilateral	10
Mild; symptoms relieved by built-up shoe or arch support	0
5277 Weak foot, bilateral:	
A symptomatic condition secondary to many constitutional conditions, characterized by atrophy of the musculature, disturbed circulation, and weakness:	
Rate the underlying condition, minimum rating	10
5278 Claw foot (pes cavus), acquired:	
Marked contraction of plantar fascia with dropped forefoot, all toes hammer toes, very painful callosities, marked varus deformity:	
Bilateral	50
Unilateral	30
All toes tending to dorsiflexion, limitation of dorsiflexion at ankle to right angle, shortened plantar fascia, and marked tenderness under metatarsal heads:	
Bilateral	30
Unilateral	20
Great toe dorsiflexed, some limitation of dorsiflexion at ankle, definite tenderness under metatarsal heads:	
Bilateral	10
Unilateral	10
Slight	0
5279 Metatarsalgia, anterior (Morton's disease), unilateral, or bilateral	10
5280 Hallux valgus, unilateral:	
Operated with resection of metatarsal head	10
Severe, if equivalent to amputation of great toe	10
5281 Hallux rigidus, unilateral, severe:	
Rate as hallux valgus, severe.	
Note: Not to be combined with claw foot ratings.	
5282 Hammer toe:	
All toes, unilateral without claw foot	10
Single toes	0
5283 Tarsal, or metatarsal bones, malunion of, or nonunion of:	
Severe	30
Moderately severe	20
Moderate	10
NOTE: With actual loss of use of the foot, rate 40 percent.	
5284 Foot injuries, other:	
Severe	30
Moderately severe	20
Moderate	10
NOTE: With actual loss of use of the foot, rate 40 percent.	

THE SKULL

	Rating
5296 Skull, loss of part of, both inner and outer tables:	
With brain hernia	80
Without brain hernia:	
Area larger than size of a 50-cent piece or 1.140 in² (7.355 cm²)	50
Area intermediate	30
Area smaller than the size of a 25-cent piece or 0.716 in² (4.619 cm²)	10

THE SKULL—Continued

	Rating
NOTE: Rate separately for intracranial complications.	

THE RIBS

	Rating
5297 Ribs, removal of:	
More than six	50
Five or six	40
Three or four	30
Two	20
One or resection of two or more ribs without regeneration	10
NOTE (1): The rating for rib resection or removal is not to be applied with ratings for purrulent pleurisy, lobectomy, pneumonectomy or injuries of pleural cavity.	
NOTE (2): However, rib resection will be considered as rib removal in thoracoplasty performed for collapse therapy or to accomplish obliteration of space and will be combined with the rating for lung collapse, or with the rating for lobectomy, pneumonectomy or the graduated ratings for pulmonary tuberculosis.	

THE COCCYX

	Rating
5298 Coccyx, removal of:	
Partial or complete, with painful residuals	10
Without painful residuals	0

(Authority: 38 U.S.C. 1155)

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 40 FR 42536, Sept. 15, 1975; 41 FR 11294, Mar. 18, 1976; 43 FR 45350, Oct. 2, 1978; 51 FR 6411, Feb. 24, 1986; 61 FR 20439, May 7, 1996; 67 FR 48785, July 26, 2002; 67 FR 54349, Aug. 22, 2002; 68 FR 51456, Aug. 27, 2003; 69 FR 32450, June 10, 2004]

§4.72 [Reserved]

§4.73 Schedule of ratings—muscle injuries.

NOTE: When evaluating any claim involving muscle injuries resulting in loss of use of any extremity or loss of use of both buttocks (diagnostic code 5317, Muscle Group XVII), refer to §3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation.

THE SHOULDER GIRDLE AND ARM

	Rating	
	Dominant	Nondominant
5301 Group I. *Function:* Upward rotation of scapula; elevation of arm above shoulder level. *Extrinsic muscles of shoulder girdle:* (1) Trapezius; (2) levator scapulae; (3) serratus magnus.		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5302 Group II. *Function:* Depression of arm from vertical overhead to hanging at side (1, 2); downward rotation of scapula (3, 4); 1 and 2 act with Group III in forward and backward swing of arm. *Extrinsic muscles of shoulder girdle: (1) Pectoralis major II (costosternal); (2) latissimus dorsi and teres major (teres major, although technically an intrinsic muscle, is included with latissimus dorsi); (3) pectoralis minor; (4) rhomboid.*		
Severe	40	30
Moderately Severe	30	20
Moderate	20	20
Slight	0	0
5303 Group III. *Function:* Elevation and abduction of arm to level of shoulder; act with 1 and 2 of Group II in forward and backward swing of arm. *Intrinsic muscles of shoulder girdle: (1) Pectoralis major I (clavicular); (2) deltoid.*		
Severe	40	30
Moderately Severe	30	20
Moderate	20	20
Slight	0	0
5304 Group IV. *Function:* Stabilization of shoulder against injury in strong movements, holding head of humerus in socket; abduction; outward rotation and inward rotation of arm. *Intrinsic muscles of shoulder girdle: (1) Supraspinatus; (2) infraspinatus and teres minor; (3) subscapularis; (4) coracobrachialis.*		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5305 Group V. *Function:* Elbow supination (1) (long head of biceps is stabilizer of shoulder joint); flexion of elbow (1, 2, 3). *Flexor muscles of elbow: (1) Biceps; (2) brachialis; (3) brachioradialis.*		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5306 Group VI. *Function:* Extension of elbow (long head of triceps is stabilizer of shoulder joint). *Extensor muscles of the elbow:* (1) Triceps; (2) anconeus..		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0

THE FOREARM AND HAND

	Rating	
	Dominant	Nondominant
5307 Group VII. *Function:* Flexion of wrist and fingers. *Muscles arising from internal condyle of humerus:* Flexors of the carpus and long flexors of fingers and thumb; pronator.		
Severe	40	30
Moderately Severe	30	20
Moderate	10	10
Slight	0	0
5308 Group VIII. *Function:* Extension of wrist, fingers, and thumb; abduction of thumb. *Muscles arising mainly from external condyle of humerus:* Extensors of carpus, fingers, and thumb; supinator.		
Severe	30	20
Moderately Severe	20	20
Moderate	10	10
Slight	0	0
5309 Group IX. *Function:* The forearm muscles act in strong grasping movements and are supplemented by the intrinsic muscles in delicate manipulative movements. *Intrinsic muscles of hand:* Thenar eminence; short flexor, opponens, abductor and adductor of thumb; hypothenar eminence; short flexor, opponens and abductor of little finger; 4 lumbricales; 4 dorsal and 3 palmar interossei.		
NOTE: The hand is so compact a structure that isolated muscle injuries are rare, being nearly always complicated with injuries of bones, joints, tendons, etc. Rate on limitation of motion, minimum 10 percent.		

THE FOOT AND LEG

	Rating
5310 Group X. *Function:* Movements of forefoot and toes; propulsion thrust in walking. *Intrinsic muscles of the foot: Plantar:* (1) Flexor digitorum brevis; (2) abductor hallucis; (3) abductor digiti minimi; (4) quadratus plantae; (5) lumbricales; (6) flexor hallucis brevis; (7) adductor hallucis; (8) flexor digiti minimi brevis; (9) dorsal and plantar interossei. Other important plantar structures: Plantar aponeurosis, long plantar and calcaneonavicular ligament, tendons of posterior tibial, peroneus longus, and long flexors of great and little toes.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
Dorsal: (1) Extensor hallucis brevis; (2) extensor digitorum brevis. Other important dorsal structures: cruciate, crural, deltoid, and other ligaments; tendons of long extensors of toes and peronei muscles.	
Severe	20
Moderately Severe	10
Moderate	10
Slight	0

THE FOOT AND LEG—Continued

	Rating
NOTE: Minimum rating for through-and-through wounds of the foot—10.	
5311 Group XI. *Function:* Propulsion, plantar flexion of foot (1); stabilization of arch (2, 3); flexion of toes (4, 5); Flexion of knee (6). *Posterior and lateral crural muscles, and muscles of the calf:* (1) Triceps surae (gastrocnemius and soleus); (2) tibialis posterior; (3) peroneus longus; (4) peroneus brevis; (5) flexor hallucis longus; (6) flexor digitorum longus; (7) popliteus; (8) plantaris.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5312 Group XII. *Function:* Dorsiflexion (1); extension of toes (2); stabilization of arch (3). *Anterior muscles of the leg:* (1) Tibialis anterior; (2) extensor digitorum longus; (3) extensor hallucis longus; (4) peroneus tertius.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

THE PELVIC GIRDLE AND THIGH

	Rating
5313 Group XIII. *Function:* Extension of hip and flexion of knee; outward and inward rotation of flexed knee; acting with rectus femoris and sartorius (see XIV, 1, 2) synchronizing simultaneous flexion of hip and knee and extension of hip and knee by belt-over-pulley action at knee joint. *Posterior thigh group, Hamstring complex of 2-joint muscles:* (1) Biceps femoris; (2) semimembranosus; (3) semitendinosus.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5314 Group XIV. *Function:* Extension of knee (2, 3, 4, 5); simultaneous flexion of hip and flexion of knee (1); tension of fascia lata and iliotibial (Maissiat's) band, acting with XVII (1) in postural support of body (6); acting with hamstrings in synchronizing hip and knee (1, 2). *Anterior thigh group:* (1) Sartorius; (2) rectus femoris; (3) vastus externus; (4) vastus intermedius; (5) vastus internus; (6) tensor vaginae femoris.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0
5315 Group XV. *Function:* Adduction of hip (1, 2, 3, 4); flexion of hip (1, 2); flexion of knee (4). *Mesial thigh group:* (1) Adductor longus; (2) adductor brevis; (3) adductor magnus; (4) gracilis.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0
5316 Group XVI. *Function:* Flexion of hip (1, 2, 3). *Pelvic girdle group 1:* (1) Psoas; (2) iliacus; (3) pectineus.	
Severe	40
Moderately Severe	30
Moderate	10
Slight	0

THE PELVIC GIRDLE AND THIGH—Continued

	Rating
5317 Group XVII. *Function:* Extension of hip (1); abduction of thigh; elevation of opposite side of pelvis (2, 3); tension of fascia lata and iliotibial (Maissiat's) band, acting with XIV (6) in postural support of body steadying pelvis upon head of femur and condyles of femur on tibia (1). *Pelvic girdle group 2:* (1) Gluteus maximus; (2) gluteus medius; (3) gluteus minimus.	
Severe	*50
Moderately Severe	40
Moderate	20
Slight	0
5318 Group XVIII. *Function:* Outward rotation of thigh and stabilization of hip joint. *Pelvic girdle group 3:* (1) Pyriformis; (2) gemellus (superior or inferior); (3) obturator (external or internal); (4) quadratus femoris.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

*If bilateral, see § 3.350(a)(3) of this chapter to determine whether the veteran may be entitled to special monthly compensation.

THE TORSO AND NECK

	Rating
5319 Group XIX. *Function:* Support and compression of abdominal wall and lower thorax; flexion and lateral motions of spine; synergists in strong downward movements of arm (1). *Muscles of the abdominal wall:* (1) Rectus abdominis; (2) external oblique; (3) internal oblique; (4) transversalis; (5) quadratus lumborum.	
Severe	50
Moderately Severe	30
Moderate	10
Slight	0
5320 Group XX. *Function:* Postural support of body; extension and lateral movements of spine. *Spinal muscles:* Sacrospinalis (erector spinae and its prolongations in thoracic and cervical regions).	
Cervical and thoracic region:.	
Severe	40
Moderately Severe	20
Moderate	10
Slight	0
Lumbar region:.	
Severe	60
Moderately Severe	40
Moderate	20
Slight	0
5321 Group XXI. *Function:* Respiration. *Muscles of respiration:* Thoracic muscle group.	
Severe or Moderately Severe	20
Moderate	10
Slight	0
5322 Group XXII. *Function:* Rotary and forward movements of the head; respiration; deglutition. *Muscles of the front of the neck:* (Lateral, supra-, and infrahyoid group.) (1) Trapezius I (clavicular insertion); (2) sternocleidomastoid; (3) the "hyoid" muscles; (4) sternothyroid; (5) digastric.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

THE TORSO AND NECK—Continued

	Rating
5323 Group XXIII. *Function:* Movements of the head; fixation of shoulder movements. *Muscles of the side and back of the neck:* Suboccipital; lateral vertebral and anterior vertebral muscles.	
Severe	30
Moderately Severe	20
Moderate	10
Slight	0

MISCELLANEOUS

	Rating
5324 Diaphragm, rupture of, with herniation. Rate under diagnostic code 7346.	
5325 Muscle injury, facial muscles. Evaluate functional impairment as seventh (facial) cranial nerve neuropathy (diagnostic code 8207), disfiguring scar (diagnostic code 7800), etc. Minimum, if interfering to any extent with mastication—10.	
5326 Muscle hernia, extensive. Without other injury to the muscle—10.	
5327 Muscle, neoplasm of, malignant (excluding soft tissue sarcoma)—100.	
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residual impairment of function.	
5328 Muscle, neoplasm of, benign, postoperative. Rate on impairment of function, *i.e.*, limitation of motion, or scars, diagnostic code 7805, etc.	
5329 Sarcoma, soft tissue (of muscle, fat, or fibrous connective tissue)—100.	
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgery, radiation treatment, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residual impairment of function.	

(Authority: 38 U.S.C. 1155)

[62 FR 30239, June 3, 1997]

THE ORGANS OF SPECIAL SENSE

§ 4.75 General considerations for evaluating visual impairment.

(a) *Visual impairment*. The evaluation of visual impairment is based on impairment of visual acuity (excluding developmental errors of refraction), visual field, and muscle function.

(b) *Examination for visual impairment*. The examination must be conducted by a licensed optometrist or by a licensed ophthalmologist. The examiner must identify the disease, injury, or other pathologic process responsible for any visual impairment found. Examinations of visual fields or muscle function will be conducted only when there is a medical indication of disease or injury that may be associated with visual field defect or impaired muscle function. Unless medically contraindicated, the fundus must be examined with the claimant's pupils dilated.

(c) *Service-connected visual impairment of only one eye*. Subject to the provisions of 38 CFR 3.383(a), if visual impairment of only one eye is service-connected, the visual acuity of the other eye will be considered to be 20/40 for purposes of evaluating the service-connected visual impairment.

(d) *Maximum evaluation for visual impairment of one eye*. The evaluation for visual impairment of one eye must not exceed 30 percent unless there is anatomical loss of the eye. Combine the evaluation for visual impairment of one eye with evaluations for other disabilities of the same eye that are not based on visual impairment (e.g., disfigurement under diagnostic code 7800).

(e) *Anatomical loss of one eye with inability to wear a prosthesis*. When the claimant has anatomical loss of one eye and is unable to wear a prosthesis, increase the evaluation for visual acuity under diagnostic code 6063 by 10 percent, but the maximum evaluation for visual impairment of both eyes must not exceed 100 percent. A 10-percent increase under this paragraph precludes an evaluation under diagnostic code 7800 based on gross distortion or asymmetry of the eye but not an evaluation under diagnostic code 7800 based on other characteristics of disfigurement.

(f) *Special monthly compensation*. When evaluating visual impairment, refer to 38 CFR 3.350 to determine whether the claimant may be entitled to special monthly compensation. Footnotes in the schedule indicate levels of visual impairment that potentially establish entitlement to special monthly compensation; however, other levels of visual impairment combined with disabilities of other body systems may also establish entitlement.

(Authority: 38 U.S.C. 1114 and 1155)

[73 FR 66549, Nov. 10, 2008]

§ 4.76 Visual acuity.

(a) *Examination of visual acuity*. Examination of visual acuity must include the central *uncorrected* and *corrected* visual acuity for *distance* and *near* vision using Snellen's test type or its equivalent.

(b) *Evaluation of visual acuity*. (1) Evaluate central visual acuity on the basis of corrected distance vision with central fixation, even if a central scotoma is present. However, when the lens required to correct distance vision in the poorer eye differs by more than three diopters from the lens required to correct distance vision in the better eye (and the difference is not due to congenital or developmental refractive error), and either the poorer eye or both eyes are service connected, evaluate the visual acuity of the poorer eye using either its uncorrected or corrected visual acuity, whichever results in better combined visual acuity.

(2) Provided that he or she customarily wears contact lenses, evaluate the visual acuity of any individual affected by a corneal disorder that results in severe irregular astigmatism that can be improved more by contact lenses than by eyeglass lenses, as corrected by contact lenses.

(3) In any case where the examiner reports that there is a difference equal to two or more scheduled steps between near and distance corrected vision, with the near vision being worse, the examination report must include at least two recordings of near and distance corrected vision and an explanation of the reason for the difference. In these cases, evaluate based on corrected distance vision adjusted to one step poorer than measured.

(4) To evaluate the impairment of visual acuity where a claimant has a reported visual acuity that is between two sequentially listed visual acuities, use the visual acuity which permits the higher evaluation.

(Authority: 38 U.S.C. 1155)

[73 FR 66549, Nov. 10, 2008]

§ 4.76a Computation of average concentric contraction of visual fields.

TABLE III—NORMAL VISUAL FIELD EXTENT AT 8 PRINCIPAL MERIDIANS

Meridian	Normal degrees
Temporally	85
Down temporally	85
Down	65
Down nasally	50
Nasally	60
Up nasally	55
Up	45
Up temporally	55
Total	500

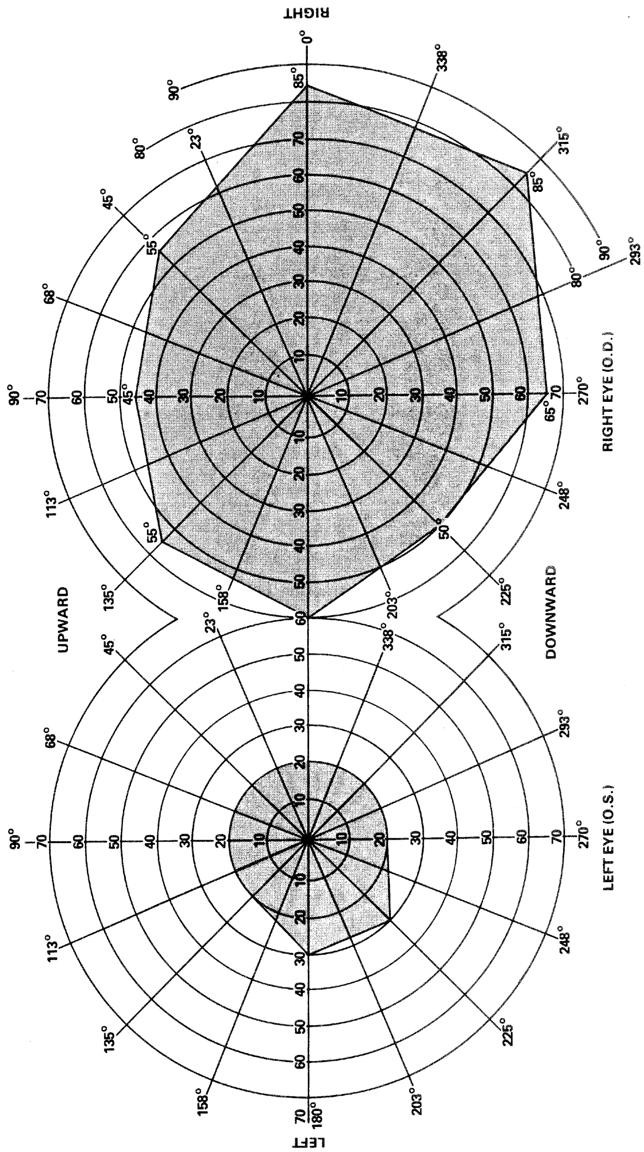


Figure 1. Chart of visual field showing normal field right eye and abnormal contraction visual field left eye.

TS-19 52a

Example of computation of concentric contraction under the schedule with abnormal findings taken from Figure 1.

Loss	Degrees
Temporally	55
Down temporally	55
Down	45

Loss	Degrees
Down nasally	30
Nasally	40
Up nasally	35
Up	25
Up temporally	35
Total loss	320

Remaining field 500° minus 320° = 180°. 180° ÷ 8 = 22½° average concentric contraction.

(Authority: 38 U.S.C. 1155)

[43 FR 45352, Oct. 2, 1978, as amended at 73 FR 66549, Nov. 10, 2008]

§4.77 Visual fields.

(a) *Examination of visual fields*. Examiners must use either Goldmann kinetic perimetry or automated perimetry using Humphrey Model 750, Octopus Model 101, or later versions of these perimetric devices with simulated kinetic Goldmann testing capability. For phakic (normal) individuals, as well as for pseudophakic or aphakic individuals who are well adapted to intraocular lens implant or contact lens correction, visual field examinations must be conducted using a standard target size and luminance, which is Goldmann's equivalent III/4e. For aphakic individuals not well adapted to contact lens correction or pseudophakic individuals not well adapted to intraocular lens implant, visual field examinations must be conducted using Goldmann's equivalent IV/4e. In all cases, the results must be recorded on a standard Goldmann chart (see Figure 2), and the Goldmann chart must be included with the examination report. The examiner must chart at least 16 meridians 22½ degrees apart for each eye and indicate the Goldmann equivalent used. See Table III for the normal extent (in degrees) of the visual fields at the 8 principal meridians (45 degrees apart). When the examiner indicates that additional testing is necessary to evaluate visual fields, the additional testing must be conducted using either a tangent screen or a 30-degree threshold visual field with the Goldmann III stimulus size. The examination report must then include the tracing of either the tangent screen or of the 30-degree threshold visual field with the Goldmann III stimulus size.

(b) *Evaluation of visual fields*. Determine the average concentric contraction of the visual field of each eye by measuring the remaining visual field (in degrees) at each of eight principal meridians 45 degrees apart, adding them, and dividing the sum by eight.

(c) *Combination of visual field defect and decreased visual acuity*. To determine the evaluation for visual impairment when both decreased visual acuity and visual field defect are present in one or both eyes and are service connected, separately evaluate the visual acuity and visual field defect (expressed as a level of visual acuity), and combine them under the provisions of §4.25.

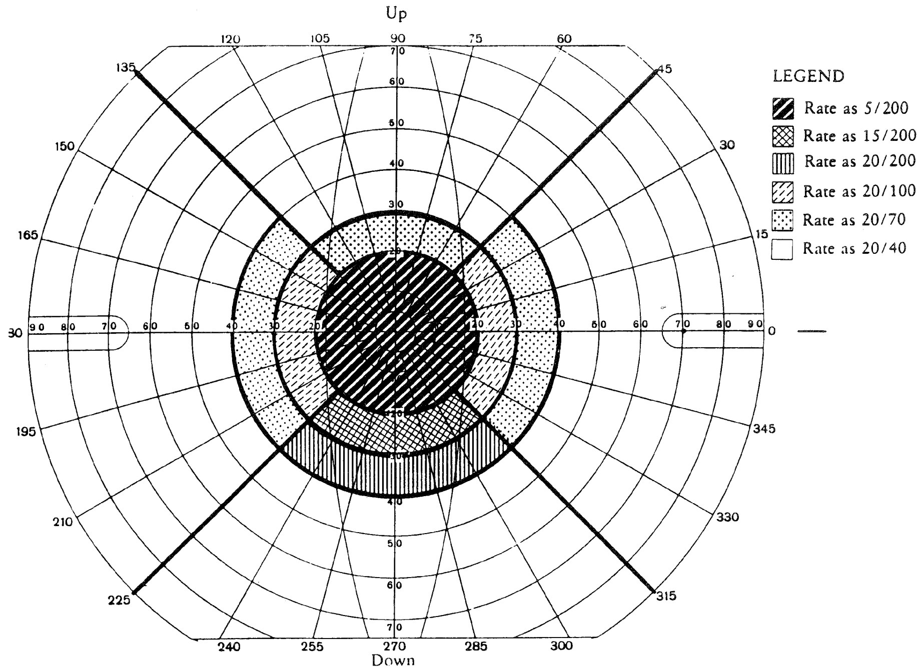


Figure 2. Goldmann Perimeter Chart

52c

(Authority: 38 U.S.C. 1155)

[53 FR 30262, Aug. 11, 1988, as amended at 73 FR 66549, Nov. 10, 2008; 74 FR 7648, Feb. 19, 2009]

§ 4.78 Muscle function.

(a) *Examination of muscle function.* The examiner must use a Goldmann perimeter chart that identifies the four major quadrants (upward, downward, left and right lateral) and the central field (20 degrees or less) (see Figure 2). The examiner must chart the areas of diplopia and include the plotted chart with the examination report.

(b) *Evaluation of muscle function.* (1) An evaluation for diplopia will be assigned to only one eye. When a claimant has both diplopia and decreased visual acuity or visual field defect, assign a level of corrected visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected) that is: one step poorer than it would otherwise warrant if the evaluation for diplopia under diagnostic code 6090 is 20/70 or 20/100; two steps poorer if the evaluation under diagnostic code 6090 is 20/200 or 15/200; or three steps poorer if the evaluation under diagnostic code 6090 is 5/200. This adjusted level of corrected visual acuity, however, must not exceed a level of 5/200. Use the adjusted visual acuity for the poorer eye (or the affected eye, if disability of only one eye is service-connected), and the corrected visual acuity for the better eye (or visual acuity of 20/40 for the other eye, if only one eye is service-connected) to determine the percentage evaluation for visual impairment under diagnostic codes 6065 through 6066.

(2) When diplopia extends beyond more than one quadrant or range of degrees, evaluate diplopia based on the quadrant and degree range that provides the highest evaluation.

(3) When diplopia exists in two separate areas of the same eye, increase the equivalent visual acuity under diagnostic code 6090 to the next poorer level of visual acuity, not to exceed 5/200.

(Authority: 38 U.S.C. 1155)

[73 FR 66550, Nov. 10, 2008]

§ 4.79 Schedule of ratings—eye.

DISEASES OF THE EYE

	Rating
6000 Choroidopathy, including uveitis, iritis, cyclitis, and choroiditis.	
6001 Keratopathy.	
6002 Scleritis.	
6006 Retinopathy or maculopathy.	
6007 Intraocular hemorrhage.	
6008 Detachment of retina.	
6009 Unhealed eye injury.	
General Rating Formula for Diagnostic Codes 6000 through 6009	
Evaluate on the basis of either visual impairment due to the particular condition or on incapacitating episodes, whichever results in a higher evaluation.	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least 4 weeks, but less than 6 weeks, during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks, but less than 4 weeks, during the past 12 months	20
With incapacitating episodes having a total duration of at least 1 week, but less than 2 weeks, during the past 12 months	10
Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider.	
6010 Tuberculosis of eye:	
Active	100
Inactive: Evaluate under § 4.88c or § 4.89 of this part, whichever is appropriate.	
6011 Retinal scars, atrophy, or irregularities:	
Localized scars, atrophy, or irregularities of the retina, unilateral or bilateral, that are centrally located and that result in an irregular, duplicated, enlarged, or diminished image	10
Alternatively, evaluate based on visual impairment due to retinal scars, atrophy, or irregularities, if this would result in a higher evaluation.	
6012 Angle-closure glaucoma:	
Evaluate on the basis of either visual impairment due to angle-closure glaucoma or incapacitating episodes, whichever results in a higher evaluation.	
With incapacitating episodes having a total duration of at least 6 weeks during the past 12 months	60
With incapacitating episodes having a total duration of at least 4 weeks, but less than 6 weeks, during the past 12 months	40
With incapacitating episodes having a total duration of at least 2 weeks, but less than 4 weeks, during the past 12 months	20
Minimum evaluation if continuous medication is required	10
Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician or other healthcare provider.	
6013 Open-angle glaucoma:	
Evaluate based on visual impairment due to open-angle glaucoma.	
Minimum evaluation if continuous medication is required	10
6014 Malignant neoplasms (eyeball only):	
Malignant neoplasm of the eyeball that requires therapy that is comparable to that used for systemic malignancies, *i.e.*, systemic chemotherapy, X-ray therapy more extensive than to the area of the eye, or surgery more extensive than enucleation	100
Note: Continue the 100-percent rating beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating will be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination will be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluate based on residuals.	
Malignant neoplasm of the eyeball that does not require therapy comparable to that for systemic malignancies:	
Separately evaluate visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6015 Benign neoplasms (of eyeball and adnexa):	

DISEASES OF THE EYE—Continued

		Rating
	Separately evaluate visual impairment and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6016	Nystagmus, central	10
6017	Trachomatous conjunctivitis:	
	Active: Evaluate based on visual impairment, minimum	30
	Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800).	
6018	Chronic conjunctivitis (nontrachomatous):	
	Active (with objective findings, such as red, thick conjunctivae, mucous secretion, etc.)	10
	Inactive: Evaluate based on residuals, such as visual impairment and disfigurement (diagnostic code 7800).	
6019	Ptosis, unilateral or bilateral:	
	Evaluate based on visual impairment or, in the absence of visual impairment, on disfigurement (diagnostic code 7800).	
6020	Ectropion:	
	Bilateral	20
	Unilateral	10
6021	Entropion:	
	Bilateral	20
	Unilateral	10
6022	Lagophthalmos:	
	Bilateral	20
	Unilateral	10
6023	Loss of eyebrows, complete, unilateral or bilateral	10
6024	Loss of eyelashes, complete, unilateral or bilateral	10
6025	Disorders of the lacrimal apparatus (epiphora, dacryocystitis, etc.):	
	Bilateral	20
	Unilateral	10
6026	Optic neuropathy:	
	Evaluate based on visual impairment.	
6027	Cataract of any type:	
	Preoperative:	
	Evaluate based on visual impairment.	
	Postoperative:	
	If a replacement lens is present (pseudophakia), evaluate based on visual impairment. If there is no replacement lens, evaluate based on aphakia.	
6029	Aphakia or dislocation of crystalline lens:	
	Evaluate based on visual impairment, and elevate the resulting level of visual impairment one step.	
	Minimum (unilateral or bilateral)	30
6030	Paralysis of accommodation (due to neuropathy of the Oculomotor Nerve (cranial nerve III)).	20
6032	Loss of eyelids, partial or complete:	
	Separately evaluate both visual impairment due to eyelid loss and nonvisual impairment, e.g., disfigurement (diagnostic code 7800), and combine the evaluations.	
6034	Pterygium:	
	Evaluate based on visual impairment, disfigurement (diagnostic code 7800), conjunctivitis (diagnostic code 6018), etc., depending on the particular findings.	
6035	Keratoconus:	
	Evaluate based on impairment of visual acuity.	
6036	Status post corneal transplant:	
	Evaluate based on visual impairment.	
	Minimum, if there is pain, photophobia, and glare sensitivity	10
6037	Pinguecula:	
	Evaluate based on disfigurement (diagnostic code 7800).	
	Impairment of Central Visual Acuity	
6061	Anatomical loss of both eyes [1]	100
6062	No more than light perception in both eyes [1]	100
6063	Anatomical loss of one eye: [1]	
	In the other eye 5/200 (1.5/60)	100
	In the other eye 10/200 (3/60)	90
	In the other eye 15/200 (4.5/60)	80
	In the other eye 20/200 (6/60)	70
	In the other eye 20/100 (6/30)	60
	In the other eye 20/70 (6/21)	60
	In the other eye 20/50 (6/15)	50
	In the other eye 20/40 (6/12)	40
6064	No more than light perception in one eye: [1]	
	In the other eye 5/200 (1.5/60)	100
	In the other eye 10/200 (3/60)	90
	In the other eye 15/200 (4.5/60)	80
	In the other eye 20/200 (6/60)	70
	In the other eye 20/100 (6/30)	60
	In the other eye 20/70 (6/21)	50

DISEASES OF THE EYE—Continued

	Rating
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6065 Vision in one eye 5/200 (1.5/60):	
In the other eye 5/200 (1.5/60)	[1]100
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
6066 Visual acuity in one eye 10/200 (3/60) or better:	
Vision in one eye 10/200 (3/60):	
In the other eye 10/200 (3/60)	90
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	50
In the other eye 20/50 (6/15)	40
In the other eye 20/40 (6/12)	30
Vision in one eye 15/200 (4.5/60):	
In the other eye 15/200 (4.5/60)	80
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/200 (6/60):	
In the other eye 20/200 (6/60)	70
In the other eye 20/100 (6/30)	60
In the other eye 20/70 (6/21)	40
In the other eye 20/50 (6/15)	30
In the other eye 20/40 (6/12)	20
Vision in one eye 20/100 (6/30):	
In the other eye 20/100 (6/30)	50
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/70 (6/21):	
In the other eye 20/70 (6/21)	30
In the other eye 20/50 (6/15)	20
In the other eye 20/40 (6/12)	10
Vision in one eye 20/50 (6/15):	
In the other eye 20/50 (6/15)	10
In the other eye 20/40 (6/12)	10
Vision in one eye 20/40 (6/12):	
In the other eye 20/40 (6/12)	0

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS

	Rating
6080 Visual field defects:	
Homonymous hemianopsia	30
Loss of temporal half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of nasal half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
Loss of inferior half of visual field:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
Loss of superior half of visual field:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	

RATINGS FOR IMPAIRMENT OF VISUAL FIELDS—Continued

	Rating
Concentric contraction of visual field:	
With remaining field of 5 degrees:[1]	
Bilateral	100
Unilateral	30
Or evaluate each affected eye as 5/200 (1.5/60).	
With remaining field of 6 to 15 degrees:	
Bilateral	70
Unilateral	20
Or evaluate each affected eye as 20/200 (6/60).	
With remaining field of 16 to 30 degrees:	
Bilateral	50
Unilateral	10
Or evaluate each affected eye as 20/100 (6/30).	
With remaining field of 31 to 45 degrees:	
Bilateral	30
Unilateral	10
Or evaluate each affected eye as 20/70 (6/21).	
With remaining field of 46 to 60 degrees:	
Bilateral	10
Unilateral	10
Or evaluate each affected eye as 20/50 (6/15).	
6081 Scotoma, unilateral:	
Minimum, with scotoma affecting at least one-quarter of the visual field (quadrantanopsia) or with centrally located scotoma of any size	10
Alternatively, evaluate based on visual impairment due to scotoma, if that would result in a higher evaluation.	

[1] Review for entitlement to special monthly compensation under 38 CFR 3.350.

RATINGS FOR IMPAIRMENT OF MUSCLE FUNCTION

Degree of diplopia	Equivalent visual acuity
6090 Diplopia (double vision):	
(a) Central 20 degrees	5/200 (1.5/60)
(b) 21 degrees to 30 degrees	
(1) Down	15/200 (4.5/60)
(2) Lateral	20/100 (6/30)
(3) Up	20/70 (6/21)
(c) 31 degrees to 40 degrees	
(1) Down	20/200 (6/60)
(2) Lateral	20/70 (6/21)
(3) Up	20/40 (6/12)
Note: In accordance with 38 CFR 4.31, diplopia that is occasional or that is correctable with spectacles is evaluated at 0 percent.	
6091 Symblepharon:	
Evaluate based on visual impairment, lagophthalmos (diagnostic code 6022), disfigurement (diagnostic code 7800), etc., depending on the particular findings.	

(Authority: 38 U.S.C. 1155)

[73 FR 66550, Nov. 10, 2008]

§§ 4.80–4.84 [Reserved]

IMPAIRMENT OF AUDITORY ACUITY

§ 4.85 Evaluation of hearing impairment.

(a) An examination for hearing impairment for VA purposes must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (Maryland CNC) and a puretone audiometry test. Examinations will be conducted without the use of hearing aids.

(b) Table VI, ''Numeric Designation of Hearing Impairment Based on Puretone Threshold Average and Speech Discrimination,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based on a combination of the percent of speech discrimination (horizontal rows) and the puretone threshold average (vertical columns). The Roman numeral designation is located at the point where the percentage of speech discrimination and puretone threshold average intersect.

(c) Table VIa, ''Numeric Designation of Hearing Impairment Based Only on Puretone Threshold Average,'' is used to determine a Roman numeral designation (I through XI) for hearing impairment based only on the puretone threshold average. Table VIa will be used when the examiner certifies that use of the speech discrimination test is not appropriate because of language difficulties, inconsistent speech discrimination scores, etc., or when indicated under the provisions of §4.86.

(d) ''Puretone threshold average,'' as used in Tables VI and VIa, is the sum of the puretone thresholds at 1000, 2000, 3000 and 4000 Hertz, divided by four. This average is used in all cases (including those in §4.86) to determine the Roman numeral designation for hearing impairment from Table VI or VIa.

(e) Table VII, ''Percentage Evaluations for Hearing Impairment,'' is used to determine the percentage evaluation by combining the Roman numeral designations for hearing impairment of each ear. The horizontal rows represent the ear having the better hearing and the vertical columns the ear having the poorer hearing. The percentage evaluation is located at the point where the row and column intersect.

(f) If impaired hearing is service-connected in only one ear, in order to determine the percentage evaluation from Table VII, the non-service-connected ear will be assigned a Roman Numeral designation for hearing impairment of I, subject to the provisions of §3.383 of this chapter.

(g) When evaluating any claim for impaired hearing, refer to §3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation due either to deafness, or to deafness in combination with other specified disabilities.

(h) *Numeric tables VI, VIA**, *and VII.*

TABLE VI

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ON PURETONE THRESHOLD AVERAGE AND SPEECH DISCRIMINATION

Puretone Threshold Average

% of discrim-ination	0-41	42-49	50-57	58-65	66-73	74-81	82-89	90-97	98+
92-100	I	I	I	II	II	II	III	III	IV
84-90	II	II	II	III	III	III	IV	IV	IV
76-82	III	III	IV	IV	IV	V	V	V	V
68-74	IV	IV	V	V	VI	VI	VII	VII	VII
60-66	V	V	VI	VI	VII	VII	VIII	VIII	VIII
52-58	VI	VI	VII	VII	VIII	VIII	VIII	VIII	IX
44-50	VII	VII	VIII	VIII	VIII	IX	IX	IX	X
36-42	VIII	VIII	VIII	IX	IX	IX	X	X	X
0-34	IX	X	XI	XI	XI	XI	XI	XI	XI

TABLE VIA*

NUMERIC DESIGNATION OF HEARING IMPAIRMENT BASED ONLY ON PURETONE THRESHOLD AVERAGE

Puretone Threshold Average

0-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90	91-97	98-104	105+
I	II	III	IV	V	VI	VII	VIII	IX	X	XI

* This table is for use only as specified in §§ 4.85 and 4.86.

TABLE VII

PERCENTAGE EVALUATION FOR HEARING IMPAIRMENT
(DIAGNOSTIC CODE 6100)

Poorer Ear

Better Ear	XI	X	IX	VIII	VII	VI	V	IV	III	II	I
XI	100*										
X	90	80									
IX	80	70	60								
VIII	70	60	50	50							
VII	60	60	50	40	40						
VI	50	50	40	40	30	30					
V	40	40	40	30	30	20	20				
IV	30	30	30	20	20	20	10	10			
III	20	20	20	20	20	10	10	10	0		
II	10	10	10	10	10	10	10	0	0	0	
I	10	10	0	0	0	0	0	0	0	0	0

* Review for entitlement to special monthly compensation under §3.350 of this chapter.

[64 FR 25206, May 11, 1999]

§4.86 Exceptional patterns of hearing impairment.

(a) When the puretone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately.

(b) When the puretone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher

Roman numeral. Each ear will be evaluated separately.

(Authority: 38 U.S.C. 1155)

[64 FR 25209, May 11, 1999]

§ 4.87 Schedule of ratings—ear.

DISEASES OF THE EAR

	Rating
6200 Chronic suppurative otitis media, mastoiditis, or cholesteatoma (or any combination):	
During suppuration, or with aural polyps	10
NOTE: Evaluate hearing impairment, and complications such as labyrinthitis, tinnitus, facial nerve paralysis, or bone loss of skull, separately.	
6201 Chronic nonsuppurative otitis media with effusion (serous otitis media):	
Rate hearing impairment	
6202 Otosclerosis:	
Rate hearing impairment	
6204 Peripheral vestibular disorders:	
Dizziness and occasional staggering	30
Occasional dizziness	10
NOTE: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.	
6205 Meniere's syndrome (endolymphatic hydrops):	
Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus	100
Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus	60
Hearing impairment with vertigo less than once a month, with or without tinnitus	30
NOTE: Evaluate Meniere's syndrome either under these criteria or by separately evaluating vertigo (as a peripheral vestibular disorder), hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But do not combine an evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under diagnostic code 6205.	
6207 Loss of auricle:	
Complete loss of both	50
Complete loss of one	30
Deformity of one, with loss of one-third or more of the substance	10
6208 Malignant neoplasm of the ear (other than skin only)	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation treatment, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6209 Benign neoplasms of the ear (other than skin only):	
Rate on impairment of function.	
6210 Chronic otitis externa:	
Swelling, dry and scaly or serous discharge, and itching requiring frequent and prolonged treatment	10
6211 Tympanic membrane, perforation of	0
6260 Tinnitus, recurrent	10
NOTE (1): A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes.	
NOTE (2): Assign only a single evaluation for recurrent tinnitus, whether the sound is perceived in one ear, both ears, or in the head.	
NOTE (3): Do not evaluate objective tinnitus (in which the sound is audible to other people and has a definable cause that may or may not be pathologic) under this diagnostic code, but evaluate it as part of any underlying condition causing it.	

(Authority: 38 U.S.C. 1155)

[64 FR 25210, May 11, 1999, as amended at 68 FR 25823, May 14, 2003]

§ 4.87a Schedule of ratings—other sense organs.

	Rating
6275 Sense of smell, complete loss	10
6276 Sense of taste, complete loss	10
NOTE: Evaluation will be assigned under diagnostic codes 6275 or 6276 only if there is an anatomical or pathological basis for the condition.	

(Authority: 38 U.S.C. 1155)

[64 FR 25210, May 11, 1999]

INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES

§ 4.88 [Reserved]

§ 4.88a Chronic fatigue syndrome.

(a) For VA purposes, the diagnosis of chronic fatigue syndrome requires:

(1) new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least six months; and

(2) the exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and

(3) six or more of the following:

(i) acute onset of the condition,

(ii) low grade fever,

(iii) nonexudative pharyngitis,

(iv) palpable or tender cervical or axillary lymph nodes,

(v) generalized muscle aches or weakness,

(vi) fatigue lasting 24 hours or longer after exercise,

(vii) headaches (of a type, severity, or pattern that is different from headaches in the pre-morbid state),

(viii) migratory joint pains,

(ix) neuropsychologic symptoms,

(x) sleep disturbance.

(b) [Reserved]

[59 FR 60902, Nov. 29, 1994]

§4.88b Schedule of ratings—infectious diseases, immune disorders and nutritional deficiencies.

		Rating
6300	Cholera, Asiatic:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as renal necrosis under the appropriate system	
6301	Visceral Leishmaniasis:	
	During treatment for active disease	100
	NOTE: A 100 percent evaluation shall continue beyond the cessation of treatment for active disease. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. Rate residuals such as liver damage or lymphadenopathy under the appropriate system.	
6302	Leprosy (Hansen's Disease):	
	As active disease	100
	NOTE: A 100 percent evaluation shall continue beyond the date that an examining physician has determined that this has become inactive. Six months after the date of inactivity, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. Rate residuals such as skin lesions or peripheral neuropathy under the appropriate system.	
6304	Malaria:	
	As active disease	100
	NOTE: The diagnosis of malaria depends on the identification of the malarial parasites in blood smears. If the veteran served in an endemic area and presents signs and symptoms compatible with malaria, the diagnosis may be based on clinical grounds alone. Relapses must be confirmed by the presence of malarial parasites in blood smears.	
	Thereafter rate residuals such as liver or spleen damage under the appropriate system	
6305	Lymphatic Filariasis:	
	As active disease	100
	Thereafter rate residuals such as epididymitis or lymphangitis under the appropriate system	
6306	Bartonellosis:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as skin lesions under the appropriate system	
6307	Plague:	
	As active disease	100
	Thereafter rate residuals such as lymphadenopathy under the appropriate system	
6308	Relapsing Fever:	
	As active disease	100
	Thereafter rate residuals such as liver or spleen damage or central nervous system involvement under the appropriate system	
6309	Rheumatic fever:	
	As active disease	100
	Thereafter rate residuals such as heart damage under the appropriate system	
6310	Syphilis, and other treponemal infections:	
	Rate the complications of nervous system, vascular system, eyes or ears. (See DC 7004, syphilitic heart disease, DC 8013, cerebrospinal syphilis, DC 8014, meningovascular syphilis, DC 8015, tabes dorsalis, and DC 9301, dementia associated with central nervous system syphilis)	
6311	Tuberculosis, miliary:	
	As active disease	100
	Inactive: See §§4.88c and 4.89.	
6313	Avitaminosis:	
	Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
	With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
	With stomatitis, diarrhea, and symmetrical dermatitis	40
	With stomatitis, or achlorhydria, or diarrhea	20
	Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6314	Beriberi:	
	As active disease:	
	With congestive heart failure, anasarca, or Wernicke-Korsakoff syndrome	100

		Rating
	With cardiomegaly, or; with peripheral neuropathy with footdrop or atrophy of thigh or calf muscles	60
	With peripheral neuropathy with absent knee or ankle jerks and loss of sensation, or; with symptoms such as weakness, fatigue, anorexia, dizziness, heaviness and stiffness of legs, headache or sleep disturbance	30
	Thereafter rate residuals under the appropriate body system.	
6315	Pellagra:	
	Marked mental changes, moist dermatitis, inability to retain adequate nourishment, exhaustion, and cachexia	100
	With all of the symptoms listed below, plus mental symptoms and impaired bodily vigor	60
	With stomatitis, diarrhea, and symmetrical dermatitis	40
	With stomatitis, or achlorhydria, or diarrhea	20
	Confirmed diagnosis with nonspecific symptoms such as: decreased appetite, weight loss, abdominal discomfort, weakness, inability to concentrate and irritability	10
6316	Brucellosis:	
	As active disease	100
	Thereafter rate residuals such as liver or spleen damage or meningitis under the appropriate system	
6317	Typhus, scrub:	
	As active disease, and for 3 months convalescence	100
	Thereafter rate residuals such as spleen damage or skin conditions under the appropriate system	
6318	Melioidosis:	
	As active disease	100
	Thereafter rate residuals such as arthritis, lung lesions or meningitis under the appropriate system	
6319	Lyme Disease:	
	As active disease	100
	Thereafter rate residuals such as arthritis under the appropriate system	
6320	Parasitic diseases otherwise not specified:	
	As active disease	100
	Thereafter rate residuals such as spleen or liver damage under the appropriate system	
6350	Lupus erythematosus, systemic (disseminated):	
	Not to be combined with ratings under DC 7809 Acute, with frequent exacerbations, producing severe impairment of health	100
	Exacerbations lasting a week or more, 2 or 3 times per year	60
	Exacerbations once or twice a year or symptomatic during the past 2 years	10
	NOTE: Evaluate this condition either by combining the evaluations for residuals under the appropriate system, or by evaluating DC 6350, whichever method results in a higher evaluation.	
6351	HIV-Related Illness:	
	AIDS with recurrent opportunistic infections or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss, without remission, or few or brief remissions	100
	Refractory constitutional symptoms, diarrhea, and pathological weight loss, or; minimum rating following development of AIDS-related opportunistic infection or neoplasm	60
	Recurrent constitutional symptoms, intermittent diarrhea, and on approved medication(s), or; minimum rating with T4 cell count less than 200, or Hairy Cell Leukoplakia, or Oral Candidiasis	30
	Following development of definite medical symptoms, T4 cell of 200 or more and less than 500, and on approved medication(s), or; with evidence of depression or memory loss with employment limitations	10
	Asymptomatic, following initial diagnosis of HIV infection, with or without lymphadenopathy or decreased T4 cell count	0
	NOTE (1): The term "approved medication(s)" includes medications prescribed as part of a research protocol at an accredited medical institution.	
	NOTE (2): Psychiatric or central nervous system manifestations, opportunistic infections, and neoplasms may be rated separately under appropriate codes if higher overall evaluation results, but not in combination with percentages otherwise assignable above.	
6354	Chronic Fatigue Syndrome (CFS):	
	Debilitating fatigue, cognitive impairments (such as inability to concentrate, forgetfulness, confusion), or a combination of other signs and symptoms:	
	Which are nearly constant and so severe as to restrict routine daily activities almost completely and which may occasionally preclude self-care	100
	Which are nearly constant and restrict routine daily activities to less than 50 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least six weeks total duration per year	60
	Which are nearly constant and restrict routine daily activities to 50 to 75 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least four but less than six weeks total duration per year	40
	Which are nearly constant and restrict routine daily activities by less than 25 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least two but less than four weeks total duration per year	20
	Which wax and wane but result in periods of incapacitation of at least one but less than two weeks total duration per year, or; symptoms controlled by continuous medication	10
	NOTE: For the purpose of evaluating this disability, the condition will be considered incapacitating only while it requires bed rest and treatment by a physician.	

[61 FR 39875, July 31, 1996]

§4.88c Ratings for inactive nonpulmonary tuberculosis initially entitled after August 19, 1968.

	Rating
For 1 year after date of inactivity, following active tuberculosis	100
Thereafter: Rate residuals under the specific body system or systems affected.	
Following the total rating for the 1 year period after date of inactivity, the schedular evaluation for residuals of nonpulmonary tuberculosis, *i.e.*, ankylosis, surgical removal of a part, etc., will be assigned under the appropriate diagnostic code for the residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hip joint with residual ankylosis would be coded 5001–5250. Where there are existing residuals of pulmonary and nonpulmonary conditions, the evaluations for residual separate functional impairment may be combined.	
Where there are existing pulmonary and nonpulmonary conditions, the total rating for the 1 year, after attainment of inactivity, may not be applied to both conditions during the same period. However, the total rating during the 1-year period for the pulmonary or for the nonpulmonary condition will be utilized, combined with evaluation for residuals of the condition not covered by the 1-year total evaluation, so as to allow any additional benefit provided during such period.	

[34 FR 5062, Mar. 11, 1969. Redesignated at 59 FR 60902, Nov. 29, 1994]

§4.89 Ratings for inactive nonpulmonary tuberculosis in effect on August 19, 1968.

Public Law 90–493 repealed section 356 of title 38, United States Code which provided graduated ratings for inactive tuberculosis. The repealed section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90–493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For use in rating cases in which the protective provisions of Pub. L. 90–493 apply, the former evaluations are retained in this section.

	Rating
For 2 years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
Thereafter, for 4 years, or in any event, to 6 years after date of inactivity	50
Thereafter, for 5 years, or to 11 years after date of inactivity	30
Thereafter, in the absence of a schedular compensable permanent residual	0
Following the total rating for the 2-year period after date of inactivity, the schedular evaluation for residuals of nonpulmonary tuberculosis, *i.e.*, ankylosis, surgical removal of a part, etc., if in excess of 50 percent or 30 percent will be assigned under the appropriate diagnostic code for the specific residual preceded by the diagnostic code for tuberculosis of the body part affected. For example, tuberculosis of the hipjoint with residual ankylosis would be coded 5001–5250.	
The graduated ratings for nonpulmonary tuberculosis will not be combined with residuals of nonpulmonary tuberculosis unless the graduated rating and the rating for residual disability cover separate functional losses, e.g., graduated ratings for tuberculosis of the kidney and residuals of tuberculosis of the spine. Where there are existing pulmonary and nonpulmonary conditions, the graduated evaluation for the pulmonary, or for the nonpulmonary, condition will be utilized, combined with evaluations for residuals of the condition not covered by the graduated evaluation utilized, so as to provide the higher evaluation over such period.	
The ending dates of all graduated ratings of nonpulmonary tuberculosis will be controlled by the date of attainment of inactivity.	
These ratings are applicable only to veterans with nonpulmonary tuberculosis active on or after October 10, 1949.	

[29 FR 6718, May 22, 1964, as amended at 34 FR 5062, Mar. 11, 1969; 43 FR 45361, Oct. 2, 1978]

The Respiratory System

§4.96 Special provisions regarding evaluation of respiratory conditions.

(a) *Rating coexisting respiratory conditions.* Ratings under diagnostic codes 6600 through 6817 and 6822 through 6847 will not be combined with each other. Where there is lung or pleural involvement, ratings under diagnostic codes 6819 and 6820 will not be combined with each other or with diagnostic codes 6600 through 6817 or 6822 through 6847. A single rating will be assigned under the diagnostic code which reflects the predominant disability with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation. However, in cases protected by the provisions of Pub. L. 90–493, the graduated ratings of 50 and 30 percent for inactive tuberculosis will not be elevated.

(b) *Rating ''protected'' tuberculosis cases.* Public Law 90–493 repealed section 356 of title 38, United States Code which had provided graduated ratings for inactive tuberculosis. The repealed section, however, still applies to the case of any veteran who on August 19, 1968, was receiving or entitled to receive compensation for tuberculosis. The use of the protective provisions of Pub. L. 90–493 should be mentioned in the discussion portion of all ratings in which these provisions are applied. For application in rating cases in which the protective provisions of Pub. L. 90–493 apply the former evaluations pertaining to pulmonary tuberculosis are retained in § 4.97.

(c) *Special monthly compensation.* When evaluating any claim involving complete organic aphonia, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.

(d) *Special provisions for the application of evaluation criteria for diagnostic codes 6600, 6603, 6604, 6825–6833, and 6840–6845.* (1) Pulmonary function tests (PFT's) are required to evaluate these conditions except:

(i) When the results of a maximum exercise capacity test are of record and are 20 ml/kg/min or less. If a maximum exercise capacity test is not of record, evaluate based on alternative criteria.

(ii) When pulmonary hypertension (documented by an echocardiogram or cardiac catheterization), cor pulmonale, or right ventricular hypertrophy has been diagnosed.

(iii) When there have been one or more episodes of acute respiratory failure.

(iv) When outpatient oxygen therapy is required.

(2) If the DLCO (SB) (Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method) test is not of record, evaluate based on alternative criteria as long as the examiner states why the test would not be useful or valid in a particular case.

(3) When the PFT's are not consistent with clinical findings, evaluate based on the PFT's unless the examiner states why they are not a valid indication of respiratory functional impairment in a particular case.

(4) Post-bronchodilator studies are required when PFT's are done for disability evaluation purposes except when the results of pre-bronchodilator pulmonary function tests are normal or when the examiner determines that post-bronchodilator studies should not be done and states why.

(5) When evaluating based on PFT's, use post-bronchodilator results in applying the evaluation criteria in the rating schedule unless the post-bronchodilator results were poorer than the pre-bronchodilator results. In those cases, use the pre-bronchodilator values for rating purposes.

(6) When there is a disparity between the results of different PFT's (FEV–1 (Forced Expiratory Volume in one second), FVC (Forced Vital Capacity), etc.), so that the level of evaluation would differ depending on which test result is used, use the test result that the examiner states most accurately reflects the level of disability.

(7) If the FEV–1 and the FVC are both greater than 100 percent, do not assign a compensable evaluation based on a decreased FEV–1/FVC ratio.

(Authority: 38 U.S.C. 1155)

[34 FR 5062, Mar. 11, 1969, as amended at 61 FR 46727, Sept. 5, 1996; 71 FR 52459, Sept. 6, 2006]

§ 4.97 Schedule of ratings—respiratory system.

	Rating
DISEASES OF THE NOSE AND THROAT	
6502 Septum, nasal, deviation of:	
Traumatic only,	
With 50-percent obstruction of the nasal passage on both sides or complete obstruction on one side	10
6504 Nose, loss of part of, or scars:	
Exposing both nasal passages	30
Loss of part of one ala, or other obvious disfigurement	10

	Rating
Note: Or evaluate as DC 7800, scars, disfiguring, head, face, or neck.	
6510 Sinusitis, pansinusitis, chronic.	
6511 Sinusitis, ethmoid, chronic.	
6512 Sinusitis, frontal, chronic.	
6513 Sinusitis, maxillary, chronic.	
6514 Sinusitis, sphenoid, chronic.	
General Rating Formula for Sinusitis (DC's 6510 through 6514):	
Following radical surgery with chronic osteomyelitis, or; near constant sinusitis characterized by headaches, pain and tenderness of affected sinus, and purulent discharge or crusting after repeated surgeries	50
Three or more incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; more than six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	30
One or two incapacitating episodes per year of sinusitis requiring prolonged (lasting four to six weeks) antibiotic treatment, or; three to six non-incapacitating episodes per year of sinusitis characterized by headaches, pain, and purulent discharge or crusting	10
Detected by X-ray only	0
Note: An incapacitating episode of sinusitis means one that requires bed rest and treatment by a physician.	
6515 Laryngitis, tuberculous, active or inactive.	
Rate under §§4.88c or 4.89, whichever is appropriate.	
6516 Laryngitis, chronic:	
Hoarseness, with thickening or nodules of cords, polyps, submucous infiltration, or pre-malignant changes on biopsy	30
Hoarseness, with inflammation of cords or mucous membrane	10
6518 Laryngectomy, total.	[1] 100
Rate the residuals of partial laryngectomy as laryngitis (DC 6516), aphonia (DC 6519), or stenosis of larynx (DC 6520).	
6519 Aphonia, complete organic:	
Constant inability to communicate by speech	[1] 100
Constant inability to speak above a whisper	60
Note: Evaluate incomplete aphonia as laryngitis, chronic (DC 6516).	
6520 Larynx, stenosis of, including residuals of laryngeal trauma (unilateral or bilateral):	
Forced expiratory volume in one second (FEV–1) less than 40 percent of predicted value, with Flow-Volume Loop compatible with upper airway obstruction, or; permanent tracheostomy	100
FEV–1 of 40- to 55-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	60
FEV–1 of 56- to 70-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	30
FEV–1 of 71- to 80-percent predicted, with Flow-Volume Loop compatible with upper airway obstruction	10
Note: Or evaluate as aphonia (DC 6519).	
6521 Pharynx, injuries to:	
Stricture or obstruction of pharynx or nasopharynx, or; absence of soft palate secondary to trauma, chemical burn, or granulomatous disease, or; paralysis of soft palate with swallowing difficulty (nasal regurgitation) and speech impairment	50
6522 Allergic or vasomotor rhinitis:	
With polyps	30
Without polyps, but with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6523 Bacterial rhinitis:	
Rhinoscleroma	50
With permanent hypertrophy of turbinates and with greater than 50-percent obstruction of nasal passage on both sides or complete obstruction on one side	10
6524 Granulomatous rhinitis:	
Wegener's granulomatosis, lethal midline granuloma	100
Other types of granulomatous infection	20

DISEASES OF THE TRACHEA AND BRONCHI

6600 Bronchitis, chronic:	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6601 Bronchiectasis:	
With incapacitating episodes of infection of at least six weeks total duration per year	100

		Rating
	With incapacitating episodes of infection of four to six weeks total duration per year, or; near constant findings of cough with purulent sputum associated with anorexia, weight loss, and frank hemoptysis and requiring antibiotic usage almost continuously	60
	With incapacitating episodes of infection of two to four weeks total duration per year, or; daily productive cough with sputum that is at times purulent or blood-tinged and that requires prolonged (lasting four to six weeks) antibiotic usage more than twice a year	30
	Intermittent productive cough with acute infection requiring a course of antibiotics at least twice a year	10
	Or rate according to pulmonary impairment as for chronic bronchitis (DC 6600).	
	Note: An incapacitating episode is one that requires bedrest and treatment by a physician.	
6602	Asthma, bronchial:	
	FEV–1 less than 40-percent predicted, or; FEV–1/FVC less than 40 percent, or; more than one attack per week with episodes of respiratory failure, or; requires daily use of systemic (oral or parenteral) high dose corticosteroids or immuno-suppressive medications	100
	FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; at least monthly visits to a physician for required care of exacerbations, or; intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids	60
	FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication	30
	FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; intermittent inhalational or oral bronchodilator therapy	10
	Note: In the absence of clinical findings of asthma at time of examination, a verified history of asthmatic attacks must be of record.	
6603	Emphysema, pulmonary:	
	FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
	FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
	FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
	FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
6604	Chronic obstructive pulmonary disease:	
	FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy.	100
	FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
	FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
	FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10

DISEASES OF THE LUNGS AND PLEURA—TUBERCULOSIS

Ratings for Pulmonary Tuberculosis Entitled on August 19, 1968

6701	Tuberculosis, pulmonary, chronic, far advanced, active	100
6702	Tuberculosis, pulmonary, chronic, moderately advanced, active	100
6703	Tuberculosis, pulmonary, chronic, minimal, active	100
6704	Tuberculosis, pulmonary, chronic, active, advancement unspecified	100
6721	Tuberculosis, pulmonary, chronic, far advanced, inactive.	
6722	Tuberculosis, pulmonary, chronic, moderately advanced, inactive.	
6723	Tuberculosis, pulmonary, chronic, minimal, inactive.	
6724	Tuberculosis, pulmonary, chronic, inactive, advancement unspecified.	
	General Rating Formula for Inactive Pulmonary Tuberculosis: For two years after date of inactivity, following active tuberculosis, which was clinically identified during service or subsequently	100
	Thereafter for four years, or in any event, to six years after date of inactivity	50
	Thereafter, for five years, or to eleven years after date of inactivity	30
	Following far advanced lesions diagnosed at any time while the disease process was active, minimum	30
	Following moderately advanced lesions, provided there is continued disability, emphysema, dyspnea on exertion, impairment of health, etc	20
	Otherwise	0

	Rating
Note (1): The 100-percent rating under codes 6701 through 6724 is not subject to a requirement of precedent hospital treatment. It will be reduced to 50 percent for failure to submit to examination or to follow prescribed treatment upon report to that effect from the medical authorities. When a veteran is placed on the 100-percent rating for inactive tuberculosis, the medical authorities will be appropriately notified of the fact, and of the necessity, as given in footnote 1 to 38 U.S.C. 1156 (and formerly in 38 U.S.C. 356, which has been repealed by Public Law 90–493), to notify the Veterans Service Center in the event of failure to submit to examination or to follow treatment.	
Note (2): The graduated 50-percent and 30-percent ratings and the permanent 30 percent and 20 percent ratings for inactive pulmonary tuberculosis are not to be combined with ratings for other respiratory disabilities. Following thoracoplasty the rating will be for removal of ribs combined with the rating for collapsed lung. Resection of the ribs incident to thoracoplasty will be rated as removal.	
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968	
6730 Tuberculosis, pulmonary, chronic, active	100
Note: Active pulmonary tuberculosis will be considered permanently and totally disabling for non-service-connected pension purposes in the following circumstances:	
(a) Associated with active tuberculosis involving other than the respiratory system.	
(b) With severe associated symptoms or with extensive cavity formation.	
(c) Reactivated cases, generally.	
(d) With advancement of lesions on successive examinations or while under treatment.	
(e) Without retrogression of lesions or other evidence of material improvement at the end of six months hospitalization or without change of diagnosis from ''active'' at the end of 12 months hospitalization. Material improvement means lessening or absence of clinical symptoms, and X-ray findings of a stationary or retrogressive lesion.	
6731 Tuberculosis, pulmonary, chronic, inactive:	
Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600). Rate thoracoplasty as removal of ribs under DC 5297.	
Note: A mandatory examination will be requested immediately following notification that active tuberculosis evaluated under DC 6730 has become inactive. Any change in evaluation will be carried out under the provisions of §3.105(e).	
6732 Pleurisy, tuberculous, active or inactive:	
Rate under §§4.88c or 4.89, whichever is appropriate.	
NONTUBERCULOUS DISEASES	
6817 Pulmonary Vascular Disease:	
Primary pulmonary hypertension, or; chronic pulmonary thromboembolism with evidence of pulmonary hypertension, right ventricular hypertrophy, or cor pulmonale, or; pulmonary hypertension secondary to other obstructive disease of pulmonary arteries or veins with evidence of right ventricular hypertrophy or cor pulmonale	100
Chronic pulmonary thromboembolism requiring anticoagulant therapy, or; following inferior vena cava surgery without evidence of pulmonary hypertension or right ventricular dysfunction	60
Symptomatic, following resolution of acute pulmonary embolism	30
Asymptomatic, following resolution of pulmonary thromboembolism	0
Note: Evaluate other residuals following pulmonary embolism under the most appropriate diagnostic code, such as chronic bronchitis (DC 6600) or chronic pleural effusion or fibrosis (DC 6844), but do not combine that evaluation with any of the above evaluations.	
6819 Neoplasms, malignant, any specified part of respiratory system exclusive of skin growths	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
6820 Neoplasms, benign, any specified part of respiratory system. Evaluate using an appropriate respiratory analogy.	
Bacterial Infections of the Lung	
6822 Actinomycosis.	
6823 Nocardiosis.	
6824 Chronic lung abscess.	
General Rating Formula for Bacterial Infections of the Lung (diagnostic codes 6822 through 6824):	
Active infection with systemic symptoms such as fever, night sweats, weight loss, or hemoptysis	100
Depending on the specific findings, rate residuals as interstitial lung disease, restrictive lung disease, or, when obstructive lung disease is the major residual, as chronic bronchitis (DC 6600).	
Interstitial Lung Disease	
6825 Diffuse interstitial fibrosis (interstitial pneumonitis, fibrosing alveolitis).	
6826 Desquamative interstitial pneumonitis.	
6827 Pulmonary alveolar proteinosis.	
6828 Eosinophilic granuloma of lung.	

	Rating
6829 Drug-induced pulmonary pneumonitis and fibrosis.	
6830 Radiation-induced pulmonary pneumonitis and fibrosis.	
6831 Hypersensitivity pneumonitis (extrinsic allergic alveolitis).	
6832 Pneumoconiosis (silicosis, anthracosis, etc.).	
6833 Asbestosis.	
General Rating Formula for Interstitial Lung Disease (diagnostic codes 6825 through 6833):	
Forced Vital Capacity (FVC) less than 50-percent predicted, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption with cardiorespiratory limitation, or; cor pulmonale or pulmonary hypertension, or; requires outpatient oxygen therapy	100
FVC of 50- to 64-percent predicted, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum exercise capacity of 15 to 20 ml/kg/min oxygen consumption with cardiorespiratory limitation	60
FVC of 65- to 74-percent predicted, or; DLCO (SB) of 56- to 65-percent predicted	30
FVC of 75- to 80-percent predicted, or; DLCO (SB) of 66- to 80-percent predicted	10
Mycotic Lung Disease	
6834 Histoplasmosis of lung.	
6835 Coccidioidomycosis.	
6836 Blastomycosis.	
6837 Cryptococcosis.	
6838 Aspergillosis.	
6839 Mucormycosis.	
General Rating Formula for Mycotic Lung Disease (diagnostic codes 6834 through 6839):	
Chronic pulmonary mycosis with persistent fever, weight loss, night sweats, or massive hemoptysis	100
Chronic pulmonary mycosis requiring suppressive therapy with no more than minimal symptoms such as occasional minor hemoptysis or productive cough	50
Chronic pulmonary mycosis with minimal symptoms such as occasional minor hemoptysis or productive cough	30
Healed and inactive mycotic lesions, asymptomatic	0
Note: Coccidioidomycosis has an incubation period up to 21 days, and the disseminated phase is ordinarily manifest within six months of the primary phase. However, there are instances of dissemination delayed up to many years after the initial infection which may have been unrecognized. Accordingly, when service connection is under consideration in the absence of record or other evidence of the disease in service, service in southwestern United States where the disease is endemic and absence of prolonged residence in this locality before or after service will be the deciding factor.	
Restrictive Lung Disease	
6840 Diaphragm paralysis or paresis.	
6841 Spinal cord injury with respiratory insufficiency.	
6842 Kyphoscoliosis, pectus excavatum, pectus carinatum.	
6843 Traumatic chest wall defect, pneumothorax, hernia, etc.	
6844 Post-surgical residual (lobectomy, pneumonectomy, etc.).	
6845 Chronic pleural effusion or fibrosis.	
General Rating Formula for Restrictive Lung Disease (diagnostic codes 6840 through 6845):	
FEV–1 less than 40 percent of predicted value, or; the ratio of Forced Expiratory Volume in one second to Forced Vital Capacity (FEV–1/FVC) less than 40 percent, or; Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO (SB)) less than 40-percent predicted, or; maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation), or; cor pulmonale (right heart failure), or; right ventricular hypertrophy, or; pulmonary hypertension (shown by Echo or cardiac catheterization), or; episode(s) of acute respiratory failure, or; requires outpatient oxygen therapy	100
FEV–1 of 40- to 55-percent predicted, or; FEV–1/FVC of 40 to 55 percent, or; DLCO (SB) of 40- to 55-percent predicted, or; maximum oxygen consumption of 15 to 20 ml/kg/min (with cardiorespiratory limit)	60
FEV–1 of 56- to 70-percent predicted, or; FEV–1/FVC of 56 to 70 percent, or; DLCO (SB) 56- to 65-percent predicted	30
FEV–1 of 71- to 80-percent predicted, or; FEV–1/FVC of 71 to 80 percent, or; DLCO (SB) 66- to 80-percent predicted	10
Or rate primary disorder.	
Note (1): A 100-percent rating shall be assigned for pleurisy with empyema, with or without pleurocutaneous fistula, until resolved.	
Note (2): Following episodes of total spontaneous pneumothorax, a rating of 100 percent shall be assigned as of the date of hospital admission and shall continue for three months from the first day of the month after hospital discharge.	
Note (3): Gunshot wounds of the pleural cavity with bullet or missile retained in lung, pain or discomfort on exertion, or with scattered rales or some limitation of excursion of diaphragm or of lower chest expansion shall be rated at least 20-percent disabling. Disabling injuries of shoulder girdle muscles (Groups I to IV) shall be separately rated and combined with ratings for respiratory involvement. Involvement of Muscle Group XXI (DC 5321), however, will not be separately rated.	
6846 Sarcoidosis:	

	Rating
Cor pulmonale, or; cardiac involvement with congestive heart failure, or; progressive pulmonary disease with fever, night sweats, and weight loss despite treatment	100
Pulmonary involvement requiring systemic high dose (therapeutic) corticosteroids for control	60
Pulmonary involvement with persistent symptoms requiring chronic low dose (maintenance) or intermittent corticosteroids	30
Chronic hilar adenopathy or stable lung infiltrates without symptoms or physiologic impairment	0
Or rate active disease or residuals as chronic bronchitis (DC 6600) and extra-pulmonary involvement under specific body system involved.	
6847 Sleep Apnea Syndromes (Obstructive, Central, Mixed):	
Chronic respiratory failure with carbon dioxide retention or cor pulmonale, or; requires tracheostomy	100
Requires use of breathing assistance device such as continuous airway pressure (CPAP) machine	50
Persistent day-time hypersomnolence	30
Asymptomatic but with documented sleep disorder breathing	0

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

[61 FR 46728, Sept. 5, 1996, as amended at 71 FR 28586, May 17, 2006]

THE CARDIOVASCULAR SYSTEM

§ 4.100 Application of the evaluation criteria for diagnostic codes 7000–7007, 7011, and 7015–7020.

(a) Whether or not cardiac hypertrophy or dilatation (documented by electrocardiogram, echocardiogram, or X-ray) is present and whether or not there is a need for continuous medication must be ascertained in all cases.

(b) Even if the requirement for a 10% (based on the need for continuous medication) or 30% (based on the presence of cardiac hypertrophy or dilatation) evaluation is met, METs testing is required in all cases except:

(1) When there is a medical contraindication.

(2) When the left ventricular ejection fraction has been measured and is 50% or less.

(3) When chronic congestive heart failure is present or there has been more than one episode of congestive heart failure within the past year.

(4) When a 100% evaluation can be assigned on another basis.

(c) If left ventricular ejection fraction (LVEF) testing is not of record, evaluate based on the alternative criteria unless the examiner states that the LVEF test is needed in a particular case because the available medical information does not sufficiently reflect the severity of the veteran's cardiovascular disability.

[71 FR 52460, Sept. 6, 2006]

§§ 4.101–4.103 [Reserved]

§ 4.104 Schedule of ratings—cardiovascular system.

DISEASES OF THE HEART

	Rating
NOTE (1): Evaluate cor pulmonale, which is a form of secondary heart disease, as part of the pulmonary condition that causes it.	
NOTE (2): One MET (metabolic equivalent) is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. When the level of METs at which dyspnea, fatigue, angina, dizziness, or syncope develops is required for evaluation, and a laboratory determination of METs by exercise testing cannot be done for medical reasons, an estimation by a medical examiner of the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope may be used.	
7000 Valvular heart disease (including rheumatic heart disease):	
During active infection with valvular heart damage and for three months following cessation of therapy for the active infection	100
Thereafter, with valvular heart disease (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7001 Endocarditis:	
For three months following cessation of therapy for active infection with cardiac involvement	100
Thereafter, with endocarditis (documented by findings on physical examination and either echocardiogram, Doppler echocardiogram, or cardiac catheterization) resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7002 Pericarditis:	
For three months following cessation of therapy for active infection with cardiac involvement	100
Thereafter, with documented pericarditis resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent.	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7003 Pericardial adhesions:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7004 Syphilitic heart disease:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: Evaluate syphilitic aortic aneurysms under DC 7110 (aortic aneurysm).	
7005 Arteriosclerotic heart disease (Coronary artery disease):	
With documented coronary artery disease resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: If nonservice-connected arteriosclerotic heart disease is superimposed on service-connected valvular or other non-arteriosclerotic heart disease, request a medical opinion as to which condition is causing the current signs and symptoms.	
7006 Myocardial infarction:	
During and for three months following myocardial infarction, documented by laboratory tests	100
Thereafter:	
With history of documented myocardial infarction, resulting in:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7007 Hypertensive heart disease:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7008 Hyperthyroid heart disease:	
Include as part of the overall evaluation for hyperthyroidism under DC 7900. However, when atrial fibrillation is present, hyperthyroidism may be evaluated either under DC 7900 or under DC 7010 (supraventricular arrhythmia), whichever results in a higher evaluation.	
7010 Supraventricular arrhythmias:	

DISEASES OF THE HEART—Continued

	Rating
Paroxysmal atrial fibrillation or other supraventricular tachycardia, with more than four episodes per year documented by ECG or Holter monitor	30
Permanent atrial fibrillation (lone atrial fibrillation), or; one to four episodes per year of paroxysmal atrial fibrillation or other supraventricular tachycardia documented by ECG or Holter monitor	10
7011 Ventricular arrhythmias (sustained):	
For indefinite period from date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia, or; for indefinite period from date of hospital admission for ventricular aneurysmectomy, or; with an automatic implantable Cardioverter-Defibrillator (AICD) in place	100
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: A rating of 100 percent shall be assigned from the date of hospital admission for initial evaluation and medical therapy for a sustained ventricular arrhythmia or for ventricular aneurysmectomy. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7015 Atrioventricular block:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30

DISEASES OF THE HEART—Continued

	Rating
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication or a pacemaker required	10
NOTE: Unusual cases of arrhythmia such as atrioventricular block associated with a supraventricular arrhythmia or pathological bradycardia should be submitted to the Director, Compensation and Pension Service. Simple delayed P-R conduction time, in the absence of other evidence of cardiac disease, is not a disability.	
7016 Heart valve replacement (prosthesis):	
For indefinite period following date of hospital admission for valve replacement	100
Thereafter:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for valve replacement. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7017 Coronary bypass surgery:	
For three months following hospital admission for surgery	100
Thereafter:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30

DISEASES OF THE HEART—Continued

	Rating
Workload greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
7018 Implantable cardiac pacemakers:	
For two months following hospital admission for implantation or reimplantation	100
Thereafter:	
Evaluate as supraventricular arrhythmias (DC 7010), ventricular arrhythmias (DC 7011), or atrioventricular block (DC 7015). Minimum	10
NOTE: Evaluate implantable Cardioverter-Defibrillators (AICD's) under DC 7011.	
7019 Cardiac transplantation:	
For an indefinite period from date of hospital admission for cardiac transplantation	100
Thereafter:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Minimum	30
NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for cardiac transplantation. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7020 Cardiomyopathy:	
Chronic congestive heart failure, or; workload of 3 METs or less results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of less than 30 percent	100
More than one episode of acute congestive heart failure in the past year, or; workload of greater than 3 METs but not greater than 5 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; left ventricular dysfunction with an ejection fraction of 30 to 50 percent	60
Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray	30
Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required	10
Diseases of the Arteries and Veins	
7101 Hypertensive vascular disease (hypertension and isolated systolic hypertension):	
Diastolic pressure predominantly 130 or more	60
Diastolic pressure predominantly 120 or more	40

DISEASES OF THE HEART—Continued

	Rating
Diastolic pressure predominantly 110 or more, or; systolic pressure predominantly 200 or more	20
Diastolic pressure predominantly 100 or more, or; systolic pressure predominantly 160 or more, or; minimum evaluation for an individual with a history of diastolic pressure predominantly 100 or more who requires continuous medication for control	10
NOTE (1): Hypertension or isolated systolic hypertension must be confirmed by readings taken two or more times on at least three different days. For purposes of this section, the term hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.	
NOTE (2): Evaluate hypertension due to aortic insufficiency or hyperthyroidism, which is usually the isolated systolic type, as part of the condition causing it rather than by a separate evaluation.	
NOTE (3): Evaluate hypertension separately from hypertensive heart disease and other types of heart disease.	
7110 Aortic aneurysm:	
If five centimeters or larger in diameter, or; if symptomatic, or; for indefinite period from date of hospital admission for surgical correction (including any type of graft insertion)	100
Precluding exertion	60
Evaluate residuals of surgical correction according to organ systems affected.	
NOTE: A rating of 100 percent shall be assigned as of the date of admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7111 Aneurysm, any large artery:	
If symptomatic, or; for indefinite period from date of hospital admission for surgical correction	100
Following surgery:	
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less	100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; persistent coldness of the extremity, one or more deep ischemic ulcers, or ankle/brachial index of 0.5 or less	60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less	40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less	20
NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.	

DISEASES OF THE HEART—Continued

	Rating
NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under §4.25), using the bilateral factor, if applicable.	
NOTE (3): A rating of 100 percent shall be assigned as of the date of hospital admission for surgical correction. Six months following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7112 Aneurysm, any small artery:	
Asymptomatic	0
NOTE: If symptomatic, evaluate according to body system affected. Following surgery, evaluate residuals under the body system affected.	
7113 Arteriovenous fistula, traumatic:	
With high output heart failure	100
Without heart failure but with enlarged heart, wide pulse pressure, and tachycardia	60
Without cardiac involvement but with edema, stasis dermatitis, and either ulceration or cellulitis:	
Lower extremity	50
Upper extremity	40
With edema or stasis dermatitis:	
Lower extremity	30
Upper extremity	20
7114 Arteriosclerosis obliterans:	
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less	100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less	60
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less	40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less	20
NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.	
NOTE (2): Evaluate residuals of aortic and large arterial bypass surgery or arterial graft as arteriosclerosis obliterans.	
NOTE (3): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under §4.25), using the bilateral factor (§4.26), if applicable.	
7115 Thrombo-angiitis obliterans (Buerger's Disease):	
Ischemic limb pain at rest, and; either deep ischemic ulcers or ankle/brachial index of 0.4 or less	100
Claudication on walking less than 25 yards on a level grade at 2 miles per hour, and; either persistent coldness of the extremity or ankle/brachial index of 0.5 or less	60

DISEASES OF THE HEART—Continued

	Rating
Claudication on walking between 25 and 100 yards on a level grade at 2 miles per hour, and; trophic changes (thin skin, absence of hair, dystrophic nails) or ankle/brachial index of 0.7 or less	40
Claudication on walking more than 100 yards, and; diminished peripheral pulses or ankle/brachial index of 0.9 or less	20
NOTE (1): The ankle/brachial index is the ratio of the systolic blood pressure at the ankle (determined by Doppler study) divided by the simultaneous brachial artery systolic blood pressure. The normal index is 1.0 or greater.	
NOTE (2): These evaluations are for involvement of a single extremity. If more than one extremity is affected, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7117 Raynaud's syndrome:	
With two or more digital ulcers plus autoamputation of one or more digits and history of characteristic attacks	100
With two or more digital ulcers and history of characteristic attacks	60
Characteristic attacks occurring at least daily	40
Characteristic attacks occurring four to six times a week	20
Characteristic attacks occurring one to three times a week	10
NOTE: For purposes of this section, characteristic attacks consist of sequential color changes of the digits of one or more extremities lasting minutes to hours, sometimes with pain and paresthesias, and precipitated by exposure to cold or by emotional upsets. These evaluations are for the disease as a whole, regardless of the number of extremities involved or whether the nose and ears are involved.	
7118 Angioneurotic edema:	
Attacks without laryngeal involvement lasting one to seven days or longer and occurring more than eight times a year, or; attacks with laryngeal involvement of any duration occurring more than twice a year	40
Attacks without laryngeal involvement lasting one to seven days and occurring five to eight times a year, or; attacks with laryngeal involvement of any duration occurring once or twice a year	20
Attacks without laryngeal involvement lasting one to seven days and occurring two to four times a year	10
7119 Erythromelalgia:	
Characteristic attacks that occur more than once a day, last an average of more than two hours each, respond poorly to treatment, and that restrict most routine daily activities	100
Characteristic attacks that occur more than once a day, last an average of more than two hours each, and respond poorly to treatment, but that do not restrict most routine daily activities	60
Characteristic attacks that occur daily or more often but that respond to treatment	30
Characteristic attacks that occur less than daily but at least three times a week and that respond to treatment	10

DISEASES OF THE HEART—Continued

	Rating
NOTE: For purposes of this section, a characteristic attack of erythromelalgia consists of burning pain in the hands, feet, or both, usually bilateral and symmetrical, with increased skin temperature and redness, occurring at warm ambient temperatures. These evaluations are for the disease as a whole, regardless of the number of extremities involved.	
7120 Varicose veins:	
With the following findings attributed to the effects of varicose veins: Massive board-like edema with constant pain at rest	100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration	60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration	40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema	20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery	10
Asymptomatic palpable or visible varicose veins	0
NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7121 Post-phlebitic syndrome of any etiology:	
With the following findings attributed to venous disease:	
Massive board-like edema with constant pain at rest	100
Persistent edema or subcutaneous induration, stasis pigmentation or eczema, and persistent ulceration	60
Persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration	40
Persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema	20
Intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery	10
Asymptomatic palpable or visible varicose veins	0
NOTE: These evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under § 4.25), using the bilateral factor (§ 4.26), if applicable.	
7122 Cold injury residuals:	

DISEASES OF THE HEART—Continued

	Rating
With the following in affected parts:	
Arthralgia or other pain, numbness, or cold sensitivity plus two or more of the following: tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis)	30
Arthralgia or other pain, numbness, or cold sensitivity plus tissue loss, nail abnormalities, color changes, locally impaired sensation, hyperhidrosis, or X-ray abnormalities (osteoporosis, subarticular punched out lesions, or osteoarthritis)	20
Arthralgia or other pain, numbness, or cold sensitivity	10
NOTE (1): Separately evaluate amputations of fingers or toes, and complications such as squamous cell carcinoma at the site of a cold injury scar or peripheral neuropathy, under other diagnostic codes. Separately evaluate other disabilities that have been diagnosed as the residual effects of cold injury, such as Raynaud's phenomenon, muscle atrophy, etc., unless they are used to support an evaluation under diagnostic code 7122.	
NOTE (2): Evaluate each affected part (e.g., hand, foot, ear, nose) separately and combine the ratings in accordance with §§ 4.25 and 4.26.	
7123 Soft tissue sarcoma (of vascular origin)	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	

(Authority: 38 U.S.C. 1155)

[62 FR 65219, Dec. 11, 1997, as amended at 63 FR 37779, July 14, 1998; 71 FR52460, Sept. 6, 2006]

THE DIGESTIVE SYSTEM

§ 4.110 Ulcers.

Experience has shown that the term "peptic ulcer" is not sufficiently specific for rating purposes. Manifest differences in ulcers of the stomach or duodenum in comparison with those at an anastomotic stoma are sufficiently recognized as to warrant two separate graduated descriptions. In evaluating the ulcer, care should be taken that the findings adequately identify the particular location.

§ 4.111 Postgastrectomy syndromes.

There are various postgastrectomy symptoms which may occur following anastomotic operations of the stomach. When present, those occurring during or immediately after eating and known as the "dumping syndrome" are characterized by gastrointestinal complaints and generalized symptoms simulating hypoglycemia; those occurring from 1 to 3 hours after eating usually present definite manifestations of hypoglycemia.

§ 4.112 Weight loss.

For purposes of evaluating conditions in § 4.114, the term "substantial weight loss" means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; and the term "minor weight loss" means a weight loss of 10 to 20 percent of the individual's baseline weight, sustained for three months or longer. The term "inability to gain weight" means that there has been substantial weight loss with inability to regain it despite appropriate therapy. "Baseline weight" means the average weight for the two-year-period preceding onset of the disease.

(Authority: 38 U.S.C. 1155)

[66 FR 29488, May 31, 2001]

§ 4.113 Coexisting abdominal conditions.

There are diseases of the digestive system, particularly within the abdomen, which, while differing in the site of pathology, produce a common disability picture characterized in the main by varying degrees of abdominal distress or pain, anemia and disturbances in nutrition. Consequently, certain coexisting diseases in this area, as indicated in the instruction under the title "Diseases of the Digestive System," do not lend themselves to distinct and separate disability evaluations without violating the fundamental principle relating to pyramiding as outlined in § 4.14.

§ 4.114 Schedule of ratings—digestive system.

Ratings under diagnostic codes 7301 to 7329, inclusive, 7331, 7342, and 7345 to 7348 inclusive will not be combined with each other. A single evaluation will be assigned under the diagnostic code which reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such elevation.

	Rating
7200 Mouth, injuries of.	
Rate as for disfigurement and impairment of function of mastication.	
7201 Lips, injuries of.	
Rate as for disfigurement of face.	
7202 Tongue, loss of whole or part:	
With inability to communicate by speech	100
One-half or more	60
With marked speech impairment	30
7203 Esophagus, stricture of:	
Permitting passage of liquids only, with marked impairment of general health	80
Severe, permitting liquids only	50
Moderate	30
7204 Esophagus, spasm of (cardiospasm).	
If not amenable to dilation, rate as for the degree of obstruction (stricture).	
7205 Esophagus, diverticulum of, acquired.	
Rate as for obstruction (stricture).	
7301 Peritoneum, adhesions of:	
Severe; definite partial obstruction shown by X-ray, with frequent and prolonged episodes of severe colic distension, nausea or vomiting, following severe peritonitis, ruptured appendix, perforated ulcer, or operation with drainage	50
Moderately severe; partial obstruction manifested by delayed motility of barium meal and less frequent and less prolonged episodes of pain	30
Moderate; pulling pain on attempting work or aggravated by movements of the body, or occasional episodes of colic pain, nausea, constipation (perhaps alternating with diarrhea) or abdominal distension	10
Mild	0
NOTE: Ratings for adhesions will be considered when there is history of operative or other traumatic or infectious (intraabdominal) process, and at least two of the following: disturbance of motility, actual partial obstruction, reflex disturbances, presence of pain.	
7304 Ulcer, gastric.	
7305 Ulcer, duodenal:	
Severe; pain only partially relieved by standard ulcer therapy, periodic vomiting, recurrent hematemesis or melena, with manifestations of anemia and weight loss productive of definite impairment of health	60
Moderately severe; less than severe but with impairment of health manifested by anemia and weight loss; or recurrent incapacitating episodes averaging 10 days or more in duration at least four or more times a year	40
Moderate; recurring episodes of severe symptoms two or three times a year averaging 10 days in duration; or with continuous moderate manifestations	20
Mild; with recurring symptoms once or twice yearly	10
7306 Ulcer, marginal (gastrojejunal):	

	Rating
Pronounced; periodic or continuous pain unrelieved by standard ulcer therapy with periodic vomiting, recurring melena or hematemesis, and weight loss. Totally incapacitating	100
Severe; same as pronounced with less pronounced and less continuous symptoms with definite impairment of health	60
Moderately severe; intercurrent episodes of abdominal pain at least once a month partially or completely relieved by ulcer therapy, mild and transient episodes of vomiting or melena	40
Moderate; with episodes of recurring symptoms several times a year	20
Mild; with brief episodes of recurring symptoms once or twice yearly	10
7307 Gastritis, hypertrophic (identified by gastroscope):	
Chronic; with severe hemorrhages, or large ulcerated or eroded areas	60
Chronic; with multiple small eroded or ulcerated areas, and symptoms	30
Chronic; with small nodular lesions, and symptoms	10
Gastritis, atrophic.	
A complication of a number of diseases, including pernicious anemia.	
Rate the underlying condition.	
7308 Postgastrectomy syndromes:	
Severe; associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia	60
Moderate; less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss	40
Mild; infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations	20
7309 Stomach, stenosis of.	
Rate as for gastric ulcer.	
7310 Stomach, injury of, residuals.	
Rate as peritoneal adhesions.	
7311 Residuals of injury of the liver:	
Depending on the specific residuals, separately evaluate as adhesions of peritoneum (diagnostic code 7301), cirrhosis of liver (diagnostic code 7312), and chronic liver disease without cirrhosis (diagnostic code 7345).	
7312 Cirrhosis of the liver, primary biliary cirrhosis, or cirrhotic phase of sclerosing cholangitis:	
Generalized weakness, substantial weight loss, and persistent jaundice, or; with one of the following refractory to treatment: ascites, hepatic encephalopathy, hemorrhage from varices or portal gastropathy (erosive gastritis)	100
History of two or more episodes of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis), but with periods of remission between attacks	70
History of one episode of ascites, hepatic encephalopathy, or hemorrhage from varices or portal gastropathy (erosive gastritis)	50
Portal hypertension and splenomegaly, with weakness, anorexia, abdominal pain, malaise, and at least minor weight loss	30
Symptoms such as weakness, anorexia, abdominal pain, and malaise	10

	Rating
NOTE: For evaluation under diagnostic code 7312, documentation of cirrhosis (by biopsy or imaging) and abnormal liver function tests must be present.	
7314 Cholecystitis, chronic:	
Severe; frequent attacks of gall bladder colic	30
Moderate; gall bladder dyspepsia, confirmed by X-ray technique, and with infrequent attacks (not over two or three a year) of gall bladder colic, with or without jaundice	10
Mild	0
7315 Cholelithiasis, chronic.	
Rate as for chronic cholecystitis.	
7316 Cholangitis, chronic.	
Rate as for chronic cholecystitis.	
7317 Gall bladder, injury of.	
Rate as for peritoneal adhesions.	
7318 Gall bladder, removal of:	
With severe symptoms	30
With mild symptoms	10
Nonsymptomatic	0
Spleen, disease or injury of.	
See Hemic and Lymphatic Systems.	
7319 Irritable colon syndrome (spastic colitis, mucous colitis, etc.):	
Severe; diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress	30
Moderate; frequent episodes of bowel disturbance with abdominal distress	10
Mild; disturbances of bowel function with occasional episodes of abdominal distress	0
7321 Amebiasis:	
Mild gastrointestinal disturbances, lower abdominal cramps, nausea, gaseous distention, chronic constipation interrupted by diarrhea	10
Asymptomatic	0
NOTE: Amebiasis with or without liver abscess is parallel in symptomatology with ulcerative colitis and should be rated on the scale provided for the latter. Similarly, lung abscess due to amebiasis will be rated under the respiratory system schedule, diagnostic code 6809.	
7322 Dysentery, bacillary.	
Rate as for ulcerative colitis..	
7323 Colitis, ulcerative:	
Pronounced; resulting in marked malnutrition, anemia, and general debility, or with serious complication as liver abscess	100
Severe; with numerous attacks a year and malnutrition, the health only fair during remissions	60
Moderately severe; with frequent exacerbations	30
Moderate; with infrequent exacerbations	10
7324 Distomiasis, intestinal or hepatic:	
Severe symptoms	30
Moderate symptoms	10
Mild or no symptoms	0
7325 Enteritis, chronic.	
Rate as for irritable colon syndrome.	
7326 Enterocolitis, chronic.	
Rate as for irritable colon syndrome.	
7327 Diverticulitis.	
Rate as for irritable colon syndrome, peritoneal adhesions, or colitis, ulcerative, depending upon the predominant disability picture.	
7328 Intestine, small, resection of:	
With marked interference with absorption and nutrition, manifested by severe impairment of health objectively supported by examination findings including material weight loss	60
With definite interference with absorption and nutrition, manifested by impairment of health objectively supported by examination findings including definite weight loss	40

	Rating
Symptomatic with diarrhea, anemia and inability to gain weight	20
NOTE: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7329 Intestine, large, resection of:	
With severe symptoms, objectively supported by examination findings	40
With moderate symptoms	20
With slight symptoms	10
NOTE: Where residual adhesions constitute the predominant disability, rate under diagnostic code 7301.	
7330 Intestine, fistula of, persistent, or after attempt at operative closure:	
Copious and frequent, fecal discharge	100
Constant or frequent, fecal discharge	60
Slight infrequent, fecal discharge	30
Healed; rate for peritoneal adhesions.	
7331 Peritonitis, tuberculous, active or inactive:	
Active	100
Inactive: See §§ 4.88b and 4.89.	
7332 Rectum and anus, impairment of sphincter control:	
Complete loss of sphincter control	100
Extensive leakage and fairly frequent involuntary bowel movements	60
Occasional involuntary bowel movements, necessitating wearing of pad	30
Constant slight, or occasional moderate leakage	10
Healed or slight, without leakage	0
7333 Rectum and anus, stricture of:	
Requiring colostomy	100
Great reduction of lumen, or extensive leakage	50
Moderate reduction of lumen, or moderate constant leakage	30
7334 Rectum, prolapse of:	
Severe (or complete), persistent	50
Moderate, persistent or frequently recurring	30
Mild with constant slight or occasional moderate leakage	10
7335 Ano, fistula in.	
Rate as for impairment of sphincter control.	
7336 Hemorrhoids, external or internal:	
With persistent bleeding and with secondary anemia, or with fissures	20
Large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences	10
Mild or moderate	0
7337 Pruritus ani.	
Rate for the underlying condition.	
7338 Hernia, inguinal:	
Large, postoperative, recurrent, not well supported under ordinary conditions and not readily reducible, when considered inoperable	60
Small, postoperative recurrent, or unoperated irremediable, not well supported by truss, or not readily reducible	30
Postoperative recurrent, readily reducible and well supported by truss or belt	10
Not operated, but remediable	0
Small, reducible, or without true hernia protrusion	0
NOTE: Add 10 percent for bilateral involvement, provided the second hernia is compensable. This means that the more severely disabling hernia is to be evaluated, and 10 percent, only, added for the second hernia, if the latter is of compensable degree.	
7339 Hernia, ventral, postoperative:	

	Rating
Massive, persistent, severe diastasis of recti muscles or extensive diffuse destruction or weakening of muscular and fascial support of abdominal wall so as to be inoperable	100
Large, not well supported by belt under ordinary conditions	40
Small, not well supported by belt under ordinary conditions, or healed ventral hernia or post-operative wounds with weakening of abdominal wall and indication for a supporting belt	20
Wounds, postoperative, healed, no disability, belt not indicated	0
7340 Hernia, femoral.	
Rate as for inguinal hernia.	
7342 Visceroptosis, symptomatic, marked	10
7343 Malignant neoplasms of the digestive system, exclusive of skin growths	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7344 Benign neoplasms, exclusive of skin growths:	
Evaluate under an appropriate diagnostic code, depending on the predominant disability or the specific residuals after treatment.	
7345 Chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug-induced hepatitis, etc., but excluding bile duct disorders and hepatitis C):	
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)	100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12-month period, but not occurring constantly	60
Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period	40
Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period	20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period	10
Nonsymptomatic	0
NOTE (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See § 4.14.).	
NOTE (2): For purposes of evaluating conditions under diagnostic code 7345, "incapacitating episode" means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.	
NOTE (3): Hepatitis B infection must be confirmed by serologic testing in order to evaluate it under diagnostic code 7345.	
7346 Hernia hiatal:	
Symptoms of pain, vomiting, material weight loss and hematemesis or melena with moderate anemia; or other symptom combinations productive of severe impairment of health	60
Persistently recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health	30
With two or more of the symptoms for the 30 percent evaluation of less severity	10
7347 Pancreatitis:	
With frequently recurrent disabling attacks of abdominal pain with few pain free intermissions and with steatorrhea, malabsorption, diarrhea and severe malnutrition	100
With frequent attacks of abdominal pain, loss of normal body weight and other findings showing continuing pancreatic insufficiency between acute attacks	60
Moderately severe; with at least 4–7 typical attacks of abdominal pain per year with good remission between attacks	30
With at least one recurring attack of typical severe abdominal pain in the past year	10
NOTE 1: Abdominal pain in this condition must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.	
NOTE 2: Following total or partial pancreatectomy, rate under above, symptoms, minimum rating 30 percent.	
7348 Vagotomy with pyloroplasty or gastroenterostomy:	
Followed by demonstrably confirmative postoperative complications of stricture or continuing gastric retention	40
With symptoms and confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea	30
Recurrent ulcer with incomplete vagotomy	20
NOTE: Rate recurrent ulcer following complete vagotomy under diagnostic code 7305, minimum rating 20 percent; and rate dumping syndrome under diagnostic code 7308.	
7351 Liver transplant:	
For an indefinite period from the date of hospital admission for transplant surgery	100
Minimum	30

	Rating
NOTE: A rating of 100 percent shall be assigned as of the date of hospital admission for transplant surgery and shall continue. One year following discharge, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter.	
7354 Hepatitis C (or non-A, non-B hepatitis):	
With serologic evidence of hepatitis C infection and the following signs and symptoms due to hepatitis C infection:	
Near-constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain)	100
Daily fatigue, malaise, and anorexia, with substantial weight loss (or other indication of malnutrition), and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least six weeks during the past 12-month period, but not occurring constantly	60
Daily fatigue, malaise, and anorexia, with minor weight loss and hepatomegaly, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least four weeks, but less than six weeks, during the past 12-month period	40
Daily fatigue, malaise, and anorexia (without weight loss or hepatomegaly), requiring dietary restriction or continuous medication, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least two weeks, but less than four weeks, during the past 12-month period	20
Intermittent fatigue, malaise, and anorexia, or; incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain) having a total duration of at least one week, but less than two weeks, during the past 12-month period	10
Nonsymptomatic	0
NOTE (1): Evaluate sequelae, such as cirrhosis or malignancy of the liver, under an appropriate diagnostic code, but do not use the same signs and symptoms as the basis for evaluation under DC 7354 and under a diagnostic code for sequelae. (See §4.14.).	
NOTE (2): For purposes of evaluating conditions under diagnostic code 7354, "incapacitating episode" means a period of acute signs and symptoms severe enough to require bed rest and treatment by a physician.	

(Authority: 38 U.S.C. 1155)

[29 FR 6718, May 22, 1964, as amended at 34 FR 5063, Mar. 11, 1969; 40 FR 42540, Sept. 15, 1975; 41 FR 11301, Mar. 18, 1976; 66 FR 29488, May 31, 2001]

THE GENITOURINARY SYSTEM

§4.115 Nephritis.

Albuminuria alone is not nephritis, nor will the presence of transient albumin and casts following acute febrile illness be taken as nephritis. The glomerular type of nephritis is usually preceded by or associated with severe infectious disease; the onset is sudden, and the course marked by red blood cells, salt retention, and edema; it may clear up entirely or progress to a chronic condition. The nephrosclerotic type, originating in hypertension or arteriosclerosis, develops slowly, with minimum laboratory findings, and is associated with natural progress. Separate ratings are not to be assigned for disability from disease of the heart and any form of nephritis, on account of the close interrelationships of cardiovascular disabilities. If, however, absence of a kidney is the sole renal disability, even if removal was required because of nephritis, the absent kidney and any hypertension or heart disease will be separately rated. Also, in the event that chronic renal disease has progressed to the point where regular dialysis is required, any coexisting hypertension or heart disease will be separately rated.

[41 FR 34258, Aug. 13, 1976, as amended at 59 FR 2527, Jan. 18, 1994]

§4.115a Ratings of the genitourinary system—dysfunctions.

Diseases of the genitourinary system generally result in disabilities related to renal or voiding dysfunctions, infections, or a combination of these. The following section provides descriptions of various levels of disability in each of these symptom areas. Where diagnostic codes refer the decisionmaker to these specific areas dysfunction, only the predominant area of dysfunction shall be considered for rating purposes. Since the areas of dysfunction described below do not cover all symptoms resulting from genitourinary diseases, specific diagnoses may include a description of symptoms assigned to that diagnosis.

	Rating
Renal dysfunction:	
Requiring regular dialysis, or precluding more than sedentary activity from one of the following: persistent edema and albuminuria; or, BUN more than 80mg%; or, creatinine more than 8mg%; or, markedly decreased function of kidney or other organ systems, estpecially cardiovascular	100
Persistent edema and albuminuria with BUN 40 to 80mg%; or, creatinine 4 to 8mg%; or, generalized poor health characterized by lethargy, weakness, anorexia, weight loss, or limitation of exertion	80
Constant albuminuria with some edema; or, definite decrease in kidney function; or, hypertension at least 40 percent disabling under diagnostic code 7101	60
Albumin constant or recurring with hyaline and granular casts or red blood cells; or, transient or slight edema or hypertension at least 10 percent disabling under diagnostic code 7101	30
Albumin and casts with history of acute nephritis; or, hypertension non-compensable under diagnostic code 7101	0
Voiding dysfunction:	
Rate particular condition as urine leakage, frequency, or obstructed voiding	
Continual Urine Leakage, Post Surgical Urinary Diversion, Urinary Incontinence, or Stress Incontinence:	
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than 4 times per day	60
Requiring the wearing of absorbent materials which must be changed 2 to 4 times per day	40
Requiring the wearing of absorbent materials which must be changed less than 2 times per day	20
Urinary frequency:	
Daytime voiding interval less than one hour, or; awakening to void five or more times per night	40
Daytime voiding interval between one and two hours, or; awakening to void three to four times per night	20
Daytime voiding interval between two and three hours, or; awakening to void two times per night	10
Obstructed voiding:	
Urinary retention requiring intermittent or continuous catheterization	30
Marked obstructive symptomatology (hesitancy, slow or weak stream, decreased force of stream) with any one or combination of the following:	
1. Post void residuals greater than 150 cc.	
2. Uroflowmetry; markedly diminished peak flow rate (less than 10 cc/sec).	
3. Recurrent urinary tract infections secondary to obstruction.	
4. Stricture disease requiring periodic dilatation every 2 to 3 months	10
Obstructive symptomatology with or without stricture disease requiring dilatation 1 to 2 times per year	0
Urninary tract infection:	
Poor renal function: Rate as renal dysfunction.	
Recurrent symptomatic infection requiring drainage/frequent hospitalization (greater than two times/year), and/or requiring continuous intensive management	30
Long-term drug therapy, 1–2 hospitalizations per year and/or requiring intermittent intensive management	10

[59 FR 2527, Jan. 18, 1994; 59 FR 10676, Mar. 7, 1994]

§ 4.115b Ratings of the genitourinary system—diagnoses.

		Rating
	Note: When evaluating any claim involving loss or loss of use of one or more creative organs, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, there are other conditions in this section which under certain circumstances also establish entitlement to special monthly compensation.	
7500	Kidney, removal of one:	
	Minimum evaluation	30
	Or rate as renal dysfunction if there is nephritis, infection, or pathology of the other.	
7501	Kidney, abscess of:	
	Rate as urinary tract infection	....
7502	Nephritis, chronic:	
	Rate as renal dysfunction.	
7504	Pyelonephritis, chronic:	
	Rate as renal dysfunction or urinary tract infection, whichever is predominant.	
7505	Kidney, tuberculosis of:	
	Rate in accordance with §§ 4.88b or 4.89, whichever is appropriate.	
7507	Nephrosclerosis, arteriolar:	
	Rate according to predominant symptoms as renal dysfunction, hypertension or heart disease. If rated under the cardiovascular schedule, however, the percentage rating which would otherwise be assigned will be elevated to the next higher evaluation.	
7508	Nephrolithiasis:	
	Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
	1. diet therapy	
	2. drug therapy	
	3. invasive or non-invasive procedures more than two times/year	30

	Rating
7509 Hydronephrosis:	
Severe; Rate as renal dysfunction.	
Frequent attacks of colic with infection (pyonephrosis), kidney function impaired	30
Frequent attacks of colic, requiring catheter drainage	20
Only an occasional attack of colic, not infected and not requiring catheter drainage	10
7510 Ureterolithiasis:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7511 Ureter, stricture of:	
Rate as hydronephrosis, *except for* recurrent stone formation requiring one or more of the following:	
1. diet therapy	
2. drug therapy	
3. invasive or non-invasive procedures more than two times/year	30
7512 Cystitis, chronic, includes interstitial and all etiologies, infectious and non-infectious:	
Rate as voiding dysfunction.	
7515 Bladder, calculus in, with symptoms interfering with function:	
Rate as voiding dysfunction	
7516 Bladder, fistula of:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
Postoperative, suprapubic cystotomy	100
7517 Bladder, injury of:	
Rate as voiding dysfunction.	
7518 Urethra, stricture of:	
Rate as voiding dysfunction.	
7519 Urethra, fistual of:	
Rate as voiding dysfunction.	
Multiple urethroperineal fistulae	100
7520 Penis, removal of half or more	30
Or rate as voiding dysfunction.	
7521 Penis removal of glans	20
Or rate as voiding dysfunction.	
7522 Penis, deformity, with loss of erectile power—20[1].	
7523 Testis, atrophy complete:.	
Both—20[1]	
One—0[1]	
7524 Testis, removal:.	
Both—30[1]	
One—0[1]	
Note: In cases of the removal of one testis as the result of a service-incurred injury or disease, other than an undescended or congenitally undeveloped testis, with the absence or nonfunctioning of the other testis unrelated to service, an evaluation of 30 percent will be assigned for the service-connected testicular loss. Testis, underscended, or congenitally undeveloped is not a ratable disability.	
7525 Epididymo-orchitis, chronic only:	
Rate as urinary tract infection.	
For tubercular infections: Rate in accordance with §§4.88b or 4.89, whichever is appropriate.	
7527 Prostate gland injuries, infections, hypertrophy, postoperative residuals:	
Rate as voiding dysfunction or urinary tract infection, whichever is predominant.	
7528 Malignant neoplasms of the genitourinary system	100
Note—Following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure, the rating of 100 percent shall continue with a mandatory VA examination at the expiration of six months. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local reoccurrence or metastasis, rate on residuals as voiding dysfunction or renal dysfunction, whichever is predominant.	
7529 Benign neoplasms of the genitourinary system:	
Rate as voiding dysfunction or renal dysfunction, whichever is predominant.	
7530 Chronic renal disease requiring regular dialysis:	
Rate as renal dysfunction.	
7531 Kidney transplant:	
Following transplant surgery	100
Thereafter: Rate on residuals as renal dysfunction, minimum rating	30

	Rating
Note—The 100 percent evaluation shall be assigned as of the date of hospital admission for transplant surgery and shall continue with a mandatory VA examination one year following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.	
7532 Renal tubular disorders (such as renal glycosurias, aminoacidurias, renal tubular acidosis, Fanconi's syndrome, Bartter's syndrome, related disorders of Henle's loop and proximal or distal nephron function, etc.):	
Minimum rating for symptomatic condition	20
Or rate as renal dysfunction.	
7533 Cystic diseases of the kidneys (polycystic disease, uremic medullary cystic disease, Medullary sponge kidney, and similar conditions):	
Rate as renal dysfunction.	
7534 Atherosclerotic renal disease (renal artery stenosis or atheroembolic renal disease):	
Rate as renal dysfunction.	
7535 Toxic nephropathy (antibotics, radiocontrast agents, nonsteroidal anti-inflammatory agents, heavy metals, and similar agents):	
Rate as renal dysfunction.	
7536 Glomerulonephritis:	
Rate as renal dysfunction.	
7537 Interstitial nephritis:	
Rate as renal dysfunction.	
7538 Papillary necrosis:	
Rate as renal dysfunction.	
7539 Renal amyloid disease:	
Rate as renal dysfunction.	
7540 Disseminated intravascular coagulation with renal cortical necrosis:	
Rate as renal dysfunction.	
7541 Renal involvement in diabetes mellitus, sickle cell anemia, systemic lupus erythematosus, vasculitis, or other systemic disease processes.	
Rate as renal dysfunction.	
7542 Neurogenic bladder:	
Rate as voiding dysfunction.	

[1] Review for entitlement to special monthly compensation under § 3.350 of this chapter.

[59 FR 2527, Jan. 18, 1994; 59 FR 14567, Mar. 29, 1994, as amended at 59 FR 46339, Sept. 8, 1994]

Gynecological Conditions and Disorders of the Breast

§ 4.116 Schedule of ratings—gynecological conditions and disorders of the breast.

	Rating
Note 1: Natural menopause, primary amenorrhea, and pregnancy and childbirth are not disabilities for rating purposes. Chronic residuals of medical or surgical complications of pregnancy may be disabilities for rating purposes.	
Note 2: When evaluating any claim involving loss or loss of use of one or more creative organs or anatomical loss of one or both breasts, refer to § 3.350 of this chapter to determine whether the veteran may be entitled to special monthly compensation. Footnotes in the schedule indicate conditions which potentially establish entitlement to special monthly compensation; however, almost any condition in this section might, under certain circumstances, establish entitlement to special monthly compensation.	
7610 Vulva, disease or injury of (including vulvovaginitis).	
7611 Vagina, disease or injury of.	
7612 Cervix, disease or injury of.	
7613 Uterus, disease, injury, or adhesions of.	
7614 Fallopian tube, disease, injury, or adhesions of (including pelvic inflammatory disease (PID)).	
7615 Ovary, disease, injury, or adhesions of.	
General Rating Formula for Disease, Injury, or Adhesions of Female Reproductive Organs (diagnostic codes 7610 through 7615):	
Symptoms not controlled by continuous treatment	30
Symptoms that require continuous treatment	10
Symptoms that do not require continuous treatment	0
7617 Uterus and both ovaries, removal of, complete:	
For three months after removal	[1] 100
Thereafter	[1] 50
7618 Uterus, removal of, including corpus:	
For three months after removal	[1] 100
Thereafter	[1] 30
7619 Ovary, removal of:	
For three months after removal	[1] 100
Thereafter:	
Complete removal of both ovaries	[1] 30
Removal of one with or without partial removal of the other	[1] 0
7620 Ovaries, atrophy of both, complete	[1] 20
7621 Uterus, prolapse:	
Complete, through vagina and introitus	50
Incomplete	30
7622 Uterus, displacement of:	
With marked displacement and frequent or continuous menstrual disturbances	30
With adhesions and irregular menstruation	10
7623 Pregnancy, surgical complications of:	
With rectocele or cystocele	50
With relaxation of perineum	10
7624 Fistula, rectovaginal:	
Vaginal fecal leakage at least once a day requiring wearing of pad	100
Vaginal fecal leakage four or more times per week, but less than daily, requiring wearing of pad	60

	Rating
Vaginal fecal leakage one to three times per week requiring wearing of pad	30
Vaginal fecal leakage less than once a week	10
Without leakage	0
7625 Fistula, urethrovaginal:	
Multiple urethrovaginal fistulae	100
Requiring the use of an appliance or the wearing of absorbent materials which must be changed more than four times per day	60
Requiring the wearing of absorbent materials which must be changed two to four times per day	40
Requiring the wearing of absorbent materials which must be changed less than two times per day	20
7626 Breast, surgery of:	
Following radical mastectomy:	
Both	[1]80
One	[1]50
Following modified radical mastectomy:	
Both	[1]60
One	[1]40
Following simple mastectomy or wide local excision with significant alteration of size or form:	
Both	[1]50
One	[1]30
Following wide local excision without significant alteration of size or form:	
Both or one	0
Note: For VA purposes:	
(1) *Radical mastectomy* means removal of the entire breast, underlying pectoral muscles, and regional lymph nodes up to the coracoclavicular ligament..	
(2) *Modified radical mastectomy* means removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact..	
(3) *Simple (or total) mastectomy* means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact..	
(4) *Wide local excision* (including partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy) means removal of a portion of the breast tissue..	
7627 Malignant neoplasms of gynecological system or breast	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7628 Benign neoplasms of the gynecological system or breast. Rate according to impairment in function of the urinary or gynecological systems, or skin.	
7629 Endometriosis:	
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control	10
Note: Diagnosis of endometriosis must be substantiated by laparoscopy.	

[1] Review for entitlement to special monthly compensation under §3.350 of this chapter.

[60 FR 19855, Apr. 21, 1995, as amended at 67 FR 6874, Feb. 14, 2002; 67 FR 37695, May 30, 2002]

THE HEMIC AND LYMPHATIC SYSTEMS

§4.117 Schedule of ratings—hemic and lymphatic systems.

	Rating
7700 Anemia, hypochromic-microcytic and megaloblastic, such as iron-deficiency and pernicious anemia:	
Hemoglobin 5gm/100ml or less, with findings such as high output congestive heart failure or dyspnea at rest	100
Hemoglobin 7gm/100ml or less, with findings such as dyspnea on mild exertion, cardiomegaly, tachycardia (100 to 120 beats per minute) or syncope (three episodes in the last six months)	70
Hemoglobin 8gm/100ml or less, with findings such as weakness, easy fatigability, headaches, lightheadedness, or shortness of breath	30
Hemoglobin 10gm/100ml or less with findings such as weakness, easy fatigability or headaches	10
Hemoglobin 10gm/100ml or less, asymptomatic	0

NOTE: Evaluate complications of pernicious anemia, such as dementia or peripheral neuropathy, separately.

7702 Agranulocytosis, acute:	
Requiring bone marrow transplant, or; requiring transfusion of platelets or red cells at least once every six weeks, or; infections recurring at least once every six weeks	100

	Rating
Requiring transfusion of platelets or red cells at least once every three months, or; infections recurring at least once every three months	60
Requiring transfusion of platelets or red cells at least once per year but less than once every three months, or; infections recurring at least once per year but less than once every three months	30
Requiring continuous medication for control	10

NOTE: The 100 percent rating for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

	Rating
7703 Leukemia:	
With active disease or during a treatment phase	100
Otherwise rate as anemia (code 7700) or aplastic anemia (code 7716), whichever would result in the greater benefit.	

NOTE: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no recurrence, rate on residuals.

	Rating
7704 Polycythemia vera:	
During periods of treatment with myelosuppressants and for three months following cessation of myelosuppressant therapy	100
Requiring phlebotomy	40
Stable, with or without continuous medication	10

NOTE: Rate complications such as hypertension, gout, stroke or thrombotic disease separately.

	Rating
7705 Thrombocytopenia, primary, idiopathic or immune:	
Platelet count of less than 20,000, with active bleeding, requiring treatment with medication and transfusions	100
Platelet count between 20,000 and 70,000, not requiring treatment, without bleeding	70
Stable platelet count between 70,000 and 100,000, without bleeding	30
Stable platelet count of 100,000 or more, without bleeding	0
7706 Splenectomy	20

NOTE: Rate complications such as systemic infections with encapsulated bacteria separately.

	Rating
7707 Spleen, injury of, healed.	
Rate for any residuals.	
7709 Hodgkin's disease:	
With active disease or during a treatment phase	100

NOTE: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

	Rating
7710 Adenitis, tuberculous, active or inactive.	
Rate under §§ 4.88c or 4.89 of this part, whichever is appropriate.	
7714 Sickle cell anemia:	
With repeated painful crises, occurring in skin, joints, bones or any major organs caused by hemolysis and sickling of red blood cells, with anemia, thrombosis and infarction, with symptoms precluding even light manual labor	100
With painful crises several times a year or with symptoms precluding other than light manual labor	60
Following repeated hemolytic sickling crises with continuing impairment of health	30
Asymptomatic, established case in remission, but with identifiable organ impairment	10

NOTE: Sickle cell trait alone, without a history of directly attributable pathological findings, is not a ratable disability. Cases of symptomatic sickle cell trait will be forwarded to the Director, Compensation and Pension Service, for consideration under § 3.321(b)(1) of this chapter.

	Rating
7715 Non-Hodgkin's lymphoma:	
With active disease or during a treatment phase	100

NOTE: The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after discontinuance of such treatment, the appropriate disability rating shall be dtermined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.

	Rating
7716 Aplastic anemia:	
Requiring bone marrow transplant, or; requiring transfusion of platelets or red cells at least once every six weeks, or; infections recurring at least once every six weeks	100
Requiring transfusion of platelets or red cells at least once every three months, or; infections recurring at least once every three months	60
Requiring transfusion of platelets or red cells at least once per year but less than once every three months, or; infections recurring at least once per year but less than once every three months	30
Requiring continuous medication for control	10

NOTE: The 100 percent rating for bone marrow transplant shall be assigned as of the date of hospital admission and shall continue with a mandatory VA examination six months following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

	Rating
7717 AL amyloidosis (primary amyloidosis)	100

[60 FR 49227, Sept. 22, 1995, as amended at 77 FR 6467, Feb. 8, 2012]

THE SKIN

§ 4.118 Schedule of ratings—skin.

A veteran whose scars were rated by VA under a prior version of diagnostic codes 7800, 7801, 7802, 7803, 7804, or 7805, as in effect before October 23, 2008, may request review under diagnostic codes 7800, 7801, 7802, 7804, and 7805, irrespective of whether his or her disability has worsened since the last review.VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic codes 7800, 7801, 7802, 7804, and 7805. A request for review pursuant to this rulemaking will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before October 23, 2008.

	Rating
7800 Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck:	
With visible or palpable tissue loss and either gross distortion or asymmetry of three or more features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with six or more characteristics of disfigurement	80
With visible or palpable tissue loss and either gross distortion or asymmetry of two features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with four or five characteristics of disfigurement	50
With visible or palpable tissue loss and either gross distortion or asymmetry of one feature or paired set of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with two or three characteristics of disfigurement	30
With one characteristic of disfigurement	10
Note (1): The 8 characteristics of disfigurement, for purposes of evaluation under §4.118, are:	
Scar 5 or more inches (13 or more cm.) in length.	
Scar at least one-quarter inch (0.6 cm.) wide at widest part.	
Surface contour of scar elevated or depressed on palpation.	
Scar adherent to underlying tissue.	
Skin hypo-or hyper-pigmented in an area exceeding six square inches (39 sq. cm.).	
Skin texture abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.).	
Underlying soft tissue missing in an area exceeding six square inches (39 sq. cm.).	
Skin indurated and inflexible in an area exceeding six square inches (39 sq. cm.).	
Note (2): Rate tissue loss of the auricle under DC 6207 (loss of auricle) and anatomical loss of the eye under DC 6061 (anatomical loss of both eyes) or DC 6063 (anatomical loss of one eye), as appropriate.	
Note (3): Take into consideration unretouched color photographs when evaluating under these criteria.	
Note (4): Separately evaluate disabling effects other than disfigurement that are associated with individual scar(s) of the head, face, or neck, such as pain, instability, and residuals of associated muscle or nerve injury, under the appropriate diagnostic code(s) and apply §4.25 to combine the evaluation(s) with the evaluation assigned under this diagnostic code.	
Note (5): The characteristic(s) of disfigurement may be caused by one scar or by multiple scars; the characteristic(s) required to assign a particular evaluation need not be caused by a single scar in order to assign that evaluation.	
7801 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are deep and nonlinear:	
Area or areas of 144 square inches (929 sq. cm.) or greater	40
Area or areas of at least 72 square inches (465 sq. cm.) but less than 144 square inches (929 sq. cm.)	30
Area or areas of at least 12 square inches (77 sq. cm.) but less than 72 square inches (465 sq. cm.)	20
Area or areas of at least 6 square inches (39 sq. cm.) but less than 12 square inches (77 sq. cm.)	10
Note (1): A deep scar is one associated with underlying soft tissue damage.	
Note (2): If multiple qualifying scars are present, or if a single qualifying scar affects more than one extremity, or a single qualifying scar affects one or more extremities and either the anterior portion or posterior portion of the trunk, or both, or a single qualifying scar affects both the anterior portion and the posterior portion of the trunk, assign a separate evaluation for each affected extremity based on the total area of the qualifying scars that affect that extremity, assign a separate evaluation based on the total area of the qualifying scars that affect the anterior portion of the trunk, and assign a separate evaluation based on the total area of the qualifying scars that affect the posterior portion of the trunk. The midaxillary line on each side separates the anterior and posterior portions of the trunk. Combine the separate evaluations under §4.25. Qualifying scars are scars that are nonlinear, deep, and are not located on the head, face, or neck.	
7802 Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are superficial and nonlinear:	
Area or areas of 144 square inches (929 sq. cm.) or greater	10

	Rating
Note (1): A superficial scar is one not associated with underlying soft tissue damage	
Note (2): If multiple qualifying scars are present, or if a single qualifying scar affects more than one extremity, or a single qualifying scar affects one or more extremities and either the anterior portion or posterior portion of the trunk, or both, or a single qualifying scar affects both the anterior portion and the posterior portion of the trunk, assign a separate evaluation for each affected extremity based on the total area of the qualifying scars that affect that extremity, assign a separate evaluation based on the total area of the qualifying scars that affect the anterior portion of the trunk, and assign a separate evaluation based on the total area of the qualifying scars that affect the posterior portion of the trunk. The midaxillary line on each side separates the anterior and posterior portions of the trunk. Combine the separate evaluations under § 4.25. Qualifying scars are scars that are nonlinear, superficial, and are not located on the head, face, or neck.	
7804 Scar(s), unstable or painful:.	
Five or more scars that are unstable or painful	30
Three or four scars that are unstable or painful	20
One or two scars that are unstable or painful	10
Note (1): An unstable scar is one where, for any reason, there is frequent loss of covering of skin over the scar.	
Note (2): If one or more scars are both unstable and painful, add 10 percent to the evaluation that is based on the total number of unstable or painful scars	
Note (3): Scars evaluated under diagnostic codes 7800, 7801, 7802, or 7805 may also receive an evaluation under this diagnostic code, when applicable	
7805 Scars, other (including linear scars) and other effects of scars evaluated under diagnostic codes 7800, 7801, 7802, and 7804:	
Evaluate any disabling effect(s) not considered in a rating provided under diagnostic codes 7800–04 under an appropriate diagnostic code..	
7806 Dermatitis or eczema.	
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period	60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period	10
Less than 5 percent of the entire body or less than 5 percent of exposed areas affected, and; no more than topical therapy required during the past 12-month period	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7807 American (New World) leishmaniasis (mucocutaneous, espundia):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.	
Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).	
7808 Old World leishmaniasis (cutaneous, Oriental sore):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's, 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disabililty.	
Note: Evaluate non-cutaneous (visceral) leishmaniasis under DC 6301 (visceral leishmaniasis).	
7809 Discoid lupus erythematosus or subacute cutaneous lupus erythematosus:	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability. Do not combine with ratings under DC 6350.	
7811 Tuberculosis luposa (lupus vulgaris), active or inactive:	
Rate under §§ 4.88c or 4.89, whichever is appropriate.	
7813 Dermatophytosis (ringworm: of body, tinea corporis; of head, tinea capitis; of feet, tinea pedis; of beard area, tinea barbae; of nails, tinea unguium; of inguinal area (jock itch), tinea cruris):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.	
7815 Bullous disorders (including pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, dermatitis herpetiformis, epidermolysis bullosa acquisita, benign chronic familial pemphigus (Hailey-Hailey), and porphyria cutanea tarda):	
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period	60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30

	Rating
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period	10
Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7816 Psoriasis:	
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period	60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period	10
Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7817 Exfoliative dermatitis (erythroderma):	
Generalized involvement of the skin, plus systemic manifestations (such as fever, weight loss, and hypoproteinemia), and; constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy required during the past 12-month period	100
Generalized involvement of the skin without systemic manifestations, and; constant or near-constant systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy required during the past 12-month period	60
Any extent of involvement of the skin, and; systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30
Any extent of involvement of the skin, and; systemic therapy such as therapeutic doses of corticosteroids, immunosuppressive retinoids, PUVA (psoralen with long-wave ultraviolet-A light) or UVB (ultraviolet-B light) treatments, or electron beam therapy required for a total duration of less than six weeks during the past 12-month period	10
Any extent of involvement of the skin, and; no more than topical therapy required during the past 12-month period	0
7818 Malignant skin neoplasms (other than malignant melanoma):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function.	
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, *i.e.*, systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.	
7819 Benign skin neoplasms:	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or impairment of function.	
7820 Infections of the skin not listed elsewhere (including bacterial, fungal, viral, treponemal and parasitic diseases):	
Rate as disfigurement of the head, face, or neck (DC 7800), scars (DC's 7801, 7802, 7803, 7804, or 7805), or dermatitis (DC 7806), depending upon the predominant disability.	
7821 Cutaneous manifestations of collagen-vascular diseases not listed elsewhere (including scleroderma, calcinosis cutis, and dermatomyositis):	
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, or; constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs required during the past 12-month period	60

	Rating
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period	10
Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7822 Papulosquamous disorders not listed elsewhere (including lichen planus, large or small plaque parapsoriasis, pityriasis lichenoides et varioliformis acuta (PLEVA), lymphomatoid papulosus, and pityriasis rubra pilaris (PRP)):	
More than 40 percent of the entire body or more than 40 percent of exposed areas affected, and; constant or near-constant systemic medications or intensive light therapy required during the past 12-month period	60
20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected, or; systemic therapy or intensive light therapy required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30
At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; systemic therapy or intensive light therapy required for a total duration of less than six weeks during the past 12-month period	10
Less than 5 percent of the entire body or exposed areas affected, and; no more than topical therapy required during the past 12-month period	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7823 Vitiligo:	
With exposed areas affected	10
With no exposed areas affected	0
7824 Diseases of keratinization (including icthyoses, Darier's disease, and palmoplantar keratoderma):	
With either generalized cutaneous involvement or systemic manifestations, and; constant or near-constant systemic medication, such as immunosuppressive retinoids, required during the past 12-month period	60
With either generalized cutaneous involvement or systemic manifestations, and; intermittent systemic medication, such as immunosuppressive retinoids, required for a total duration of six weeks or more, but not constantly, during the past 12-month period	30
With localized or episodic cutaneous involvement and intermittent systemic medication, such as immunosuppressive retinoids, required for a total duration of less than six weeks during the past 12-month period	10
No more than topical therapy required during the past 12-month period	0
7825 Urticaria:	
Recurrent debilitating episodes occurring at least four times during the past 12-month period despite continuous immunosuppressive therapy	60
Recurrent debilitating episodes occurring at least four times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy for control	30
Recurrent episodes occurring at least four times during the past 12-month period, and; responding to treatment with antihistamines or sympathomimetics	10
7826 Vasculitis, primary cutaneous:	
Recurrent debilitating episodes occurring at least four times during the past 12-month period despite continuous immunosuppressive therapy	60
Recurrent debilitating episodes occurring at least four times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy for control	30
Recurrent episodes occurring one to three times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy for control	10
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7827 Erythema multiforme; Toxic epidermal necrolysis:	
Recurrent debilitating episodes occurring at least four times during the past 12-month period despite ongoing immunosuppressive therapy	60
Recurrent episodes occurring at least four times during the past 12-month period, and; requiring intermittent systemic immunosuppressive therapy	30
Recurrent episodes occurring during the past 12-month period that respond to treatment with antihistamines or sympathomimetics, or; one to three episodes occurring during the past 12-month period requiring intermittent systemic immunosuppressive therapy	10
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7828 Acne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck, or; deep acne other than on the face and neck	10
Superficial acne (comedones, papules, pustules, superficial cysts) of any extent	0

	Rating
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7829 Chloracne:	
Deep acne (deep inflamed nodules and pus-filled cysts) affecting 40 percent or more of the face and neck	30
Deep acne (deep inflamed nodules and pus-filled cysts) affecting less than 40 percent of the face and neck, or; deep acne other than on the face and neck	10
Superficial acne (comedones, papules, pustules, superficial cysts) of any extent	0
Or rate as disfigurement of the head, face, or neck (DC 7800) or scars (DC's 7801, 7802, 7803, 7804, or 7805), depending upon the predominant disability.	
7830 Scarring alopecia:	
Affecting more than 40 percent of the scalp	20
Affecting 20 to 40 percent of the scalp	10
Affecting less than 20 percent of the scalp	0
7831 Alopecia areata:	
With loss of all body hair	10
With loss of hair limited to scalp and face	0
7832 Hyperhidrosis:	
Unable to handle paper or tools because of moisture, and unresponsive to therapy	30
Able to handle paper or tools after therapy	0
7833 Malignant melanoma:	
Rate as scars (DC's 7801, 7802, 7803, 7804, or 7805), disfigurement of the head, face, or neck (DC 7800), or impairment of function (under the appropriate body system).	
Note: If a skin malignancy requires therapy that is comparable to that used for systemic malignancies, *i.e.*, systemic chemotherapy, X-ray therapy more extensive than to the skin, or surgery more extensive than wide local excision, a 100-percent evaluation will be assigned from the date of onset of treatment, and will continue, with a mandatory VA examination six months following the completion of such antineoplastic treatment, and any change in evaluation based upon that or any subsequent examination will be subject to the provisions of §3.105(e). If there has been no local recurrence or metastasis, evaluation will then be made on residuals. If treatment is confined to the skin, the provisions for a 100-percent evaluation do not apply.	

(Authority: 38 U.S.C. 1155)

[67 FR 49596, July 31, 2002; 67 FR 58448, 58449, Sept. 16, 2002; 73 FR 54710, Oct. 23, 2008; 77 FR 2910, Jan. 20, 2012]

THE ENDOCRINE SYSTEM

§4.119 Schedule of ratings—endocrine system.

	Rating
7900 Hyperthyroidism	
Thyroid enlargement, tachycardia (more than 100 beats per minute), eye involvement, muscular weakness, loss of weight, and sympathetic nervous system, cardiovascular, or astrointestinal symptoms	100
Emotional instability, tachycardia, fatigability, and increased pulse pressure or blood pressure	60
Tachycardia, tremor, and increased pulse pressure or blood pressure	30
Tachycardia, which may be intermittent, and tremor, or; continuous medication required for control	10
NOTE (1): If disease of the heart is the predominant finding, evaluate as hyperthyroid heart disease (DC 7008) if doing so would result in a higher evaluation than using the criteria above.	
NOTE (2): If ophthalmopathy is the sole finding, evaluate as field vision, impairment of (DC 6080); diplopia (DC 6090); or impairment of central visual acuity (DC 6061–6079).	
7901 Thyroid gland, toxic adenoma of	
Thyroid enlargement, tachycardia (more than 100 beats per minute), eye involvement, muscular weakness, loss of weight, and sympathetic nervous system, cardiovascular, or gastrointestinal symptoms	100
Emotional instability, tachycardia, fatigability, and increased pulse pressure or blood pressure	60
Tachycardia, tremor, and increased pulse pressure or blood pressure	30
Tachycardia, which may be intermittent, and tremor, or; continuous medication required for control	10
NOTE (1): If disease of the heart is the predominant finding, evaluate as hyperthyroid heart disease (DC 7008) if doing so would result in a higher evaluation than using the criteria above.	
NOTE (2): If ophthalmopathy is the sole finding, evaluate as field vision, impairment of (DC 6080); diplopia (DC 6090); or impairment of central visual acuity (DC 6061–6079).	
7902 Thyroid gland, nontoxic adenoma of	
With disfigurement of the head or neck	20
Without disfigurement of the head or neck	0
NOTE: If there are symptoms due to pressure on adjacent organs such as the trachea, larynx, or esophagus, evaluate under the diagnostic code for disability of that organ, if doing so would result in a higher evaluation than using this diagnostic code.	
7903 Hypothyroidism	
Cold intolerance, muscular weakness, cardiovascular involvement, mental disturbance (dementia, slowing of thought, depression), bradycardia (less than 60 beats per minute), and sleepiness	100
Muscular weakness, mental disturbance, and weight gain	60
Fatigability, constipation, and mental sluggishness	30
Fatigability, or; continuous medication required for control	10
7904 Hyperparathyroidism	
Generalized decalcification of bones, kidney stones, gastrointestinal symptoms (nausea, vomiting, anorexia, constipation, weight loss, or peptic ulcer), and weakness	100
Gastrointestinal symptoms and weakness	60
Continuous medication required for control	10
NOTE: Following surgery or treatment, evaluate as digestive, skeletal, renal, or cardiovascular residuals or as endocrine dysfunction.	
7905 Hypoparathyroidism	

	Rating
Marked neuromuscular excitability (such as convulsions, muscular spasms (tetany), or laryngeal stridor) plus either cataract or evidence of increased intracranial pressure (such as papilledema)	100
Marked neuromuscular excitability, or; paresthesias (of arms, legs, or circumoral area) plus either cataract or evidence of increased intracranial pressure	60
Continuous medication required for control	10
7907 Cushing's syndrome	
As active, progressive disease including loss of muscle strength, areas of osteoporosis, hypertension, weakness, and enlargement of pituitary or adrenal gland	100
Loss of muscle strength and enlargement of pituitary or adrenal gland	60
With striae, obesity, moon face, glucose intolerance, and vascular fragility	30
NOTE: With recovery or control, evaluate as residuals of adrenal insufficiency or cardiovascular, psychiatric, skin, or skeletal complications under appropriate diagnostic code.	
7908 Acromegaly	
Evidence of increased intracranial pressure (such as visual field defect), arthropathy, glucose intolerance, and either hypertension or cardiomegaly	100
Arthropathy, glucose intolerance, and hypertension	60
Enlargement of acral parts or overgrowth of long bones, and enlarged sella turcica	30
7909 Diabetes insipidus	
Polyuria with near-continuous thirst, and more than two documented episodes of dehydration requiring parenteral hydration in the past year	100
Polyuria with near-continuous thirst, and one or two documented episodes of dehydration requiring parenteral hydration in the past year	60
Polyuria with near-continuous thirst, and one or more episodes of dehydration in the past year not requiring parenteral hydration	40
Polyuria with near-continuous thirst	20
7911 Addison's disease (Adrenal Cortical Hypofunction)	
Four or more crises during the past year	60
Three crises during the past year, or; five or more episodes during the past year	40
One or two crises during the past year, or; two to four episodes during the past year, or; weakness and fatigability, or; corticosteroid therapy required for control	20
NOTE (1): An Addisonian "crisis" consists of the rapid onset of peripheral vascular collapse (with acute hypotension and shock), with findings that may include: anorexia; nausea; vomiting; dehydration; profound weakness; pain in abdomen, legs, and back; fever; apathy, and depressed mentation with possible progression to coma, renal shutdown, and death.	
NOTE (2): An Addisonian "episode," for VA purposes, is a less acute and less severe event than an Addisonian crisis and may consist of anorexia, nausea, vomiting, diarrhea, dehydration, weakness, malaise, orthostatic hypotension, or hypoglycemia, but no peripheral vascular collapse.	
NOTE (3): Tuberculous Addison's disease will be evaluated as active or inactive tuberculosis. If inactive, these evaluations are not to be combined with the graduated ratings of 50 percent or 30 percent for non-pulmonary tuberculosis specified under § 4.88b. Assign the higher rating.	
7912 Pluriglandular syndrome	
Evaluate according to major manifestations.	
7913 Diabetes mellitus	
Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated	100
Requiring insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated	60
Requiring insulin, restricted diet, and regulation of activities	40
Requiring insulin and restricted diet, or; oral hypoglycemic agent and restricted diet	20
Manageable by restricted diet only	10
NOTE (1): Evaluate compensable complications of diabetes separately unless they are part of the criteria used to support a 100 percent evaluation. Noncompensable complications are considered part of the diabetic process under diagnostic code 7913.	
NOTE (2): When diabetes mellitus has been conclusively diagnosed, do not request a glucose tolerance test solely for rating purposes.	
7914 Neoplasm, malignant, any specified part of the endocrine system	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7915 Neoplasm, benign, any specified part of the endocrine system rate as residuals of endocrine dysfunction.	

	Rating
7916 Hyperpituitarism (prolactin secreting pituitary dysfunction)	
7917 Hyperaldosteronism (benign or malignant)	
7918 Pheochromocytoma (benign or malignant)	
NOTE: Evaluate diagnostic codes 7916, 7917, and 7918 as malignant or benign neoplasm as appropriate.	
7919 C-cell hyperplasia of the thyroid	100
NOTE: A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	

[61 FR 20446, May 7, 1996]

NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS

§ 4.120 Evaluations by comparison.

Disability in this field is ordinarily to be rated in proportion to the impairment of motor, sensory or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, injury to the skull, etc. In rating disability from the conditions in the preceding sentence refer to the appropriate schedule. In rating peripheral nerve injuries and their residuals, attention should be given to the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances.

§ 4.121 Identification of epilepsy.

When there is doubt as to the true nature of epileptiform attacks, neurological observation in a hospital adequate to make such a study is necessary. To warrant a rating for epilepsy, the seizures must be witnessed or verified at some time by a physician. As to frequency, competent, consistent lay testimony emphasizing convulsive and immediate post-convulsive characteristics may be accepted. The frequency of seizures should be ascertained under the ordinary conditions of life (while not hospitalized).

§ 4.122 Psychomotor epilepsy.

The term psychomotor epilepsy refers to a condition that is characterized by seizures and not uncommonly by a chronic psychiatric disturbance as well.

(a) Psychomotor seizures consist of episodic alterations in conscious control that may be associated with automatic states, generalized convulsions, random motor movements (chewing, lip smacking, fumbling), hallucinatory phenomena (involving taste, smell, sound, vision), perceptual illusions (deja vu, feelings of loneliness, strangeness, macropsia, micropsia, dreamy states), alterations in thinking (not open to reason), alterations in memory, abnormalities of mood or affect (fear, alarm, terror, anger, dread, well-being), and autonomic disturbances (sweating, pallor, flushing of the face, visceral phenomena such as nausea, vomiting, defecation, a rising feeling of warmth in the abdomen). Automatic states or automatisms are characterized by episodes of irrational, irrelevant, disjointed, unconventional, asocial, purposeless though seemingly coordinated and purposeful, confused or inappropriate activity of one to several minutes (or, infrequently, hours) duration with subsequent amnesia for the seizure. Examples: A person of high social standing remained seated, muttered angrily, and rubbed the arms of his chair while the National Anthem was being played; an apparently normal person suddenly disrobed in public; a man traded an expensive automobile for an antiquated automobile in poor mechanical condition and after regaining conscious control, discovered that he had signed an agreement to pay an additional sum of money in the trade. The seizure manifestations of psychomotor epilepsy vary from patient to patient and in the same patient from seizure to seizure.

(b) A chronic mental disorder is not uncommon as an interseizure manifestation of psychomotor epilepsy and may include psychiatric disturbances extending from minimal anxiety to severe personality disorder (as distinguished from developmental) or almost complete personality disintegration (psychosis). The manifestations of a chronic mental disorder associated with psychomotor epilepsy, like those of the seizures, are protean in character.

§ 4.123 Neuritis, cranial or peripheral.

Neuritis, cranial or peripheral, characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. See nerve involved for diagnostic code number and rating. The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate, or with sciatic nerve involvement, for moderately severe, incomplete paralysis.

§ 4.124 Neuralgia, cranial or peripheral.

Neuralgia, cranial or peripheral, characterized usually by a dull and intermittent pain, of typical distribution so as to identify the nerve, is to be rated on the same scale, with a maximum equal to moderate incomplete paralysis. See nerve involved for diagnostic code number and rating. Tic douloureux, or trifacial neuralgia, may be rated up to complete paralysis of the affected nerve.

§ 4.124a Schedule of ratings—neurological conditions and convulsive disorders.

[With the exceptions noted, disability from the following diseases and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves]

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM

	Rating
8000 Encephalitis, epidemic, chronic:	
As active febrile disease	100
Rate residuals, minimum	10
Brain, new growth of:	
8002 Malignant	100
NOTE: The rating in code 8002 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8003 Benign, minimum	60
Rate residuals, minimum	10
8004 Paralysis agitans:	
Minimum rating	30
8005 Bulbar palsy	100
8007 Brain, vessels, embolism of.	
8008 Brain, vessels, thrombosis of.	
8009 Brain, vessels, hemorrhage from:	
Rate the vascular conditions under Codes 8007 through 8009, for 6 months	100
Rate residuals, thereafter, minimum	10
8010 Myelitis:	
Minimum rating	10
8011 Poliomyelitis, anterior:	
As active febrile disease	100
Rate residuals, minimum	10
8012 Hematomyelia:	
For 6 months	100
Rate residuals, minimum	10
8013 Syphilis, cerebrospinal.	
8014 Syphilis, meningovascular.	
8015 Tabes dorsalis.	
NOTE: Rate upon the severity of convulsions, paralysis, visual impairment or psychotic involvement, etc.	
8017 Amyotrophic lateral sclerosis	100
NOTE: Consider the need for special monthly compensation.	
8018 Multiple sclerosis:	
Minimum rating	30
8019 Meningitis, cerebrospinal, epidemic:	
As active febrile disease	100
Rate residuals, minimum	10
8020 Brain, abscess of:	
As active disease	100
Rate residuals, minimum	10
Spinal cord, new growths of:.	
8021 Malignant	100
NOTE: The rating in code 8021 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.	
Minimum rating	30
8022 Benign, minimum rating	60
Rate residuals, minimum	10
8023 Progressive muscular atrophy:	
Minimum rating	30
8024 Syringomyelia:	
Minimum rating	30
8025 Myasthenia gravis:	
Minimum rating	30

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
NOTE: It is required for the minimum ratings for residuals under diagnostic codes 8000–8025, that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, *i.e.*, headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease. It is of exceptional importance that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses.	
8045 Residuals of traumatic brain injury (TBI):	
There are three main areas of dysfunction that may result from TBI and have profound effects on functioning: cognitive (which is common in varying degrees after TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation..	
Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Evaluate cognitive impairment under the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''.	
Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.'' However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table.	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Evaluate emotional/behavioral dysfunction under §4.130 (Schedule of ratings—mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified.''.	
Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: Motor and sensory dysfunction, including pain, of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions..	
The preceding list of types of physical dysfunction does not encompass all possible residuals of TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under §4.25 the evaluations for each separately rated condition. The evaluation assigned based on the ''Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified'' table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.	
Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc.	

ORGANIC DISEASES OF THE CENTRAL NERVOUS SYSTEM—Continued

	Rating
Evaluation of Cognitive Impairment and Subjective Symptoms	
The table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" contains 10 important facets of TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, labeled "total." However, not every facet has every level of severity. The Consciousness facet, for example, does not provide for an impairment level other than "total," since any level of impaired consciousness would be totally disabling. Assign a 100-percent evaluation if "total" is the level of evaluation for one or more facets. If no facet is evaluated as "total," assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet..	
Note (1): There may be an overlap of manifestations of conditions evaluated under the table titled "Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified" with manifestations of a comorbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition..	
Note (2): Symptoms listed as examples at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation..	
Note (3): "Instrumental activities of daily living" refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from "Activities of daily living," which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet..	
Note (4): The terms "mild," "moderate," and "severe" TBI, which may appear in medical records, refer to a classification of TBI made at, or close to, the time of injury rather than to the current level of functioning. This classification does not affect the rating assigned under diagnostic code 8045..	
Note (5): A veteran whose residuals of TBI are rated under a version of § 4.124a, diagnostic code 8045, in effect before October 23, 2008 may request review under diagnostic code 8045, irrespective of whether his or her disability has worsened since the last review. VA will review that veteran's disability rating to determine whether the veteran may be entitled to a higher disability rating under diagnostic code 8045. A request for review pursuant to this note will be treated as a claim for an increased rating for purposes of determining the effective date of an increased rating awarded as a result of such review; however, in no case will the award be effective before October 23, 2008. For the purposes of determining the effective date of an increased rating awarded as a result of such review, VA will apply 38 CFR 3.114, if applicable..	
8046 Cerebral arteriosclerosis:	
Purely neurological disabilities, such as hemiplegia, cranial nerve paralysis, etc., due to cerebral arteriosclerosis will be rated under the diagnostic codes dealing with such specific disabilities, with citation of a hyphenated diagnostic code (e.g., 8046–8207).	
Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated 10 percent and no more under diagnostic code 9305. This 10 percent rating will not be combined with any other rating for a disability due to cerebral or generalized arteriosclerosis. Ratings in excess of 10 percent for cerebral arteriosclerosis under diagnostic code 9305 are not assignable in the absence of a diagnosis of multi-infarct dementia with cerebral arteriosclerosis.	
NOTE: The ratings under code 8046 apply only when the diagnosis of cerebral arteriosclerosis is substantiated by the entire clinical picture and not solely on findings of retinal arteriosclerosis.	

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Memory, attention, concentration, executive functions.	0	No complaints of impairment of memory, attention, concentration, or executive functions.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
	1	A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing.
	2	Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment.
	3	Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment.
	Total	Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.
Judgment	0	Normal.
	1	Mildly impaired judgment. For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	2	Moderately impaired judgment. For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions.
	3	Moderately severely impaired judgment. For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision.
	Total	Severely impaired judgment. For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.
Social interaction	0	Social interaction is routinely appropriate.
	1	Social interaction is occasionally inappropriate.
	2	Social interaction is frequently inappropriate.
	3	Social interaction is inappropriate most or all of the time.
Orientation	0	Always oriented to person, time, place, and situation.
	1	Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation.
	2	Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation.
	3	Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation.
	Total	Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Motor activity (with intact motor and sensory system).	0	Motor activity normal.
	1	Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function).
	2	Motor activity mildly decreased or with moderate slowing due to apraxia.
	3	Motor activity moderately decreased due to apraxia.
	Total	Motor activity severely decreased due to apraxia.
Visual spatial orientation	0	Normal.
	1	Mildly impaired. Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system).
	2	Moderately impaired. Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS (global positioning system).
	3	Moderately severely impaired. Gets lost even in familiar surroundings, unable to use assistive devices such as GPS (global positioning system).
	Total	Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.
Subjective symptoms	0	Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety.
	1	Three or more subjective symptoms that mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light.
	2	Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.

EVALUATION OF COGNITIVE IMPAIRMENT AND OTHER RESIDUALS OF TBI NOT OTHERWISE CLASSIFIED—Continued

Facets of cognitive impairment and other residuals of TBI not otherwise classified	Level of impairment	Criteria
Neurobehavioral effects ..	0	One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects.
	1	One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them.
	2	One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them.
	3	One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.
Communication	0	Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language.
	1	Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas.
	2	Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas.
	3	Inability to communicate either by spoken language, written language, or both, at least half of the time but not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs.
	Total	Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.
Consciousness	Total	Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma.

MISCELLANEOUS DISEASES

	Rating
8100 Migraine:	
With very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability	50

MISCELLANEOUS DISEASES—Continued

	Rating
With characteristic prostrating attacks occurring on an average once a month over last several months	30
With characteristic prostrating attacks averaging one in 2 months over last several months	10
With less frequent attacks	0
8103 Tic, convulsive:	
Severe	30
Moderate	10
Mild	0
NOTE: Depending upon frequency, severity, muscle groups involved.	
8104 Paramyoclonus multiplex (convulsive state, myoclonic type):	
Rate as tic; convulsive; severe cases	60
8105 Chorea, Sydenham's:	
Pronounced, progressive grave types	100
Severe	80
Moderately severe	50
Moderate	30
Mild	10
NOTE: Consider rheumatic etiology and complications.	
8106 Chorea, Huntington's.	
Rate as Sydenham's chorea. This, though a familial disease, has its onset in late adult life, and is considered a ratable disability.	
8107 Athetosis, acquired.	
Rate as chorea.	
8108 Narcolepsy.	
Rate as for epilepsy, petit mal.	

DISEASES OF THE CRANIAL NERVES

	Rating
Disability from lesions of peripheral portions of first, second, third, fourth, sixth, and eighth nerves will be rated under the Organs of Special Sense. The ratings for the cranial nerves are for unilateral involvement; when bilateral, combine but without the bilateral factor.	
Fifth (trigeminal) cranial nerve	
8205 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE: Dependent upon relative degree of sensory manifestation or motor loss.	
8305 Neuritis.	
8405 Neuralgia.	
NOTE: Tic douloureux may be rated in accordance with severity, up to complete paralysis.	
Seventh (facial) cranial nerve	
8207 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon relative loss of innervation of facial muscles.	
8307 Neuritis.	
8407 Neuralgia.	
Ninth (glossopharyngeal) cranial nerve.	
8209 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10

DISEASES OF THE CRANIAL NERVES—Continued

	Rating
NOTE: Dependent upon relative loss of ordinary sensation in mucous membrane of the pharynx, fauces, and tonsils.	
8309 Neuritis.	
8409 Neuralgia.	
Tenth (pneumogastric, vagus) cranial nerve.	
8210 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE : Dependent upon extent of sensory and motor loss to organs of voice, respiration, pharynx, stomach and heart.	
8310 Neuritis.	
8410 Neuralgia.	
Eleventh (spinal accessory, external branch) cranial nerve.	
8211 Paralysis of:	
Complete	30
Incomplete, severe	20
Incomplete, moderate	10
NOTE: Dependent upon loss of motor function of sternomastoid and trapezius muscles.	
8311 Neuritis.	
8411 Neuralgia.	
Twelfth (hypoglossal) cranial nerve.	
8212 Paralysis of:	
Complete	50
Incomplete, severe	30
Incomplete, moderate	10
NOTE: Dependent upon loss of motor function of tongue.	
8312 Neuritis.	
8412 Neuralgia.	

DISEASES OF THE PERIPHERAL NERVES

Schedule of ratings	Rating	
	Major	Minor
The term "incomplete paralysis," with this and other peripheral nerve injuries, indicates a degree of lost or impaired function substantially less than the type picture for complete paralysis given with each nerve, whether due to varied level of the nerve lesion or to partial regeneration. When the involvement is wholly sensory, the rating should be for the mild, or at most, the moderate degree. The ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the bilateral factor.		
Upper radicular group (fifth and sixth cervicals)		
8510 Paralysis of:		
Complete; all shoulder and elbow movements lost or severely affected, hand and wrist movements not affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
8610 Neuritis.		
8710 Neuralgia.		
Middle radicular group		
8511 Paralysis of:		
Complete; adduction, abduction and rotation of arm, flexion of elbow, and extension of wrist lost or severely affected	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8611 Neuritis.		
8711 Neuralgia.		
Lower radicular group		
8512 Paralysis of:		
Complete; all intrinsic muscles of hand, and some or all of flexors of wrist and fingers, paralyzed (substantial loss of use of hand)	70	60
Incomplete:		
Severe	50	40
Moderate	40	30
Mild	20	20
8612 Neuritis.		
8712 Neuralgia.		
All radicular groups		
8513 Paralysis of:		
Complete	90	80
Incomplete:		
Severe	70	60
Moderate	40	30
Mild	20	20
8613 Neuritis.		
8713 Neuralgia.		
The musculospiral nerve (radial nerve)		
8514 Paralysis of:		
Complete; drop of hand and fingers, wrist and fingers perpetually flexed, the thumb adducted falling within the line of the outer border of the index finger; can not extend hand at wrist, extend proximal phalanges of fingers, extend thumb, or make lateral movement of wrist; supination of hand, extension and flexion of elbow weakened, the loss of synergic motion of extensors impairs the hand grip seriously; total paralysis of the triceps occurs only as the greatest rarity	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	20	20

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
8614 Neuritis.		
8714 Neuralgia.		

NOTE: Lesions involving only "dissociation of extensor communis digitorum" and "paralysis below the extensor communis digitorum," will not exceed the moderate rating under code 8514.

Schedule of ratings	Major	Minor
The median nerve		
8515 Paralysis of:		
Complete; the hand inclined to the ulnar side, the index and middle fingers more extended than normally, considerable atrophy of the muscles of the thenar eminence, the thumb in the plane of the hand (ape hand); pronation incomplete and defective, absence of flexion of index finger and feeble flexion of middle finger, cannot make a fist, index and middle fingers remain extended; cannot flex distal phalanx of thumb, defective opposition and abduction of the thumb, at right angles to palm; flexion of wrist weakened; pain with trophic disturbances	70	60
Incomplete:		
Severe	50	40
Moderate	30	20
Mild	10	10
8615 Neuritis.		
8715 Neuralgia.		
The ulnar nerve		
8516 Paralysis of:		
Complete; the "griffin claw" deformity, due to flexor contraction of ring and little fingers, atrophy very marked in dorsal interspace and thenar and hypothenar eminences; loss of extension of ring and little fingers cannot spread the fingers (or reverse), cannot adduct the thumb; flexion of wrist weakened	60	50
Incomplete:		
Severe	40	30
Moderate	30	20
Mild	10	10
8616 Neuritis.		
8716 Neuralgia.		
Musculocutaneous nerve		
8517 Paralysis of:		
Complete; weakness but not loss of flexion of elbow and supination of forearm	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0
8617 Neuritis.		
8717 Neuralgia.		
Circumflex nerve		
8518 Paralysis of:		
Complete; abduction of arm is impossible, outward rotation is weakened; muscles supplied are deltoid and teres minor	50	40
Incomplete:		
Severe	30	20
Moderate	10	10

DISEASES OF THE PERIPHERAL NERVES—Continued

Schedule of ratings	Rating	
	Major	Minor
Mild	0	0
8618 Neuritis.		
8718 Neuralgia.		
Long thoracic nerve		
8519 Paralysis of:		
Complete; inability to raise arm above shoulder level, winged scapula deformity	30	20
Incomplete:		
Severe	20	20
Moderate	10	10
Mild	0	0

NOTE: Not to be combined with lost motion above shoulder level.

8619 Neuritis.		
8719 Neuralgia.		

NOTE: Combined nerve injuries should be rated by reference to the major involvement, or if sufficient in extent, consider radicular group ratings.

	Rating
Sciatic nerve	
8520 Paralysis of:	
Complete; the foot dangles and drops, no active movement possible of muscles below the knee, flexion of knee weakened or (very rarely) lost	80
Incomplete:	
Severe, with marked muscular atrophy	60
Moderately severe	40
Moderate	20
Mild	10
8620 Neuritis.	
8720 Neuralgia.	
External popliteal nerve (common peroneal)	
8521 Paralysis of:	
Complete; foot drop and slight droop of first phalanges of all toes, cannot dorsiflex the foot, extension (dorsal flexion) of proximal phalanges of toes lost; abduction of foot lost, adduction weakened; anesthesia covers entire dorsum of foot and toes	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8621 Neuritis.	
8721 Neuralgia.	
Musculocutaneous nerve (superficial peroneal)	
8522 Paralysis of:	
Complete; eversion of foot weakened	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8622 Neuritis.	
8722 Neuralgia.	
Anterior tibial nerve (deep peroneal)	
8523 Paralysis of:	
Complete; dorsal flexion of foot lost	30
Incomplete:	
Severe	20
Moderate	10
Mild	0
8623 Neuritis.	
8723 Neuralgia.	
Internal popliteal nerve (tibial)	
8524 Paralysis of:	
Complete; plantar flexion lost, frank adduction of foot impossible, flexion and separation of toes abolished; no muscle in sole can move; in lesions of the nerve high in popliteal fossa, plantar flexion of foot is lost	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8624 Neuritis.	
8724 Neuralgia.	
Posterior tibial nerve	
8525 Paralysis of:	
Complete; paralysis of all muscles of sole of foot, frequently with painful paralysis of a causalgic nature; toes cannot be flexed; adduction is weakened; plantar flexion is impaired	30
Incomplete:	
Severe	20
Moderate	10
Mild	10
8625 Neuritis.	
8725 Neuralgia.	
Anterior crural nerve (femoral)	
8526 Paralysis of:	
Complete; paralysis of quadriceps extensor muscles	40
Incomplete:	
Severe	30
Moderate	20
Mild	10
8626 Neuritis.	
8726 Neuralgia.	
Internal saphenous nerve	
8527 Paralysis of:	
Severe to complete	10
Mild to moderate	0
8627 Neuritis.	
8727 Neuralgia.	
Obturator nerve	
8528 Paralysis of:	
Severe to complete	10
Mild or moderate	0

	Rating
8628 Neuritis.	
8728 Neuralgia.	
External cutaneous nerve of thigh	
8529 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8629 Neuritis.	
8729 Neuralgia.	
Ilio-inguinal nerve	
8530 Paralysis of:	
Severe to complete	10
Mild or moderate	0
8630 Neuritis.	
8730 Neuralgia.	
8540 Soft-tissue sarcoma (of neurogenic origin)	100

NOTE: The 100 percent rating will be continued for 6 months following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.

THE EPILEPSIES

	Rating
A thorough study of all material in §§ 4.121 and 4.122 of the preface and under the ratings for epilepsy is necessary prior to any rating action.	
8910 Epilepsy, grand mal.	
Rate under the general rating formula for major seizures.	
8911 Epilepsy, petit mal.	
Rate under the general rating formula for minor seizures.	
NOTE (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.	
NOTE (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head (“pure” petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type).	
General Rating Formula for Major and Minor Epileptic Seizures:	
Averaging at least 1 major seizure per month over the last year	100
Averaging at least 1 major seizure in 3 months over the last year; or more than 10 minor seizures weekly	80
Averaging at least 1 major seizure in 4 months over the last year; or 9–10 minor seizures per week	60
At least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least 5 to 8 minor seizures weekly	40
At least 1 major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months	20
A confirmed diagnosis of epilepsy with a history of seizures	10

THE EPILEPSIES—Continued

	Rating
NOTE (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.	
NOTE (2): In the presence of major and minor seizures, rate the predominating type.	
NOTE (3): There will be no distinction between diurnal and nocturnal major seizures.	
8912 Epilepsy, Jacksonian and focal motor or sensory.	
8913 Epilepsy, diencephalic.	
Rate as minor seizures, except in the presence of major and minor seizures, rate the predominating type.	
8914 Epilepsy, psychomotor.	
Major seizures:	
Psychomotor seizures will be rated as major seizures under the general rating formula when characterized by automatic states and/or generalized convulsions with unconsciousness.	
Minor seizures:	
Psychomotor seizures will be rated as minor seizures under the general rating formula when characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood, or autonomic disturbances.	

Mental Disorders in Epilepsies: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9326). In the absence of a diagnosis of non-psychotic organic psychiatric disturbance (psychotic, psychoneurotic or personality disorder) if diagnosed and shown to be secondary to or directly associated with epilepsy will be rated separately. The psychotic or psychroneurotic disorder will be rated under the appropriate diagnostic code. The personality disorder will be rated as a dementia (e.g., diagnostic code 9304 or 9326).

Epilepsy and Unemployability: (1) Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.

(2) Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.

(3) The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:

(a) Education;
(b) Occupations prior and subsequent to service;
(c) Places of employment and reasons for termination;
(d) Wages received;
(e) Number of seizures.

(4) Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran's unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Director, Compensation and Pension Service.

(Authority: 38 U.S.C. 1155)

[29 FR 6718, May 22, 1964, as amended at 40 FR 42540, Sept. 15, 1975; 41 FR 11302, Mar. 18, 1976; 43 FR 45362, Oct. 2, 1978; 54 FR 4282, Jan. 30, 1989; 54 FR 49755, Dec. 1, 1989; 55 FR 154, Jan. 3, 1990; 56 FR 51653, Oct. 15, 1991; 57 FR 24364, June 9, 1992; 70 FR 75399, Dec. 20, 2005; 73 FR 54705, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 76 FR 78824, Dec. 20, 2011]

MENTAL DISORDERS

§ 4.125 Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM-IV or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner to substantiate the diagnosis.

(b) If the diagnosis of a mental disorder is changed, the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§ 4.126 Evaluation of disability from mental disorders.

(a) When evaluating a mental disorder, the rating agency shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during periods of remission. The rating agency shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner's assessment of the level of disability at the moment of the examination.

(b) When evaluating the level of disability from a mental disorder, the rating agency will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment.

(c) Delirium, dementia, and amnestic and other cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnestic or other cognitive disorder (see § 4.25).

(d) When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating agency shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition (see § 4.14).

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§ 4.127 Mental retardation and personality disorders.

Mental retardation and personality disorders are not diseases or injuries for compensation purposes, and, except as provided in § 3.310(a) of this chapter, disability resulting from them may not be service-connected. However, disability resulting from a mental disorder that is superimposed upon mental retardation or a personality disorder may be service-connected.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§ 4.128 Convalescence ratings following extended hospitalization.

If a mental disorder has been assigned a total evaluation due to a continuous period of hospitalization lasting six months or more, the rating agency shall continue the total evaluation indefinitely and schedule a mandatory examination six months after the veteran is discharged or released to nonbed care. A change in evaluation based on that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§ 4.129 Mental disorders due to traumatic stress.

When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996]

§4.130 Schedule of ratings—mental disorders.

The nomenclature employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM-IV). Rating agencies must be thoroughly familiar with this manual to properly implement the directives in §4.125 through §4.129 and to apply the general rating formula for mental disorders in §4.130. The schedule for rating for mental disorders is set forth as follows:

	Rating
Schizophrenia and Other Psychotic Disorders	
9201 Schizophrenia, disorganized type	
9202 Schizophrenia, catatonic type	
9203 Schizophrenia, paranoid type	
9204 Schizophrenia, undifferentiated type	
9205 Schizophrenia, residual type; other and unspecified types	
9208 Delusional disorder	
9210 Psychotic disorder, not otherwise specified (atypical psychosis)	
9211 Schizoaffective disorder	
Delirium, Dementia, and Amnestic and Other Cognitive Disorders	
9300 Delirium	
9301 Dementia due to infection (HIV infection, syphilis, or other systemic or intracranial infections)	
9304 Dementia due to head trauma	
9305 Vascular dementia	
9310 Dementia of unknown etiology	
9312 Dementia of the Alzheimer's type	
9326 Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or that are substance-induced (drugs, alcohol, poisons)	
9327 Organic mental disorder, other (including personality change due to a general medical condition)	
Anxiety Disorders	
9400 Generalized anxiety disorder	
9403 Specific (simple) phobia; social phobia	
9404 Obsessive compulsive disorder	
9410 Other and unspecified neurosis	
9411 Posttraumatic stress disorder	
9412 Panic disorder and/or agoraphobia	
9413 Anxiety disorder, not otherwise specified	
Dissociative Disorders	
9416 Dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder)	
9417 Depersonalization disorder	
Somatoform Disorders	
9421 Somatization disorder	
9422 Pain disorder	
9423 Undifferentiated somatoform disorder	
9424 Conversion disorder	
9425 Hypochondriasis	
Mood Disorders	
9431 Cyclothymic disorder	
9432 Bipolar disorder	
9433 Dysthymic disorder	
9434 Major depressive disorder	
9435 Mood disorder, not otherwise specified	
Chronic Adjustment Disorder	
9440 Chronic adjustment disorder	

	Rating
General Rating Formula for Mental Disorders:	
Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication	0
Eating Disorders	
9520 Anorexia nervosa	
9521 Bulimia nervosa	
Rating Formula for Eating Disorders:	
Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding	100
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year	60
Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year	30
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year	10
Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes	0

NOTE: An incapacitating episode is a period during which bed rest and treatment by a physician are required.

(Authority: 38 U.S.C. 1155)

[61 FR 52700, Oct. 8, 1996, as amended at 74 FR 18467, Apr. 23, 2009]

DENTAL AND ORAL CONDITIONS

§ 4.149 [Reserved]

§ 4.150 Schedule of ratings—dental and oral conditions.

	Rating
9900 Maxilla or mandible, chronic osteomyelitis or osteoradionecrosis of:	
Rate as osteomyelitis, chronic under diagnostic code 5000.	
9901 Mandible, loss of, complete, between angles	100
9902 Mandible, loss of approximately one-half:	
Involving temporomandibular articulation	50
Not involving temporomandibular articulation	30
9903 Mandible, nonunion of:	
Severe	30
Moderate	10
NOTE—Dependent upon degree of motion and relative loss of masticatory function.	
9904 Mandible, malunion of:	
Severe displacement	20
Moderate displacement	10
Slight displacement	0
NOTE—Dependent upon degree of motion and relative loss of masticatory function.	

	Rating
9905 Temporomandibular articulation, limited motion of:	
Inter-incisal range:	
0 to 10 mm	40
11 to 20 mm	30
21 to 30 mm	20
31 to 40 mm	10
Range of lateral excursion:	
0 to 4 mm	10
NOTE—Ratings for limited inter-incisal movement shall not be combined with ratings for limited lateral excursion.	
9906 Ramus, loss of whole or part of:	
Involving loss of temporomandibular articulation	
Bilateral	50
Unilateral	30
Not involving loss of temporomandibular articulation	
Bilateral	30
Unilateral	20
9907 Ramus, loss of less than one-half the substance of, not involving loss of continuity:	
Bilateral	20
Unilateral	10
9908 Condyloid process, loss of, one or both sides	30
9909 Coronoid process, loss of:	
Bilateral	20
Unilateral	10
9911 Hard palate, loss of half or more:	
Not replaceable by prosthesis	30
Replaceable by prosthesis	10
9912 Hard palate, loss of less than half of:	
Not replaceable by prosthesis	20
Replaceable by prosthesis	0
9913 Teeth, loss of, due to loss of substance of body of maxilla or mandible without loss of continuity:	
Where the lost masticatory surface cannot be restored by suitable prosthesis:	
Loss of all teeth	40
Loss of all upper teeth	30
Loss of all lower teeth	30
All upper and lower posterior teeth missing	20
All upper and lower anterior teeth missing	20
All upper anterior teeth missing	10
All lower anterior teeth missing	10
All upper and lower teeth on one side missing	10
Where the loss of masticatory surface can be restored by suitable prosthesis	0
NOTE—These ratings apply only to bone loss through trauma or disease such as osteomyelitis, and not to the loss of the alveolar process as a result of periodontal disease, since such loss is not considered disabling.	
9914 Maxilla, loss of more than half:	
Not replaceable by prosthesis	100
Replaceable by prosthesis	50
9915 Maxilla, loss of half or less:	
Loss of 25 to 50 percent:	
Not replaceable by prosthesis	40
Replaceable by prosthesis	30
Loss of less than 25 percent:	
Not replaceable by prosthesis	20
Replaceable by prosthesis	0
9916 Maxilla, malunion or nonunion of:	
Severe displacement	30
Moderate displacement	10
Slight displacement	0

[59 FR 2530, Jan. 18, 1994]

APPENDIX A TO PART 4—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

Sec.	Diagnostic code No.	
4.71a	5000	Evaluation February 1, 1962.
	5001	Evaluation March 11, 1969.
	5002	Evaluation March 1, 1963.
	5003	Added July 6, 1950.
	5012	Criterion March 10, 1976.
	5024	Criterion March 1, 1963.
	5025	Added May 7, 1996.
	5051	Added September 22, 1978.
	5052	Added September 22, 1978.
	5053	Added September 22, 1978.
	5054	Added September 22, 1978.
	5055	Added September 22, 1978.
	5056	Added September 22, 1978.
	5100–5103	Removed March 10, 1976.
	5104	Criterion March 10, 1976.
	5105	Criterion March 10, 1976.
	5164	Evaluation June 9, 1952.
	5166	Criterion September 22, 1978.
	5172	Added July 6, 1950.
	5173	Added June 9, 1952.
	5174	Added September 9, 1975; removed September 22, 1978.
	5211	Criterion September 22, 1978.
	5212	Criterion September 22, 1978.
	5214	Criterion September 22, 1978.
	5216	Preceding paragraph criterion September 22, 1978.
	5217	Criterion August 26, 2002.

Sec.	Diagnostic code No.	
	5218	Criterion August 26, 2002.
	5219	Criterion September 22, 1978; criterion August 26, 2002.
	5220	Preceding paragraph criterion September 22, 1978; criterion August 26, 2002.
	5223	Criterion August 26, 2002.
	5224	Criterion August 26, 2002.
	5225	Criterion August 26, 2002.
	5226	Criterion August 26, 2002.
	5227	Criterion September 22, 1978; criterion August 26, 2002.
	5228	Added August 26, 2002.
	5229	Added August 26, 2002.
	5230	Added August 26, 2002.
	5235–5243	Replaces 5285–5295 September 26, 2003.
	5243	Criterion September 26, 2003.
	5255	Criterion July 6, 1950.
	5257	Evaluation July 6, 1950.
	5264	Added September 9, 1975; removed September 22, 1978.
	5275	Criterion March 10, 1976; criterion September 22, 1978.
	5285–5292	Revised to 5235–5243 September 26, 2003.
	5293	Criterion March 10, 1976; criterion September 23, 2002; revised and moved to 5235–5243 September 26, 2003.
	5294	Evaluation March 10, 1976; revised and moved to 5235–5243 September 26, 2003.
	5295	Evaluation March 10, 1976; revised and moved to 5235–5243 September 26, 2003.
	5296	Criterion March 10, 1976.
	5297	Criterion August 23, 1948; criterion February 1, 1962.
	5298	Added August 23, 1948.
4.73	....	Introduction NOTE criterion July 3, 1997.
	5317	Criterion September 22, 1978.
	5324	Added February 1, 1962.
	5325	Criterion July 3, 1997.
	5327	Added March 10, 1976; criterion October 15, 1991; criterion July 3, 1997.
	5328	Added NOTE March 10, 1976.
	5329	Added NOTE July 3, 1997.
4.84a	....	Table V criterion July 1, 1994.
	6010	Criterion March 11, 1969.
	6019	Criterion September 22, 1978.
	6029	NOTE August 23, 1948; criterion September 22, 1978.
	6035	Added September 9, 1975.
	6050–6062	Removed March 10, 1976.
	6061	Added March 10, 1976.
	6062	Added March 10, 1976.
	6063–6079	Criterion September 22, 1978.
	6064	Criterion March 10, 1976.
	6071	Criterion March 10, 1976.
	6076	Evaluation August 23, 1948.
	6080	Criterion September 22, 1978.
	6081	Criterion March 10, 1976.
	6090	Criterion September 22, 1978; criterion September 12, 1988.
4.84b	6260	Added October 1, 1961; criterion October 1, 1961; evaluation March 10, 1976; removed December 18, 1987; re-designated §4.87a December 18, 1987.
4.87	....	Tables VI and VII replaced by new Tables VI, VIA, and VII December 18, 1987. 6200–6260 revised and re-designated §4.87 June 10, 1999.
4.87a	6200–6260	Moved to §4.87 June 10, 1999.
	6275–6276	Moved from §4.87b June 10, 1999.
	6277–6297	March 23, 1956 removed, December 17, 1987; Table II revised Table V March 10, 1976; Table II revised to Table VII September 22, 1978; text from §4.84b Schedule of ratings-ear re-designated from §4.87 December 17, 1987.
	6286	Removed December 17, 1987.
	6291	Criterion March 10, 1976; removed December 17, 1987.
	6297	Criterion March 10, 1976; removed December 17, 1987.
4.87b	....	Removed June 10, 1999.
4.88a	....	March 11, 1969; re-designated §4.88b November 29, 1994; §4.88a added to read "Chronic fatigue syndrome"; criterion November 29, 1994.
4.88b	....	Added March 11, 1969; re-designated §4.88c November 29, 1994; §4.88a re-designated to §4.88b November 29, 1994.
	6300	Criterion August 30, 1996.
	6302	Criterion September 22, 1978; criterion August 30, 1996.
	6304	Evaluation August 30, 1996.
	6305	Criterion March 1, 1989; evaluation August 30, 1996.
	6306	Evaluation August 30, 1996.
	6307	Criterion August 30, 1996.
	6308	Criterion August 30, 1996.

Sec.	Diagnostic code No.	
	6309	Added March 1, 1963; criterion March 1, 1989; criterion August 30, 1996.
	6314	Evaluation March 1, 1989; evaluation August 30, 1996.
	6315	Criterion August 30, 1996.
	6316	Evaluation March 1, 1989; evaluation August 30, 1996.
	6317	Criterion August 30, 1996.
	6318	Added March 1, 1989; criterion August 30, 1996.
	6319	Added August 30, 1996.
	6320	Added August 30, 1996.
	6350	Evaluation March 1, 1963; evaluation March 10, 1976; evaluation August 30, 1996.
	6351	Added March 1, 1989; evaluation March 24, 1992; criterion August 30, 1996.
	6352	Added March 1, 1989; removed March 24, 1992.
	6353	Added March 1, 1989; removed March 24, 1992.
	6354	Added November 29, 1994; criterion August 30, 1996.
4.88c		Re-designated from § 4.88b November 29, 1994.
4.89		Ratings for nonpulmonary TB December 1, 1949; criterion March 11, 1969.
4.97	6502	Criterion October 7, 1996.
	6504	Criterion October 7, 1996.
	6510–6514	Criterion October 7, 1996.
	6515	Criterion March 11, 1969.
	6516	Criterion October 7, 1996.
	6517	Removed October 7, 1996.
	6518	Criterion October 7, 1996.
	6519	Criterion October 7, 1996.
	6520	Criterion October 7, 1996.
	6521	Added October 7, 1996.
	6522	Added October 7, 1996.
	6523	Added October 7, 1996.
	6524	Added October 7, 1996.
	6600	Evaluation September 9, 1975; criterion October 7, 1996.
	6601	Criterion October 7, 1996.
	6602	Criterion September 9, 1975; criterion October 7, 1996.
	6603	Added September 9, 1975; criterion October 7, 1996.
	6604	Added October 7, 1996.
	6701	Evaluation October 7, 1996.
	6702	Evaluation October 7, 1996.
	6703	Evaluation October 7, 1996.
	6704	Subparagraph (1) following December 1, 1949; criterion March 11, 1969; criterion September 22, 1978.
	6705	Removed March 11, 1969.
	6707–6710	Added March 11, 1969; removed September 22, 1978.
	6721	Criterion July 6, 1950; criterion September 22, 1978.
	6724	Second note following December 1, 1949; criterion March 11, 1969; evaluation October 7, 1996.
	6725–6728	Added March 11, 1969; removed September 22, 1978.
	6730	Added September 22, 1978; criterion October 7, 1996.
	6731	Evaluation September 22, 1978; criterion October 7, 1996.
	6732	Criterion March 11, 1969.
	6800	Criterion September 9, 1975; removed October 7, 1996.
	6801	Removed October 7, 1996.
	6802	Criterion September 9, 1975; removed October 7, 1996.
	6810–6813	Removed October 7, 1996.
	6814	Criterion March 10, 1976; removed October 7, 1996.
	6815	Removed October 7, 1996.
	6816	Removed October 7, 1996.
	6817	Evaluation October 7, 1996.
	6818	Removed October 7, 1996.
	6819	Criterion March 10, 1976; criterion October 7, 1996.
	6821	Evaluation August 23, 1948.
	6822–6847	Added October 7, 1996.
4.104	7000	Evaluation July 6, 1950; evaluation September 22, 1978; evaluation January 12, 1998.
	7001	Evaluation January 12, 1998.
	7002	Evaluation January 12, 1998.
	7003	Evaluation January 12, 1998.
	7004	Criterion September 22, 1978; evaluation January 12, 1998.
	7005	Evaluation September 9, 1975; evaluation September 22, 1978; evaluation January 12, 1998.
	7006	Evaluation January 12, 1998.
	7007	Evaluation September 22, 1978; evaluation January 12, 1998.
	7008	Evaluation January 12, 1998.
	7010	Evaluation January 12, 1998.
	7011	Evaluation January 12, 1998.

Sec.	Diagnostic code No.	
	7013	Removed January 12, 1998.
	7014	Removed January 12, 1998.
	7015	Evaluation September 9, 1975; criterion January 12, 1998.
	7016	Added September 9, 1975; evaluation January 12, 1998.
	7017	Added September 22, 1978; evaluation January 12, 1998.
	7018	Added January 12, 1998.
	7019	Added January 12, 1998.
	7020	Added January 12, 1998.
	7100	Evaluation July 6, 1950.
	7101	Criterion September 1, 1960; criterion September 9, 1975; criterion January 12, 1998.
	7110	Evaluation September 9, 1975; evaluation January 12, 1998.
	7111	Criterion September 9, 1975; evaluation January 12, 1998.
	7112	Evaluation January 12, 1998.
	7113	Evaluation January 12, 1998.
	7114	Added June 9, 1952; evaluation January 12, 1998.
	7115	Added June 9, 1952; evaluation January 12, 1998.
	7116	Added June 9, 1952; evaluation March 10, 1976; removed January 12, 1998.
	7117	Added June 9, 1952; evaluation January 12, 1998.
	7118	Criterion January 12, 1998.
	7119	Evaluation January 12, 1998.
	7120	Note following July 6, 1950; evaluation January 12, 1998.
	7121	Criterion July 6, 1950; evaluation March 10, 1976; evaluation January 12, 1998.
	7122	Last sentence of Note following July 6, 1950; evaluation January 12, 1998; criterion August 13, 1998.
	7123	Added October 15, 1991; criterion January 12, 1998.
4.114	....	Introduction paragraph revised March 10, 1976.
	7304	Evaluation November 1, 1962.
	7305	Evaluation November 1, 1962.
	7308	Evaluation April 8, 1959.
	7311	Criterion July 2, 2001.
	7312	Evaluation March 10, 1976; evaluation July 2, 2001.
	7313	Evaluation March 10, 1976; removed July 2, 2001.
	7319	Evaluation November 1, 1962.
	7321	Evaluation July 6, 1950; criterion March 10, 1976.
	7328	Evaluation November 1, 1962.
	7329	Evaluation November 1, 1962.
	7330	Evaluation November 1, 1962.
	7331	Criterion March 11, 1969.
	7332	Evaluation November 1, 1962.
	7334	Evaluation July 6, 1950; evaluation November 1, 1962.
	7339	Criterion March 10, 1976.
	7341	Removed March 10, 1976.
	7343	Criterion March 10, 1976; criterion July 2, 2001.
	7344	Criterion July 2, 2001.
	7345	Evaluation August 23, 1948; evaluation February 17, 1955; evaluation July 2, 2001.
	7346	Evaluation February 1, 1962.
	7347	Added September 9, 1975.
	7348	Added March 10, 1976.
	7351	Added July 2, 2001.
	7354	Added July 2, 2001.
4.115a	....	Re-designated and revised as §4.115b; new §4.115a "Ratings of the genito-urinary system-dysfunctions" added February 17, 1994.
4.115b	7500	Note July 6, 1950; evaluation February 17, 1994, criterion September 8, 1994.
	7501	Evaluation February 17, 1994.
	7502	Evaluation February 17, 1994.
	7503	Removed February 17, 1994.
	7504	Criterion February 17, 1994.
	7505	Criterion March 11, 1969; evaluation February 17, 1994.
	7507	Criterion February 17, 1994.
	7508	Evaluation February 17, 1994.
	7509	Criterion February 17, 1994.
	7510	Evaluation February 17, 1994.
	7511	Evaluation February 17, 1994.
	7512	Evaluation February 17, 1994.
	7513	Removed February 17, 1994.
	7514	Criterion March 11, 1969; removed February 17, 1994.
	7515	Criterion February 17, 1994.
	7516	Criterion February 17, 1994.
	7517	Criterion February 17, 1994.
	7518	Evaluation February 17, 1994.
	7519	Evaluation March 10, 1976; evaluation February 17, 1994.

Sec.	Diagnostic code No.	
	7520	Criterion February 17, 1994.
	7521	Criterion February 17, 1994.
	7522	Criterion September 8, 1994.
	7523	Criterion September 8, 1994.
	7524	Note July 6, 1950; evaluation February 17, 1994; evaluation September 8, 1994.
	7525	Criterion March 11, 1969; evaluation February 17, 1994.
	7526	Removed February 17, 1994.
	7527	Criterion February 17, 1994.
	7528	Criterion March 10, 1976; criterion February 17, 1994.
	7529	Criterion February 17, 1994.
	7530	Added September 9, 1975; evaluation February 17, 1994.
	7531	Added September 9, 1975; criterion February 17, 1994.
	7532–7542	Added February 17, 1994.
4.116	....	§4.116 removed and §4.116a re-designated §4.116 "Schedule of ratings-gynecological conditions and disorders of the breasts" May 22, 1995.
	7610	Criterion May 22, 1995.
	7611	Criterion May 22, 1995.
	7612	Criterion May 22, 1995.
	7613	Criterion May 22, 1995.
	7614	Criterion May 22, 1995.
	7615	Criterion May 22, 1995.
	7617	Criterion May 22, 1995.
	7618	Criterion May 22, 1995.
	7619	Criterion May 22, 1995.
	7620	Criterion May 22, 1995.
	7621	Criterion May 22, 1995.
	7622	Evaluation May 22, 1995.
	7623	Evaluation May 22, 1995.
	7624	Criterion August 9, 1976; evaluation May 22, 1995.
	7625	Criterion August 9, 1976; evaluation May 22, 1995.
	7626	Criterion May 22, 1995; criterion March 18, 2002.
	7627	Criterion March 10, 1976; criterion May 22, 1995.
	7628	Added May 22, 1995.
	7629	Added May 22, 1995.
4.117	7700	Evaluation October 23, 1995.
	7701	Removed October 23, 1995.
	7702	Evaluation October 23, 1995.
	7703	Evaluation August 23, 1948; criterion October 23, 1995.
	7704	Evaluation October 23, 1995.
	7705	Evaluation October 23, 1995.
	7706	Evaluation October 23, 1995.
	7707	Criterion October 23, 1995.
	7709	Evaluation March 10, 1976; criterion October 23, 1995.
	7710	Criterion October 23, 1995.
	7711	Criterion October 23, 1995.
	7712	Criterion October 23, 1995.
	7713	Removed October 23, 1995.
	7714	Added September 9, 1975; criterion October 23, 1995.
	7715	Added October 26, 1990.
	7716	Added October 23, 1995.
	7717	Added March 9, 2012.
4.118	7800	Evaluation August 30, 2002; criterion October 23, 2008.
	7801	Criterion July 6, 1950; criterion August 30, 2002; criterion October 23, 2008.
	7802	Criterion September 22, 1978; criterion August 30, 2002; criterion October 23, 2008.
	7803	Criterion August 30, 2002; removed October 23, 2008.
	7804	Criterion July 6, 1950; criterion September 22, 1978; criterion and evaluation October 23, 2008.
	7805	Criterion October 23, 2008.
	7806	Criterion September 9, 1975; evaluation August 30, 2002.
	7807	Criterion August 30, 2002.
	7808	Criterion August 30, 2002.
	7809	Criterion August 30, 2002.
	7810	Removed August 30, 2002.
	7811	Criterion March 11, 1969; evaluation August 30, 2002.
	7812	Removed August 30, 2002.
	7813	Criterion August 30, 2002.
	7814	Removed August 30, 2002.
	7815	Evaluation August 30, 2002.
	7816	Evaluation August 30, 2002.
	7817	Evaluation August 30, 2002.
	7818	Criterion August 30, 2002.
	7819	Criterion August 30, 2002.

Sec.	Diagnostic code No.	
	7820–7833	Added August 30, 2002.
4.119	7900	Criterion August 13, 1981; evaluation June 9, 1996.
	7901	Criterion August 13, 1981; evaluation June 9, 1996.
	7902	Evaluation August 13, 1981; criterion June 9, 1996.
	7903	Criterion August 13, 1981; evaluation June 9, 1996.
	7904	Criterion August 13, 1981; evaluation June 9, 1996.
	7905	Evaluation; August 13, 1981; evaluation June 9, 1996.
	7907	Evaluation August 13, 1981; evaluation June 9, 1996.
	7908	Criterion August 13, 1981; criterion June 9, 1996.
	7909	Evaluation August 13, 1981; criterion June 9, 1996.
	7910	Removed June 9, 1996.
	7911	Evaluation March 11, 1969; evaluation August 13, 1981; criterion June 9, 1996.
	7913	Criterion September 9, 1975; criterion August 13, 1981; criterion June 6, 1996.
	7914	Criterion March 10, 1976; criterion August 13, 1981; criterion June 9, 1996.
	7916	Added June 9, 1996.
	7917	Added June 9, 1996.
	7918	Added June 9, 1996.
	7919	Added June 9, 1996.
4.124a	8002	Criterion September 22, 1978.
	8021	Criterion September 22, 1978; criterion October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8045	Criterion and evaluation October 23, 2008.
	8046	Added October 1, 1961; criterion March 10, 1976; criterion March 1, 1989.
	8100	Evaluation June 9, 1953.
	8540	Added October 15, 1991.
	8910	Added October 1, 1961.
	8911	Added October 1, 1961; evaluation September 9, 1975.
	8912	Added October 1, 1961.
	8913	Added October 1, 1961.
	8914	Added October 1, 1961; criterion September 9, 1975; criterion March 10, 1976.
	8910–8914	Evaluations September 9, 1975.
4.125—4.132	....	All Diagnostic Codes under Mental Disorders October 1, 1961; except as to evaluation for Diagnostic Codes 9500 through 9511 September 9, 1975.
4.130	....	Re-designated from § 4.132 November 7, 1996.
	9200	Removed February 3, 1988.
	9201	Criterion February 3, 1988.
	9202	Criterion February 3, 1988.
	9203	Criterion February 3, 1988.
	9204	Criterion February 3, 1988.
	9205	Criterion February 3, 1988; criterion November 7, 1996.
	9206	Criterion February 3, 1988; removed November 7, 1996.
	9207	Criterion February 3, 1988; removed November 7, 1996.
	9208	Criterion February 3, 1988; removed November 7, 1996.
	9209	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9210	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9211	Added November 7, 1996.
	9300	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9301	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9302	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9303	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9304	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9305	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9306	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9307	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9308	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9309	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9310	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9311	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9312	Added March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9313	Added March 10, 1976; removed February 3, 1988.
	9314	Added March 10, 1976; removed February 3, 1988.
	9315	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9316–9321	Added March 10, 1976; removed February 3, 1988.
	9322	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9323	Added March 10, 1976; removed February 3, 1988.

Sec.	Diagnostic code No.	
	9324	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9325	Added March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9326	Added March 10, 1976; removed February 3, 1988; added November 7, 1996.
	9327	Added November 7, 1996.
	9400–9411	Evaluations February 3, 1988.
	9400	Criterion March 10, 1976; criterion February 3, 1988.
	9401	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9402	Criterion March 10, 1976; criterion February 3, 1988; removed November 7, 1996.
	9403	Criterion March 10, 1976; criterion February 3, 1988; criterion November 7, 1996.
	9410	Added March 10, 1976; criterion February 3, 1988.
	9411	Added February 3, 1988.
	9412	Added November 7, 1996.
	9413	Added November 7, 1996.
	9416	Added November 7, 1996.
	9417	Added November 7, 1996.
	9421	Added November 7, 1996.
	9422	Added November 7, 1996.
	9423	Added November 7, 1996.
	9424	Added November 7, 1996.
	9425	Added November 7, 1996.
	9431	Added November 7, 1996.
	9432	Added November 7, 1996.
	9433	Added November 7, 1996.
	9434	Added November 7, 1996.
	9435	Added November 7, 1996.
	9440	Added November 7, 1996.
	9500	Criterion March 10, 1976; criterion February 3, 1988.
	9501	Criterion March 10, 1976; criterion February 3, 1988.
	9502	Criterion March 10, 1976; criterion February 3, 1988.
	9503	Removed March 10, 1976.
	9504	Criterion September 9, 1975; removed March 10, 1976.
	9505	Added March 10, 1976; criterion February 3, 1988.
	9506	Added March 10, 1976; criterion February 3, 1988.
	9507	Added March 10, 1976; criterion February 3, 1988.
	9508	Added March 10, 1976; criterion February 3, 1988.
	9509	Added March 10, 1976; criterion February 3, 1988.
	9510	Added March 10, 1976; criterion February 3, 1988.
	9511	Added March 10, 1976; criterion February 3, 1988.
	9520	Added November 7, 1996.
	9521	Added November 7, 1996.
4.132		Re-designated as §4.130 November 7, 1996.
4.150	9900	Criterion September 22, 1978; criterion February 17, 1994.
	9901	Criterion February 17, 1994.
	9902	Criterion February 17, 1994.
	9903	Criterion February 17, 1994.
	9905	Criterion September 22, 1978; evaluation February 17, 1994.
	9910	Removed February 17, 1994.
	9913	Criterion February 17, 1994.
	9914	Added February 17, 1994.
	9915	Added February 17, 1994.
	9916	Added February 17, 1994.

[72 FR 12983, Mar. 20, 2007; 72 FR 16728, Apr. 5, 2007, as amended at 73 FR 54708, 54711, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 77 FR 6467, Feb. 8, 2012]

APPENDIX B TO PART 4—NUMERICAL INDEX OF DISABILITIES

Diagnostic Code No.	
THE MUSCULOSKELETAL SYSTEM **Acute, Subacute, or Chronic Diseases**	
5000	Osteomyelitis, acute, subacute, or chronic.
5001	Bones and Joints, tuberculosis.
5002	Arthritis, rheumatoid (atrophic).
5003	Arthritis, degenerative (hypertrophic or osteoarthritis).
5004	Arthritis, gonorrheal.
5005	Arthritis, pneumococcic.
5006	Arthritis, typhoid.
5007	Arthritis, syphilitic.

Diagnostic Code No.	
5008	Arthritis, streptococcic.
5009	Arthritis, other types (specify).
5010	Arthritis, due to trauma.
5011	Bones, caisson disease.
5012	Bones, new growths, malignant.
5013	Osteoporosis, with joint manifestations.
5014	Osteomalacia.
5015	Bones, new growths, benign.
5016	Osteitis deformans.
5017	Gout.
5018	Hydrarthrosis, intermittent.
5019	Bursitis.
5020	Synovitis.
5021	Myositis.
5022	Periostitis.
5023	Myositis ossificans.
5024	Tenosynovitis.
5025	Fibromyalgia.
Prosthetic Implants	
5051	Shoulder replacement (prosthesis).
5052	Elbow replacement (prosthesis).
5053	Wrist replacement (prosthesis).
5054	Hip replacement (prosthesis).
5055	Knee replacement (prosthesis).
5056	Ankle replacement (prosthesis).
Combination of Disabilities	
5104	Anatomical loss of one hand and loss of use of one foot.
5105	Anatomical loss of one foot and loss of use of one hand.
5106	Anatomical loss of both hands.
5107	Anatomical loss of both feet.
5108	Anatomical loss of one hand and one foot.
5109	Loss of use of both hands.
5110	Loss of use of both feet.
5111	Loss of use of one hand and one foot.
Amputations: Upper Extremity	
Arm amputation of:	
5120	Disarticulation.
5121	Above insertion of deltoid.
5122	Below insertion of deltoid.
Forearm amputation of:	
5123	Above insertion of pronator teres.
5124	Below insertion of pronator teres.
5125	Hand, loss of use of.
Multiple Finger Amputations	
5126	Five digits of one hand.
Four digits of one hand:	
5127	Thumb, index, long and ring.
5128	Thumb, index, long and little.
5129	Thumb, index, ring and little.
5130	Thumb, long, ring and little.
5131	Index, long, ring and little.
Three digits of one hand:	
5132	Thumb, index and long.
5133	Thumb, index and ring.
5134	Thumb, index and little.
5135	Thumb, long and ring.
5136	Thumb, long and little.
5137	Thumb, ring and little.
5138	Index, long and ring.
5139	Index, long and little.
5140	Index, ring and little.
5141	Long, ring and little.
Two digits of one hand:	

Diagnostic Code No.	
5142	Thumb and index.
5143	Thumb and long.
5144	Thumb and ring.
5145	Thumb and little.
5146	Index and long.
5147	Index and ring.
5148	Index and little.
5149	Long and ring.
5150	Long and little.
5151	Ring and little.
Single finger:	
5152	Thumb.
5153	Index finger.
5154	Long finger.
5155	Ring finger.
5156	Little finger.
Amputations: Lower Extremity	
Thigh amputation of:	
5160	Disarticulation.
5161	Upper third.
5162	Middle or lower thirds.
Leg amputation of:	
5163	With defective stump.
5164	Not improvable by prosthesis controlled by natural knee action.
5165	At a lower level, permitting prosthesis.
5166	Forefoot, proximal to metatarsal bones.
5167	Foot, loss of use of.
5170	Toes, all, without metatarsal loss.
5171	Toe, great.
5172	Toes, other than great, with removal of metatarsal head.
5173	Toes, three or more, without metatarsal involvement.
Shoulder and Arm	
5200	Scapulohumeral articulation, ankylosis.
5201	Arm, limitation of motion.
5202	Humerus, other impairment.
5203	Clavicle or scapula, impairment.
Elbow and Forearm	
5205	Elbow, ankylosis.
5206	Forearm, limitation of flexion.
5207	Forearm, limitation of extension.
5208	Forearm, flexion limited.
5209	Elbow, other impairment.
5210	Radius and ulna, nonunion.
5211	Ulna, impairment.
5212	Radius, impairment.
5213	Supination and pronation, impairment.
Wrist	
5214	Wrist, ankylosis.
5215	Wrist, limitation of motion.
Limitation of Motion	
Multiple Digits: Unfavorable Ankylosis:	
5216	Five digits of one hand.
5217	Four digits of one hand.
5218	Three digits of one hand.
5219	Two digits of one hand.
Multiple Digits: Favorable Ankylosis:	
5220	Five digits of one hand.
5221	Four digits of one hand.
5222	Three digits of one hand.
5223	Two digits of one hand.

Diagnostic Code No.	
Ankylosis of Individual Digits:	
5224	Thumb.
5225	Index finger.
5226	Long finger.
5227	Ring or little finger.
Limitation of Motion of Individual Digits:	
5228	Thumb.
5229	Index or long finger.
5230	Ring or little finger.
Spine	
5235	Vertebral fracture or dislocation.
5236	Sacroiliac injury and weakness.
5237	Lumbosacral or cervical strain.
5238	Spinal stenosis.
5239	Spondylolisthesis or segmental instability.
5240	Ankylosing spondylitis.
5241	Spinal fusion.
5242	Degenerative arthritis.
5243	Intervertebral disc syndrome.
Hip and Thigh	
5250	Hip, ankylosis.
5251	Thigh, limitation of extension.
5252	Thigh, limitation of flexion.
5253	Thigh, impairment.
5254	Hip, flail joint.
5255	Femur, impairment.
Knee and Leg	
5256	Knee, ankylosis.
5257	Knee, other impairment.
5258	Cartilage, semilunar, dislocated.
5259	Cartilage, semilunar, removal.
5260	Leg, limitation of flexion.
5261	Leg, limitation of extension.
5262	Tibia and fibula, impairment.
5263	Genu recurvatum.
Ankle	
5270	Ankle, ankylosis.
5271	Ankle, limited motion.
5272	Subastragalar or tarsal joint, ankylosis.
5273	Os calcis or astragalus, malunion.
5274	Astragalectomy.
Shortening of the Lower Extremity	
5275	Bones, of the lower extremity
The Foot	
5276	Flatfoot, acquired.
5277	Weak foot, bilateral.
5278	Claw foot (pes cavus), acquired.
5279	Metatarsalgia, anterior (Morton's disease).
5280	Hallux valgus.
5281	Hallux rigidus.
5282	Hammer toe.
5283	Tarsal or metatarsal bones.
5284	Foot injuries, other.
The Skull	
5296	Loss of part of.
The Ribs	
5297	Removal of.

Diagnostic Code No.	
	The Coccyx
5298	Removal of.
	MUSCLE INJURIES **Shoulder Girdle and Arm**
5301	Group I Function: Upward rotation of scapula.
5302	Group II Function: Depression of arm.
5303	Group III Function: Elevation and abduction of arm.
5304	Group IV Function: Stabilization of shoulder.
5305	Group V Function: Elbow supination.
5306	Group VI Function: Extension of elbow.
	Forearm and Hand
5307	Group VII Function: Flexion of wrist and fingers.
5308	Group VIII Function: Extension of wrist, fingers, thumb.
5309	Group IX Function: Forearm muscles.
	Foot and Leg
5310	Group X Function: Movement of forefoot and toes.
5311	Group XI Function: Propulsion of foot.
5312	Group XII Function: Dorsiflexion.
	Pelvic Girdle and Thigh
5313	Group XIII Function: Extension of hip and flexion of knee.
5314	Group XIV Function: Extension of knee.
5315	Group XV Function: Adduction of hip.
5316	Group XVI Function: Flexion of hip.
5317	Group XVII Function: Extension of hip.
5318	Group XVIII Function: Outward rotation of thigh.
	Torso and Neck
5319	Group XIX Function: Abdominal wall and lower thorax.
5320	Group XX Function: Postural support of body.
5321	Group XXI Function: Respiration.
5322	Group XXII Function: Rotary and forward movements, head.
5323	Group XXIII Function: Movements of head.
	Miscellaneous
5324	Diaphragm, rupture.
5325	Muscle injury, facial muscles.
5326	Muscle hernia.
5327	Muscle, neoplasm of, malignant.
5328	Muscle, neoplasm of, benign.
5329	Sarcoma, soft tissue.
	THE EYE **Diseases of the Eye**
6000	Uveitis.
6001	Keratitis.
6002	Scleritis.
6003	Iritis.
6004	Cyclitis.
6005	Choroiditis.
6006	Retinitis.
6007	Hemorrhage, intra-ocular, recent.
6008	Retina, detachment.
6009	Eye, injury of, unhealed.
6010	Eye, tuberculosis.
6011	Retina, localized scars.
6012	Glaucoma, congestive or inflammatory.
6013	Glaucoma, simple, primary, noncongestive.
6014	New growths, malignant, eyeball.
6015	New growths, benign, eyeball and adnexa.
6016	Nystagmus, central.
6017	Conjunctivitis, trachomatous, chronic.
6018	Conjunctivitis, other, chronic.
6019	Ptosis unilateral or bilateral.

Diagnostic Code No.	
6020	Ectropion.
6021	Entropion.
6022	Lagophthalmos.
6023	Eyebrows, loss.
6024	Eyelashes, loss.
6025	Epiphora.
6026	Neuritis, optic.
6027	Cataract, traumatic.
6028	Cataract, senile, and others.
6029	Aphakia.
6030	Accommodation, paralysis.
6031	Dacryocystitis.
6032	Eyelids, loss of portion.
6033	Lens, crystalline, dislocation.
6034	Pterygium.
6035	Keratoconus.
Impairment of Central Visual Acuity	
6061	Anatomical loss both eyes.
6062	Blindness, both eyes, only light perception.
Anatomical loss of 1 eye:	
6063	Other eye 5/200 (1.5/60).
6064	Other eye 10/200 (3/60).
6064	Other eye 15/200 (4.5/60).
6064	Other eye 20/200 (6/60).
6065	Other eye 20/100 (6/30).
6065	Other eye 20/70 (6/21).
6065	Other eye 20/50 (6/15).
6066	Other eye 20/40 (6/12).
Blindness in 1 eye, only light perception:	
6067	Other eye 5/200 (1.5/60).
6068	Other eye 10/200 (3/60).
6068	Other eye 15/200 (4.5/60).
6068	Other eye 20/200 (6/60).
6069	Other eye 20/100 (6/30).
6069	Other eye 20/70 (6/21).
6069	Other eye 20/50 (6/15).
6070	Other eye 20/40 (6/12).
Vision in 1 eye 5/200 (1.5/60):	
6071	Other eye 5/200 (1.5/60).
6072	Other eye 10/200 (3/60).
6072	Other eye 15/200 (4.5/60).
6072	Other eye 20/200 (6/60).
6073	Other eye 20/100 (6/30).
6073	Other eye 20/70 (6/21).
6073	Other eye 20/50 (6/15).
6074	Other eye 20/40 (6/12).
Vision in 1 eye 10/200 (3/60):	
6075	Other eye 10/200 (3/60).
6075	Other eye 15/200 (4.5/60).
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 15/200 (4.5/60):	
6075	Other eye 15/200 (4.5/60).
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).
6077	Other eye 20/40 (6/12).
Vision in 1 eye 20/200 (6/60):	
6075	Other eye 20/200 (6/60).
6076	Other eye 20/100 (6/30).
6076	Other eye 20/70 (6/21).
6076	Other eye 20/50 (6/15).

Diagnostic Code No.	
6077	Other eye 20/40 (6/12).
Vision in 1 eye 20/100 (6/30):	
6078	Other eye 20/100 (6/30).
6078	Other eye 20/70 (6/21).
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Vision in 1 eye 20/70 (6/21):	
6078	Other eye 20/70 (6/21).
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Vision in 1 eye 20/50 (6/15):	
6078	Other eye 20/50 (6/15).
6079	Other eye 20/40 (6/12).
Impairment of Field Vision:	
6080	Field vision, impairment.
6081	Scotoma.
Impairment of Muscle Function:	
6090	Diplopia.
6091	Symblepharon.
6092	Diplopia, limited muscle function.
THE EAR	
6200	Chronic suppurative otitis media.
6201	Chronic nonsuppurative otitis media.
6202	Otosclerosis.
6204	Peripheral vestibular disorders.
6205	Meniere's syndrome.
6207	Loss of auricle.
6208	Malignant neoplasm.
6209	Benign neoplasm.
6210	Chronic otitis externa.
6211	Tympanic membrane.
6260	Tinnitus, recurrent.
OTHER SENSE ORGANS	
6275	Smell, complete loss.
6276	Taste, complete loss.
INFECTIOUS DISEASES, IMMUNE DISORDERS AND NUTRITIONAL DEFICIENCIES	
6300	Cholera, Asiatic.
6301	Visceral Leishmaniasis.
6302	Leprosy (Hansen's Disease).
6304	Malaria.
6305	Lymphatic Filariasis.
6306	Bartonellosis.
6307	Plague.
6308	Relapsing fever.
6309	Rheumatic fever.
6310	Syphilis.
6311	Tuberculosis, miliary.
6313	Avitaminosis.
6314	Beriberi.
6315	Pellagra.
6316	Brucellosis.
6317	Typhus, scrub.
6318	Melioidosis.
6319	Lyme disease.
6320	Parasitic diseases.
6350	Lupus erythematosus.
6351	HIV-Related Illness.
6354	Chronic Fatigue Syndrome (CFS).
THE RESPIRATORY SYSTEM **Nose and Throat**	
6502	Septum, nasal, deviation.
6504	Nose, loss of part of, or scars.

Diagnostic Code No.	
6510	Sinusitis, pansinusitis, chronic.
6511	Sinusitis, ethmoid, chronic.
6512	Sinusitis, frontal, chronic.
6513	Sinusitis, maxillary, chronic.
6514	Sinusitis, sphenoid, chronic.
6515	Laryngitis, tuberculous.
6516	Laryngitis, chronic.
6518	Laryngectomy, total.
6519	Aphonia, complete organic.
6520	Larynx, stenosis of.
6521	Pharynx, injuries to.
6522	Allergic or vasomotor rhinitis.
6523	Bacterial rhinitis.
6524	Granulomatous rhinitis.
Trachea and Bronchi	
6600	Bronchitis, chronic.
6601	Bronchiectasis.
6602	Asthma, bronchial.
6603	Emphysema, pulmonary.
6604	Chronic obstructive pulmonary disease.
Lungs and Pleura Tuberculosis	
Ratings for Pulmonary Tuberculosis (Chronic) Entitled on August 19, 1968:	
6701	Active, far advanced.
6702	Active, moderately advanced.
6703	Active, minimal.
6704	Active, advancement unspecified.
6721	Inactive, far advanced.
6722	Inactive, moderately advanced.
6723	Inactive, minimal.
6724	Inactive, advancement unspecified.
Ratings for Pulmonary Tuberculosis Initially Evaluated After August 19, 1968:	
6730	Chronic, active.
6731	Chronic, inactive.
6732	Pleurisy, active or inactive.
Nontuberculous Diseases	
6817	Pulmonary Vascular Disease.
6819	Neoplasms, malignant.
6820	Neoplasms, benign.
Bacterial Infections of the Lung	
6822	Actinomycosis.
6823	Nocardiosis.
6824	Chronic lung abscess.
Interstitial Lung Disease	
6825	Fibrosis of lung, diffuse interstitial.
6826	Desquamative interstitial pneumonitis.
6827	Pulmonary alveolar proteinosis.
6828	Eosinophilic granuloma.
6829	Drug-induced, pneumonitis & fibrosis.
6830	Radiation-induced, pneumonitis & fibrosis.
6831	Hypersensitivity pneumonitis.
6832	Pneumoconiosis.
6833	Asbestosis.
Mycotic Lung Disease	
6834	Histoplasmosis.
6835	Coccidioidomycosis.
6836	Blastomycosis.
6837	Cryptococcosis.
6838	Aspergillosis.
6839	Mucormycosis.
Restrictive Lung Disease	
6840	Diaphragm paralysis or paresis.

Diagnostic Code No.	
6841	Spinal cord injury with respiratory insufficiency.
6842	Kyphoscoliosis, pectus excavatum/carinatum.
6843	Traumatic chest wall defect.
6844	Post-surgical residual.
6845	Pleural effusion or fibrosis.
6846	Sarcoidosis.
6847	Sleep Apnea Syndromes.
THE CARDIOVASCULAR SYSTEM **Diseases of the Heart**	
7000	Valvular heart disease.
7001	Endocarditis.
7002	Pericarditis.
7003	Pericardial adhesions.
7004	Syphilitic heart disease.
7005	Arteriosclerotic heart disease.
7006	Myocardial infarction.
7007	Hypertensive heart disease.
7008	Hyperthyroid heart disease.
7010	Supraventricular arrhythmias.
7011	Ventricular arrhythmias.
7015	Atrioventricular block.
7016	Heart valve replacement.
7017	Coronary bypass surgery.
7018	Implantable cardiac pacemakers.
7019	Cardiac transplantation.
7020	Cardiomyopathy.
Diseases of the Arteries and Veins	
7101	Hypertensive vascular disease.
7110	Aortic aneurysm.
7111	Aneurysm, large artery.
7112	Aneurysm, small artery.
7113	Arteriovenous fistula, traumatic.
7114	Arteriosclerosis obliterans.
7115	Thrombo-angiitis obliterans (Buerger's Disease).
7117	Raynaud's syndrome.
7118	Angioneurotic edema.
7119	Erythromelalgia.
7120	Varicose veins.
7121	Post-phlebitic syndrome.
7122	Cold injury residuals.
7123	Soft tissue sarcoma.
THE DIGESTIVE SYSTEM	
7200	Mouth, injuries.
7201	Lips, injuries.
7202	Tongue, loss.
7203	Esophagus, stricture.
7204	Esophagus, spasm.
7205	Esophagus, diverticulum.
7301	Peritoneum, adhesions.
7304	Ulcer, gastric.
7305	Ulcer, duodenal.
7306	Ulcer, marginal.
7307	Gastritis, hypertrophic.
7308	Postgastrectomy syndromes.
7309	Stomach, stenosis.
7310	Stomach, injury of, residuals.
7311	Liver, injury of, residuals.
7312	Liver, cirrhosis.
7314	Cholecystitis, chronic.
7315	Cholelithiasis, chronic.
7316	Cholangitis, chronic.
7317	Gall bladder, injury.
7318	Gall bladder, removal.
7319	Colon, irritable syndrome.
7321	Amebiasis.
7322	Dysentery, bacillary.
7323	Colitis, ulcerative.
7324	Distomiasis, intestinal or hepatic.

Diagnostic Code No.	
7325	Enteritis, chronic.
7326	Enterocolitis, chronic.
7327	Diverticulitis.
7328	Intestine, small, resection.
7329	Intestine, large, resection.
7330	Intestine, fistula.
7331	Peritonitis.
7332	Rectum & anus, impairment.
7333	Rectum & anus, stricture.
7334	Rectum, prolapse.
7335	Ano, fistula in.
7336	Hemorrhoids.
7337	Pruritus ani.
7338	Hernia, inguinal.
7339	Hernia, ventral, postoperative.
7340	Hernia, femoral.
7342	Visceroptosis.
7343	Neoplasms, malignant.
7344	Neoplasms, benign.
7345	Liver disease, chronic, without cirrhosis.
7346	Hernia, hiatal.
7347	Pancreatitis.
7348	Vagotomy.
7351	Liver transplant.
7354	Hepatitis C.
THE GENITOURINARY SYSTEM	
7500	Kidney, removal.
7501	Kidney, abscess.
7502	Nephritis, chronic.
7504	Pyelonephritis, chronic.
7505	Kidney, tuberculosis.
7507	Nephrosclerosis, arteriolar.
7508	Nephrolithiasis.
7509	Hydronephrosis.
7510	Ureterolithiasis.
7511	Ureter, stricture.
7512	Cystitis, chronic.
7515	Bladder, calculus.
7516	Bladder, fistula.
7517	Bladder, injury.
7518	Urethra, stricture.
7519	Urethra, fistula.
7520	Penis, removal of half or more.
7521	Penis, removal of glans.
7522	Penis, deformity, with loss of erectile power.
7523	Testis, atrophy, complete.
7524	Testis, removal.
7525	Epididymo-orchitis, chronic only.
7527	Prostate gland.
7528	Malignant neoplasms.
7529	Benign neoplasms.
7530	Renal disease, chronic.
7531	Kidney transplant.
7532	Renal tubular disorders.
7533	Kidneys, cystic diseases.
7534	Atherosclerotic renal disease.
7535	Toxic nephropathy.
7536	Glomerulonephritis.
7537	Interstitial nephritis.
7538	Papillary necrosis.
7539	Renal amyloid disease.
7540	Disseminated intravascular coagulation.
7541	Renal involvement in systemic diseases.
7542	Neurogenic bladder.
GYNECOLOGICAL CONDITIONS AND DISORDERS OF THE BREAST	
7610	Vulva, disease or injury.
7611	Vagina, disease or injury.
7612	Cervix, disease or injury.
7613	Uterus, disease or injury.
7614	Fallopian tube, disease or injury.

Diagnostic Code No.	
7615	Ovary, disease or injury.
7617	Uterus and both ovaries, removal.
7618	Uterus, removal.
7619	Ovary, removal.
7620	Ovaries, atrophy of both.
7621	Uterus, prolapse.
7622	Uterus, displacement.
7623	Pregnancy, surgical complications.
7624	Fistula, rectovaginal.
7625	Fistula, urethrovaginal.
7626	Breast, surgery.
7627	Malignant neoplasms.
7628	Benign neoplasms.
7629	Endometriosis.
THE HEMIC AND LYMPHATIC SYSTEMS	
7700	Anemia.
7702	Agranulocytosis, acute.
7703	Leukemia.
7704	Polycythemia vera.
7705	Thrombocytopenia.
7706	Splenectomy.
7707	Spleen, injury of, healed.
7709	Hodgkin's disease.
7710	Adenitis, tuberculous.
7714	Sickle cell anemia.
7715	Non-Hodgkin's lymphoma.
7716	Aplastic anemia.
7717	AL amyloidosis (primary amyloidosis).
THE SKIN	
7800	Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck.
7801	Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are deep and nonlinear.
7802	Burn scar(s) or scar(s) due to other causes, not of the head, face, or neck, that are superficial and nonlinear.
7804	Scar(s), unstable or painful.
7805	Scars, other.
7806	Dermatitis or eczema.
7807	Leishmaniasis, American (New World).
7808	Leishmaniasis, Old World.
7809	Lupus erythematosus, discoid.
7811	Tuberculosis luposa (lupus vulgaris).
7813	Dermatophytosis.
7815	Bullous disorders.
7816	Psoriasis.
7817	Exfoliative dermatitis.
7818	Malignant skin neoplasms.
7819	Benign skin neoplasms.
7820	Infections of the skin.
7821	Cutaneous manifestations of collagen-vascular diseases.
7822	Papulosquamous disorders.
7823	Vitiligo.
7824	Keratinization, diseases.
7825	Urticaria.
7826	Vasculitis, primary cutaneous.
7827	Erythema multiforme.
7828	Acne.
7829	Chloracne.
7830	Scarring alopecia.
7831	Alopecia areata.
7832	Hyperhidrosis.
7833	Malignant melanoma.
THE ENDOCRINE SYSTEM	
7900	Hyperthyroidism.
7901	Thyroid gland, toxic adenoma.
7902	Thyroid gland, nontoxic adenoma.
7903	Hypothyroidism.
7904	Hyperparathyroidism.

Diagnostic Code No.	
7905	Hypoparathyroidism.
7907	Cushing's syndrome.
7908	Acromegaly.
7909	Diabetes insipidus.
7911	Addison's disease.
7912	Pluriglandular syndrome.
7913	Diabetes mellitus.
7914	Malignant neoplasm.
7915	Benign neoplasm.
7916	Hyperpituitarism.
7917	Hyperaldosteronism.
7918	Pheochromocytoma.
7919	C-cell hyperplasia, thyroid.
NEUROLOGICAL CONDITIONS AND CONVULSIVE DISORDERS **Organic Diseases of the Central Nervous System**	
8000	Encephalitis, epidemic, chronic.
Brain, New Growth of	
8002	Malignant.
8003	Benign.
8004	Paralysis agitans.
8005	Bulbar palsy.
8007	Brain, vessels, embolism.
8008	Brain, vessels, thrombosis.
8009	Brain, vessels, hemorrhage.
8010	Myelitis.
8011	Poliomyelitis, anterior.
8012	Hematomyelia.
8013	Syphilis, cerebrospinal.
8014	Syphilis, meningovascular.
8015	Tabes dorsalis.
8017	Amyotrophic lateral sclerosis.
8018	Multiple sclerosis.
8019	Meningitis, cerebrospinal, epidemic.
8020	Brain, abscess.
Spinal Cord, New Growths	
8021	Malignant.
8022	Benign.
8023	Progressive muscular atrophy.
8024	Syringomyelia.
8025	Myasthenia gravis.
8045	Residuals of traumatic brain injury (TBI).
8046	Cerebral arteriosclerosis.
Miscellaneous Diseases	
8100	Migraine
8103	Tic, convulsive.
8104	Paramyoclonus multiplex.
8105	Chorea, Sydenham's.
8106	Chorea, Huntington's.
8107	Athetosis, acquired.
8108	Narcolepsy.
The Cranial Nerves	
8205	Fifth (trigeminal), paralysis.
8207	Seventh (facial), paralysis.
8209	Ninth (glossopharyngeal), paralysis.
8210	Tenth (pneumogastric, vagus), paralysis.
8211	Eleventh (spinal accessory, external branch), paralysis.
8212	Twelfth (hypoglossal), paralysis.
8305	Neuritis, fifth cranial nerve.
8307	Neuritis, seventh cranial nerve.
8309	Neuritis, ninth cranial nerve.
8310	Neuritis, tenth cranial nerve.
8311	Neuritis, eleventh cranial nerve.
8312	Neuritis, twelfth cranial nerve.
8405	Neuralgia, fifth cranial nerve.
8407	Neuralgia, seventh cranial nerve.

Diagnostic Code No.	
8409	Neuralgia, ninth cranial nerve.
8410	Neuralgia, tenth cranial nerve.
8411	Neuralgia, eleventh cranial nerve.
8412	Neuralgia, twelfth cranial nerve.
Peripheral Nerves	
8510	Upper radicular group, paralysis.
8511	Middle radicular group, paralysis.
8512	Lower radicular group, paralysis.
8513	All radicular groups, paralysis.
8514	Musculospiral nerve (radial), paralysis.
8515	Median nerve, paralysis.
8516	Ulnar nerve, paralysis.
8517	Musculocutaneous nerve, paralysis.
8518	Circumflex nerve, paralysis.
8519	Long thoracic nerve, paralysis.
8520	Sciatic nerve, paralysis.
8521	External popliteal nerve (common peroneal), paralysis.
8522	Musculocutaneous nerve (superficial peroneal), paralysis.
8523	Anterior tibial nerve (deep peroneal), paralysis.
8524	Internal popliteal nerve (tibial), paralysis.
8525	Posterior tibial nerve, paralysis.
8526	Anterior crural nerve (femoral), paralysis.
8527	Internal saphenous nerve, paralysis.
8528	Obturator nerve, paralysis.
8529	External cutaneous nerve of thigh, paralysis.
8530	Ilio-inguinal nerve, paralysis.
8540	Soft-tissue sarcoma (Neurogenic origin).
8610	Neuritis, upper radicular group.
8611	Neuritis, middle radicular group.
8612	Neuritis, lower radicular group.
8613	Neuritis, all radicular group.
8614	Neuritis, musculospiral (radial) nerve.
8615	Neuritis, median nerve.
8616	Neuritis, ulnar nerve.
8617	Neuritis, musculocutaneous nerve.
8618	Neuritis, circumflex nerve.
8619	Neuritis, long thoracic nerve.
8620	Neuritis, sciatic nerve.
8621	Neuritis, external popliteal (common peroneal) nerve.
8622	Neuritis, musculocutaneous (superficial peroneal) nerve.
8623	Neuritis, anterior tibial (deep peroneal) nerve.
8624	Neuritis, internal popliteal (tibial) nerve.
8625	Neuritis, posterior tibial nerve.
8626	Neuritis, anterior crural (femoral) nerve.
8627	Neuritis, internal saphenous nerve.
8628	Neuritis, obturator nerve.
8629	Neuritis, external cutaneous nerve of thigh.
8630	Neuritis, ilio-inguinal nerve.
8710	Neuralgia, upper radicular group.
8711	Neuralgia, middle radicular group.
8712	Neuralgia, lower radicular group.
8713	Neuralgia, all radicular groups.
8714	Neuralgia, musculospiral nerve (radial).
8715	Neuralgia, median nerve.
8716	Neuralgia, ulnar nerve.
8717	Neuralgia, musculocutaneous nerve.
8718	Neuralgia, circumflex nerve.
8719	Neuralgia, long thoracic nerve.
8720	Neuralgia, sciatic nerve.
8721	Neuralgia, external popliteal nerve (common peroneal).
8722	Neuralgia, musculocutaneous nerve (superficial peroneal).
8723	Neuralgia, anterior tibial nerve (deep peroneal).
8724	Neuralgia, internal popliteal nerve (tibial).
8725	Neuralgia, posterior tibial nerve.
8726	Neuralgia, anterior crural nerve (femoral).
8727	Neuralgia, internal saphenous nerve.
8728	Neuralgia, obturator nerve.
8729	Neuralgia, external cutaneous nerve of thigh.
8730	Neuralgia, ilio-inguinal nerve.
The Epilepsies	
8910	Grand mal.

Diagnostic Code No.	
8911	Petit mal.
8912	Jacksonian and focal motor or sensory.
8913	Diencephalic.
8914	Psychomotor.
	Mental Disorders
9201	Schizophrenia, disorganized type.
9202	Schizophrenia, catatonic type.
9203	Schizophrenia, paranoid type.
9204	Schizophrenia, undifferentiated type.
9205	Schizophrenia, residual type.
9208	Delusional disorder.
9210	Psychotic disorder.
9211	Schizoaffective disorder.
	Delirium, Dementia, Amnestic and Other Cognitive Disorders
9300	Delirium.
9301	Dementia due to infection.
9304	Dementia due to head trauma.
9305	Vascular dementia.
9310	Dementia of unknown etiology.
9312	Dementia of Alzheimer's type.
9326	Dementia due to other medical conditions.
9327	Organic mental disorder.
	Anxiety Disorders
9400	Generalized anxiety disorder.
9403	Specific (simple) phobia.
9404	Obsessive compulsive disorder.
9410	Other and unspecified neurosis.
9411	Posttraumatic stress disorder.
9412	Panic disorder.
9413	Anxiety disorder, not otherwise specified.
	Dissociative Disorder
9416	Amnesia, fugue, identity disorder.
9417	Depersonalization disorder.
	Somatoform Disorders
9421	Somatization disorder.
9422	Pain disorder.
9423	Undifferentiated somatoform disorder.
9424	Conversion disorder.
9425	Hypochondriasis.
	Mood Disorders
9431	Cyclothymic disorder.
9432	Bipolar disorder.
9433	Dysthymic disorder.
9434	Major depressive disorder.
9435	Mood disorder not otherwise specified.
	Chronic Adjustment Disorder
9440	Chronic adjustment disorder.
	Eating Disorders
9520	Anorexia nervosa.
9521	Bulimia nervosa.
	DENTAL AND ORAL CONDITIONS
9900	Maxilla or mandible, chronic.
9901	Mandible, loss of, complete.
9902	Mandible, loss of approximately one-half.
9903	Mandible, nonunion.
9904	Mandible, malunion.
9905	Temporomandibular articulation, limited motion.

Diagnostic Code No.	
9906	Ramus, loss of whole or part.
9907	Ramus, loss of less than one-half.
9908	Condyloid process.
9909	Coronoid process.
9911	Hard palate, loss of half or more.
9912	Hard palate, loss of less than half.
9913	Teeth, loss of.
9914	Maxilla, loss of more than half.
9915	Maxilla, loss of half or less.
9916	Maxilla, malunion or nonunion of.

[72 FR 12990, Mar. 20, 2007, as amended at 73 FR 54708, 54711, Sept.. 23, 2008; 74 FR 18467, Apr. 23, 2009; 77 FR 6467, Feb. 8, 2012]

APPENDIX C TO PART 4—ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic code No.
Abscess:	
Brain	8020
Kidney	7501
Lung	6824
Acne	7828
Acromegaly	7908
Actinomycosis	6822
Addison's disease	7911
Agranulocytosis	7702
AL amyloidosis	7717
Alopecia areata	7831
Amebiasis	7321
Amputation:	
Arm:	
Disarticulation	5120
Above insertion of deltoid	5121
Below insertion of deltoid	5122
Digits, five of one hand	5126
Digits, four of one hand:	
Thumb, index, long and ring	5127
Thumb, index, long and little	5128
Thumb, index, ring and little	5129
Thumb, long, ring and little	5130
Index, long, ring and little	5131
Digits, three of one hand:	
Thumb, index and long	5132
Thumb, index and ring	5133
Thumb, index and little	5134
Thumb, long and ring	5135
Thumb, long and little	5136
Thumb, ring and little	5137
Index, long and ring	5138
Index, long and little	5139
Index, ring and little	5140
Long, ring and little	5141
Digits, two of one hand:	
Thumb and index	5142
Thumb and long	5143
Thumb and ring	5144
Thumb and little	5145
Index and long	5146
Index and ring	5147
Index and little	5148
Long and ring	5149
Long and little	5150
Ring and little	5151
Single finger:	
Thumb	5152
Index finger	5153
Long finger	5154
Ring finger	5155
Little finger	5156
Forearm:	
Above insertion of pronator teres	5123

	Diagnostic code No.
Below insertion of pronator teres	5124
Leg:	
With defective stump	5163
Not improvable by prosthesis controlled by natural knee action	5164
At a lower level, permitting prosthesis	5165
Forefoot, proximal to metatarsal bones	5166
Toes, all, without metatarsal loss	5170
Toe, great	5171
Toes, other than great, with removal of metatarsal head	5172
Toes, three or more, without metatarsal involvement	5173
Thigh:	
Disarticulation	5160
Upper third	5161
Middle or lower thirds	5162
Amyotrophic lateral sclerosis	8017
Anatomical loss of:	
Both eyes	6061
One eye, with visual acuity of other eye:	
5/200 (1.5/60)	6063
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6064
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6065
20/40 (6/12)	6066
Both feet	5107
Both hands	5106
One hand and one foot	5108
One foot and loss of use of one hand	5105
One hand and loss of use of one foot	5104
Anemia	7700
Aneurysm:	
Aortic	7110
Large artery	7111
Small artery	7112
Angioneurotic edema	7118
Ankylosis:	
Ankle	5270
Digits, individual:	
Thumb	5224
Index finger	5225
Long finger	5226
Ring or little finger	5227
Elbow	5205
Hand	
Favorable:	
Five digits of one hand	5220
Four digits of one hand	5221
Three digits of one hand	5222
Two digits of one hand	5223
Unfavorable:	
Five digits of one hand	5216
Four digits of one hand	5217
Three digits of one hand	5218
Two digits of one hand	5219
Hip	5250
Knee	5256
Scapulohumeral articulation	5200
Subastragalar or tarsal joint	5272
Wrist	5214
Ankylosing spondylitis	5240
Aphakia	6029
Aphonia, organic	6519
Aplastic anemia	7716
Arrhythmia:	
Supraventricular	7010
Ventricular	7011
Arteriosclerosis obliterans	7114
Arteriosclerotic heart disease	7005
Arteriovenous fistula	7113
Arthritis:	
Degenerative (hypertrophic or osteoarthritis)	5003
Due to trauma	5010
Gonorrheal	5004
Other types	5009
Pneumococcic	5005

	Diagnostic code No.
Rheumatoid (atrophic)	5002
Streptococcic	5008
Syphilitic	5007
Typhoid	5006
Asbestosis	6833
Aspergillosis	6838
Asthma, bronchial	6602
Astragalectomy	5274
Atherosclerotic renal disease	7534
Athetosis	8107
Atrioventricular block	7015
Avitaminosis	6313
Bartonellosis	6306
Beriberi	6314
Bladder:	
Calculus in	7515
Fistula in	7516
Injury of	7517
Neurogenic	7542
Blastomycosis	6836
Blindness: *see also* Vision and Anatomical Loss	
Both eyes, only light perception	6062
One eye, only light perception and other eye:	
5/200 (1.5/60)	6067
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6068
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6069
20/40 (6/12)	6070
Bones:	
Caisson disease	5011
New growths, benign	5015
New growths, malignant	5012
Shortening of the lower extremity	5275
Brain:	
Abscess	8020
Breast surgery	7626
Bronchiectasis	6601
Bronchitis	6600
Brucellosis	6316
Buerger's disease	7115
Bulbar palsy	8005
Bullous disorders	7815
Bursitis	5019
Cardiac:	
Pacemakers, implantable	7018
Transplantation	7019
Cardiomyopathy	7020
C-cell hyperplasia, thyroid	7919
Cataract:	
Senile and others	6028
Traumatic	6027
Cerebral arteriosclerosis	8046
Cervical strain	5237
Cervix disease or injury	7612
Chorea:	
Huntington's	8106
Sydenham's	8105
Chloracne	7829
Cholangitis, chronic	7316
Cholecystitis, chronic	7314
Cholelithiasis, chronic	7315
Cholera, Asiatic	6300
Choroiditis	6005
Chronic Fatigue Syndrome (CFS)	6354
Chronic lung abscess	6824
Chronic obstructive pulmonary disease	6604
Coccidioidomycosis	6835
Cold injury residuals	7122
Colitis, ulcerative	7323
Conjunctivitis:	
Trachomatous	6017
Other	6018
Coronary bypass surgery	7017
Cryptococcosis	6837

	Diagnostic code No.
Cushing's syndrome	7907
Cutaneous manifestations of collagen-vascular diseases	7821
Cyclitis	6004
Cystitis, chronic	7512
Dacryocystitis	6031
Dermatitis or eczema	7806
Dermatophytosis	7813
Desquamative interstitial pneumonitis	6826
Diabetes:	
Insipidus	7909
Mellitus	7913
Diaphragm:	
Paralysis or paresis	6840
Rupture	5324
Diplopia	6090
Diplopia, limited muscle function, eye	6092
Disease:	
Addison's	7911
Buerger's	7115
Chronic obstructive pulmonary disease	6604
Hodgkin's	7709
Leprosy (Hansen's)	6302
Lyme	6319
Morton's	5279
Parasitic	6320
Disfigurement of, head, face or neck	7800
Dislocated:	
Cartilage, semilunar	5258
Lens, crystalline	6033
Disseminated intravascular coagulation	7540
Distomiasis, intestinal or hepatic	7324
Diverticulitis	7327
Dysentery, bacillary	7322
Ectropion	6020
Embolism, brain	8007
Emphysema, pulmonary	6603
Encephalitis, epidemic, chronic	8000
Endocarditis	7001
Endometriosis	7629
Enteritis, chronic	7325
Enterocolitis, chronic	7326
Entropion	6021
Eosinophilic granuloma of lung	6828
Epididymo-orchitis	7525
Epilepsies:	
Diencephalic	8913
Grand mal	8910
Jacksonian and focal motor or sensory	8912
Petit mal	8911
Psychomotor	8914
Epiphora	6025
Erythema multiforme	7827
Erythromelalgia	7119
Esophagus:	
Diverticulum	7205
Spasm	7204
Stricture	7203
Exfoliative dermatitis	7817
Fallopian tube	7614
Fever:	
Relapsing	6308
Rheumatic	6309
Fibrosis of lung, diffuse interstitial	6825
Fibromyalgia	5025
Fistula in ano	7335
Fistula:	
Rectovaginal	7624
Urethrovaginal	7625
Flatfoot, acquired	5276
Gastritis, hypertrophic	7307
Genu recurvatum	5263
Glaucoma:	
Congestive or inflammatory	6012

	Diagnostic code No.
Simple, primary, noncongestive	6013
Glomerulonephritis	7536
Gout	5017
Hallux:	
Rigidus	5281
Valgus	5280
Hammer toe	5282
Heart valve replacement	7016
Hematomyelia	8012
Hemorrhage:	
Brain	8009
Intra-ocular	6007
Hemorrhoids	7336
Hepatitis C	7354
Hernia:	
Femoral	7340
Hiatal	7346
Inguinal	7338
Muscle	5326
Ventral	7339
Hip:	
Degenerative arthritis	5242
Flail joint	5254
Histoplasmosis	6834
HIV-Related Illness	6351
Hodgkin's disease	7709
Hydrarthrosis, intermittent	5018
Hydronephrosis	7509
Hyperaldosteronism	7917
Hyperhidrosis	7832
Hyperparathyroidism	7904
Hyperpituitarism	7916
Hypersensitivity	6831
Hypertensive:	
Heart disease	7007
Vascular disease	7101
Hyperthyroid heart disease	7008
Hyperthyroidism	7900
Hypoparathyroidism	7905
Hypothyroidism	7903
Impairment of:	
Humerus	5202
Clavicle or scapula	5203
Elbow	5209
Thigh	5253
Femur	5255
Knee, other	5257
Field vision	6080
Tibia and fibula	5262
Rectum & anus	7332
Ulna	5211
Implantable cardiac pacemakers	7018
Infections of the skin	7820
Injury:	
Bladder	7517
Eye, unhealed	6009
Foot	5284
Gall bladder	7317
Lips	7201
Liver, residuals	7311
Mouth	7200
Muscle:	
Facial	5325
Group I Function: Upward rotation of scapula	5301
Group II Function: Depression of arm	5302
Group III Function: Elevation and abduction of arm	5303
Group IV Function: Stabilization of shoulder	5304
Group V Function: Elbow supination	5305
Group VI Function: Extension of elbow	5306
Group VII Function: Flexion of wrist and fingers	5307
Group VIII Function: Extension of wrist, fingers, thumb	5308
Group IX Function: Forearm muscles	5309
Group X Function: Movement of forefoot and toes	5310

	Diagnostic code No.
Group XI Function: Propulsion of foot	5311
Group XII Function: Dorsiflexion	5312
Group XIII Function: Extension of hip and flexion of knee	5313
Group XIV Function: Extension of knee	5314
Group XV Function: Adduction of hip	5315
Group XVI Function: Flexion of hip	5316
Group XVII Function: Extension of hip	5317
Group XVIII Function: Outward rotation of thigh	5318
Group XIX Function: Abdominal wall and lower thorax	5319
Group XX Function: Postural support of body	5320
Group XXI Function: Respiration	5321
Group XXII Function: Rotary and forward movements, head	5322
Group XXIII Function: Movements of head	5323
Pharynx	6521
Sacroiliac	5236
Spinal cord	6841
Stomach, residuals of	7310
Iritis	6003
Interstitial nephritis	7537
Intervertebral disc syndrome	5243
Intestine, fistula of	7330
Irritable colon syndrome	7319
Keratinization, diseases of	7824
Keratitis	6001
Keratoconus	6035
Kidney:	
Abscess	7501
Cystic diseases	7533
Removal	7500
Transplant	7531
Tuberculosis	7505
Kyphoscoliosis, pectus excavatum / carinatum	6842
Lagophthalmos	6022
Laryngectomy	6518
Laryngitis:	
Tuberculous	6515
Chronic	6516
Larynx, stenosis of	6520
Leishmaniasis:	
American (New World)	7807
Old World	7808
Leprosy (Hansen's Disease)	6302
Leukemia	7703
Limitation of extension:	
Forearm	5207
Leg	5261
Radius	5212
Supination and pronation	5213
Thigh	5251
Limitation of extension and flexion:	
Forearm	5208
Limitation of flexion:	
Forearm	5206
Leg	5260
Thigh	5252
Limitation of motion:	
Ankle	5271
Arm	5201
Index or long finger	5229
Ring or little finger	5230
Temporomandibular articulation	9905
Thumb	5228
Wrist, limitation of motion	5215
Liver:	
Disease, chronic, without cirrhosis	7345
Transplant	7351
Cirrhosis	7312
Loss of:	
Auricle	6207
Condyloid process	9908
Coronoid process	9909
Eyebrows	6023
Eyelashes	6024

	Diagnostic code No.
Eyelids	6032
Mandible:	
One-half	9902
Complete	9901
Maxilla:	
More than half	9914
Less than half	9915
Nose, part of, or scars	6504
Palate, hard:	
Half or more	9911
Less than half	9912
Ramus:	
Whole or part	9906
Less than one-half	9907
Skull, part of	5296
Smell, sense of	6275
Taste, sense of	6276
Teeth, loss of	9913
Tongue, loss of whole or part	7202
Loss of use of:	
Both feet	5110
Both hands	5109
Foot	5167
Hand	5125
One hand and one foot	5111
Lumbosacral strain	5237
Lupus:	
Erythematosus	6350
Erythematosus, discoid	7809
Lyme disease	6319
Lymphatic filariasis	6305
Malaria	6304
Malignant melanoma	7833
Malunion:	
Mandible	9904
Os calcis or astragalus	5273
Maxilla, malunion or nonunion	9916
Melioidosis	6318
Meniere's syndrome	6205
Meningitis, cerebrospinal, epidemic	8019
Mental disorders:	
Anxiety disorders:	
Generalized anxiety disorder	9400
Obsessive compulsive disorder	9404
Other and unspecified neurosis	9410
Not otherwise specified	9413
Panic disorder	9412
Posttraumatic stress disorder	9411
Specific (simple) phobia	9403
Chronic adjustment disorder	9440
Delirium, dementia, amnestic and other cognitive disorders	
Alzheimers	9312
Delirium	9300
Head trauma	9304
Infection	9301
Organic mental disorder	9327
Other medical conditions	9326
Unknown etiology	9310
Vascular dementia	9305
Dissociative disorders:	
Amnesia, fugue, identity disorders	9416
Depersonalization disorder	9417
Eating Disorder:	
Anorexia nervosa	9520
Bulimia nervosa	9521
Mood Disorders:	
Bipolar disorder	9432
Cyclothymic disorder	9431
Dysthymic disorder	9433
Major depressive disorder	9434
Mood disorder not otherwise specified	9435
Schizophrenia and other psychotic disorders:	
Catatonic type	9202

	Diagnostic code No.
Delusional disorder	9208
Disorganized type	9201
Psychotic disorder	9210
Paranoid type	9203
Residual type	9205
Schizoaffective disorder	9211
Undifferentiated type	9204
Somatoform:	
Conversion disorder	9424
Hypochondriasis	9425
Pain disorder	9422
Somatization disorder	9421
Undifferentiated somatoform disorder	9423
Metatarsalgia	5279
Migraine	8100
Morton's disease	5279
Mucormycosis	6839
Multiple sclerosis	8018
Myasthenia gravis	8025
Myelitis	8010
Myocardial infarction	7006
Myositis ossificans	5023
Myositis	5021
Narcolepsy	8108
Neoplasms:	
Benign:	
Digestive system	7344
Ear	6209
Endocrine	7915
Genitourinary	7529
Gynecological or breast	7628
Muscle	5328
Respiratory	6820
Skin	7819
Malignant:	
Digestive system	7343
Ear	6208
Endocrine	7914
Genitourinary	7528
Gynecological or breast	7627
Muscle	5327
Respiratory	6819
Skin	7818
Nephritis, chronic	7502
Nephrolithiasis	7508
Nephrosclerosis, arteriolar	7507
Neuralgia:	
Cranial Nerves	
Fifth (trigeminal)	8405
Seventh (facial)	8407
Ninth (glossopharyngeal)	8409
Tenth (pneumogastric, vagus)	8410
Eleventh (spinal accessory, external branch)	8411
Twelfth (hypoglossal)	8412
Peripheral Nerves	
Upper radicular group	8710
Middle radicular group	8711
Lower radicular group	8712
All radicular groups	8713
Musculospiral (radial)	8714
Median	8715
Ulnar	8716
Musculocutaneous	8717
Circumflex	8718
Long thoracic	8719
Sciatic	8720
External popliteal (common peroneal)	8721
Musculocutaneous (superficial peroneal)	8722
Anterior tibial (deep peroneal)	8723
Internal popliteal (tibial)	8724
Posterior tibial	8725
Anterior crural (femoral)	8726
Internal saphenous	8727

	Diagnostic code No.
Obturator	8728
External cutaneous nerve of thigh	8729
Ilio-inguinal	8730
Neuritis:	
Cranial nerves	
Fifth (trigeminal)	8305
Seventh (facial)	8307
Ninth (glossopharyngeal)	8309
Tenth (pneumogastric, vagus)	8310
Eleventh (spinal accessory, external branch)	8311
Twelfth (hypoglossal)	8312
Optic	6026
Peripheral Nerves	
Upper radicular group	8610
Middle radicular group	8611
Lower radicular group	8612
All radicular groups	8613
Musculospiral (radial)	8614
Median	8615
Ulnar	8616
Musculocutaneous	8617
Circumflex	8618
Long thoracic	8619
Sciatic	8620
External popliteal (common peroneal)	8621
Musculocutaneous (superficial peroneal)	8622
Anterior tibial (deep peroneal)	8623
Internal popliteal (tibial)	8624
Posterior tibial	8625
Anterior crural (femoral)	8626
Internal saphenous	8627
Obturator	8628
External cutaneous nerve of thigh	8629
Ilio-inguinal	8630
Neurogenic bladder	7542
New growths:	
Benign	
Bones	5015
Brain	8003
Eyeball and adnexa	6015
Spinal cord	8022
Malignant	
Bones	5012
Brain	8002
Eyeball	6014
Spinal cord	8021
Nocardiosis	6823
Non-Hodgkin's lymphoma	7715
Nonunion:	
Mandible	9903
Radius and ulna	5210
Nystagmus, central	6016
Osteitis deformans	5016
Osteomalacia	5014
Osteomyelitis	5000
Osteomyelitis maxilla or mandible	9900
Osteoporosis, with joint manifestations	5013
Otitis media:	
Externa	6210
Nonsuppurative	6201
Suppurative	6200
Otosclerosis	6202
Ovaries, atrophy of both	7620
Ovary:	
Disease or injury	7615
Removal	7619
Palsy, bulbar	8005
Pancreatitis	7347
Papillary necrosis	7538
Papulosquamous disorders	7822
Paralysis:	
Accommodation	6030
Agitans	8004

	Diagnostic code No.
Paralysis, nerve:	
Cranial nerves	
Fifth (trigeminal)	8205
Seventh (facial)	8207
Ninth (glossopharyngeal)	8209
Tenth (pneumogastric, vagus)	8210
Eleventh (spinal accessory, external branch)	8211
Twelfth (hypoglossal)	8212
Peripheral Nerves:	
Upper radicular group	8510
Middle radicular group	8511
Lower radicular group	8512
All radicular groups	8513
Musculospiral (radial)	8514
Median	8515
Ulnar	8516
Musculocutaneous	8517
Circumflex	8518
Long thoracic	8519
Sciatic	8520
External popliteal (common peroneal)	8521
Musculocutaneous (superficial peroneal)	8522
Anterior tibial nerve (deep peroneal)	8523
Internal popliteal (tibial)	8524
Posterior tibial nerve	8525
Anterior crural nerve (femoral)	8526
Internal saphenous	8527
Obturator	8528
External cutaneous nerve of thigh	8529
Ilio-inguinal	8530
Paramyoclonus multiplex	8104
Parasitic disease	6320
Pellagra	6315
Penis	
Deformity, with loss of erectile power	7522
Removal of glans	7521
Removal of half or more	7520
Pericardial adhesions	7003
Pericarditis	7002
Periostitis	5022
Peripheral vestibular disorders	6204
Peritoneum, adhesions	7301
Peritonitis	7331
Pes cavus (Claw foot) acquired	5278
Pheochromocytoma	7918
Plague	6307
Pleural effusion or fibrosis	6845
Pluriglandular syndrome	7912
Pneumoconiosis	6832
Pneumonitis & fibrosis:	
Drug-induced	6829
Radiation-induced	6830
Poliomyelitis, anterior	8011
Polycythemia vera	7704
Postgastrectomy syndromes	7308
Post-phlebitic syndrome	7121
Post-surgical residual	6844
Pregnancy, surgical complications	7623
Progressive muscular atrophy	8023
Prostate gland	7527
Prosthetic Implants:	
Ankle replacement	5056
Elbow replacement	5052
Hip replacement	5054
Knee replacement	5055
Shoulder replacement	5051
Wrist replacement	5053
Psoriasis	7816
Pterygium	6034
Ptosis	6019
Pulmonary:	
Alveolar proteinosis	6827
Vascular disease	6817

	Diagnostic code No.
Syringomyelia	8024
Tabes dorsalis	8015
Tarsal or metatarsal bones	5283
Tenosynovitis	5024
Testis:	
Atrophy, complete	7523
Removal	7524
Thrombocytopenia	7705
Thrombosis, brain	8008
Thyroid gland:	
Nontoxic adenoma	7902
Toxic adenoma	7901
Tic, convulsive	8103
Tinnitus, recurrent	6260
Toxic nephropathy	7535
Traumatic brain injury residuals	8045
Traumatic chest wall defect	6843
Tuberculosis:	
Adenitis	7710
Bones and joints	5001
Eye	6010
Kidney	7505
Luposa (lupus vulgaris)	7811
Miliary	6311
Pleurisy, active or inactive	6732
Pulmonary:	
Active, far advanced	6701
Active, moderately advanced	6702
Active, minimal	6703
Active, advancement unspecified	6704
Active, chronic	6730
Inactive, chronic	6731
Inactive, far advanced	6721
Inactive, moderately advanced	6722
Inactive, minimal	6723
Inactive, advancement unspecified	6724
Tuberculosis luposa (lupus vulgaris)	7811
Tympanic membrane	6211
Typhus, scrub	6317
Ulcer:	
Duodenal	7305
Gastric	7304
Marginal	7306
Ureter, stricture of	7511
Ureterolithiasis	7510
Urethra.	
Fistula	7519
Stricture	7518
Urticaria	7825
Uterus:	
And both ovaries, removal	7617
Disease or injury	7613
Displacement	7622
Prolapse	7621
Removal	7618
Uveitis	6000
Vagina, disease or injury	7611
Vagotomy	7348
Valvular heart disease	7000
Varicose veins	7120
Vasculitis, primary cutaneous	7826
Vertebral fracture or dislocation	5235
Visceral Leishmaniasis	6301
Visceroptosis	7342
Vision: *see also* Blindness and Loss of	
One eye 5/200 (1.5/60), with visual acuity of other eye:	
5/200 (1.5/60)	6071
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6072
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6073
20/40 (6/12)	6074
One eye 10/200 (3/60), with visual acuity of other eye:	
10/200 (3/60); 15/200 (4.5/60); 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076

	Diagnostic code No.
20/40 (6/12)	6077
One eye 15/200 (4.5/60), with visual acuity of other eye:	
15/200 (4.5/60) or 20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/200 (6/60), with visual acuity of other eye:	
20/200 (6/60)	6075
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6076
20/40 (6/12)	6077
One eye 20/100 (6/30), with visual acuity of other eye: and other eye:	
20/100 (6/30); 20/70 (6/21); 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/70 (6/21), with visual acuity of other eye:	
20/70 (6/21) or 20/50 (6/15)	6078
20/40 (6/12)	6079
One eye 20/50 (6/15), with visual acuity of other eye:	
20/50 (6/15)	6078
20/40 (6/12)	6079
Each eye 20/40 (6/12)	6079
Vitiligo	7823
Vulva disease or injury of	7610
Weak foot	5277

[72 FR 13003, Mar. 20, 2007, as amended at 73 FR 54708, 54712, Sept. 23, 2008; 73 FR 69554, Nov. 19, 2008; 74 FR 18467, Apr. 23, 2009; 77 FR 6467, Feb. 8, 2012]

PART 5 [RESERVED]

PART 6—UNITED STATES GOVERNMENT LIFE INSURANCE

AUTHORITY: 38 U.S.C. 501, 1940–1963, 1981–1988, unless otherwise noted.

Exhibit D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA

FRANK MOUSSER,)
Plaintiffs,)
VS.)No. 7:23-cv-00667-D
)
UNITED STATES OF AMERICA)
Defendant.)

****
ORAL AND VIDEOTAPED DEPOSITION OF
FRANK MOUSSER
JANUARY 19, 2024
****

ORAL AND VIDEOTAPED DEPOSITION of FRANK MOUSSER, produced as a witness at the instance of the Defendant, and duly sworn, was taken in the above-styled and numbered cause on the 19th day of January, 2024, from 8:52 a.m. to 3:33 p.m., before Rebecca Jones, Certified Shorthand Reporter in and for the State of Texas, reported by computerized stenotype machine, at Holiday Inn Express & Suites, 2801 Jay Road, Seguin, Texas 78155 pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

A P P E A R A N C E S

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Also present:

Videographer, Jason Lemley

I N D E X

ORAL AND VIDEOGRAPHER DEPOSITION OF
FRANK MOUSSER

EXHIBITS

EXHIBITS (CONT'D)

THE VIDEOGRAPHER: We are now on the record. My name is Jason Lemley, I'm a videographer with Golkow Litigation Services. Today's date is January 19th, 2024, and the time is 8:52. This video deposition is being held in Seguin, Texas in the Matter of Frank Mousser versus the United States of America. The deponent is Frank Mousser.

Counsel, please identify yourselves for the video record.

MR. GARAND: My name is Carson Garand, I represent the United States.

MR. CARPENITO: My name is Joshua Carpenito on behalf of the United States.

MR. DOWLING: Mike Dowling on behalf of the Plaintiff.

MR. DAULT: And I'm Brian Dault, I'm from Keller Postman on behalf of the Plaintiff.

THE VIDEOGRAPHER: The court reporter is Rebecca Jones, who will now swear in the witness.

FRANK MOUSSER,

having been first duly sworn, testified as follows:

THE REPORTER: Terrific. Ready to proceed.

EXAMINATION

BY MR. GARAND:

Q. Good morning, Mr. Mousser. My name is Carson Garand as we discussed, and I represent the United States? How are you this morning?

A. Fine. Thank you.

Q. Okay. We are here today in Texas for your deposition taken pursuant to Rule 30 of the Federal Rules of Civil Procedure.

Do you understand that?

A. Yes.

Q. Okay. Let's start by having you state and spell your name for the record, please?

A. My name full?

Q. Yes, please.

A. It's Frank Wayne Mousser, F.R.A.N.K, W.A.Y.N.E, M.O.U.S.S.E.R.

Q. Thank you. Mr. Mousser, I'm going to start by showing you what I've marked as Exhibit 1 for identification, and I'll ask that you examine it.

MR. DOWLING: Carson, just preliminarily, are we stipulating that all objections are reserved except as to form?

MR. GARAND: Correct. Yes, sir.

Q (By Mr. Garand) Mr. Mousser, have you seen this

A. You know, and so -- because, you know, I enjoyed the business. Unfortunately, I -- you know, there was other -- other -- my body had other plans, so...

Q. Would you experience those symptoms weekly, daily?

A. Towards the end they were getting pretty frequent, where I would actually call -- there is entries on my V.A.gov to my doctor about what I was experiencing. Because I basically had, like, a medical diary, and I would -- you know, the fatigue. You know, he said, "Oh, that's low T."

And I'm like, "Doc, I'm 60. Of course, it's going to be low T." You know, I love the V.A. and what they did for me and the medical people, you know, but the road where I'm at today hadn't been -- not an easy one.

Q. Sure.

A. And so, anyway.

Q. Before and, you know, you kind of touched on this a little bit, but before you got sick, were you planning to work part-time at all before fully retiring or just full-time until you retired?

A. No. I planned on working all of the way through -- my wife will tell you she wanted me to work

CHANGES AND SIGNATURE

WITNESS NAME: FRANK MOUSSER

DATE OF DEPOSITION: JANUARY 19, 2024

PAGE LINE CHANGE REASON

I, FRANK MOUSSER, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

____
FRANK MOUSSER

THE STATE OF________________)

COUNTY OF___________________)

, ______________________, on this day personally appeared FRANK MOUSSER, known to me (or proved to me under oath or through attestation of counsel, description of identity card or other document)) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this ____day of ____________, ______.

____
NOTARY PUBLIC IN AND FOR
THE STATE OF ___________

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA

FRANK MOUSSER,)
Plaintiffs,)
VS.)No. 7:23-cv-00667-D
)
UNITED STATES OF AMERICA)
Defendant.)

REPORTER'S CERTIFICATION
ORAL AND VIDEOTAPED DEPOSITION OF FRANK MOUSSER
JANUARY 19, 2024

I, Rebecca Jones, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, FRANK MOUSSER, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

I further certify that pursuant to FRCP Rule 30(e)(1) that the signature of the deponent:

________ was requested by the deponent or a party before the completion of the deposition and is to be returned within 30 days from the date of receipt of the transcript. If returned, the attached Changes and Signature Page contains any changes and the reasons therefor;

________ was not requested by the deponent or a party before the completion of the deposition.

That the amount of time used by each party at the deposition is as follows:

Carson Garand (05 hours:25 minutes)

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes counsel for all parties of record:

FOR THE PLAINTIFF:
CARSON GARAND
JOSHUA CARPENITO
Trial Attorney, Torts Branch
Environmental Torts Litigation Section
U.S. Department Of Justice
P.O. Box 146, Ben Franklin Station
Washington, DC 20044-0146
Telephone: 202.445.0759
E-mail: carson.m.garand@usdoj.gov

FOR THE DEFENDANT:
W. MICHAEL DOWLING
THE DOWLING FIRM PLLC
Post Office Box 27843
Raleigh, North Carolina 27611
Telephone: 512.463.2100
E-mail: mike@dowlingfirm.com

- and -

BRIAN DAULT, ESQUIRE
KELLER POSTMAN, LLC
1101 150 N. Riverside Plaza #4100
Chicago, IL 60606
Telephone: 312.741.5220
E-mail: brian.dault@kellerpostman.com

I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of this action.

Certified to by me this 22nd day of January, 2024.

Rebecca Jones, CSR
Texas CSR #4925
Expiration: 10/31/2025
Firm Registration No. 690
Golkow Litigation Services
One Liberty Place
1650 Market Place, Suite 5150
Philadelphia, PA 19103

Exhibit E

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD. SAFEGUARD IT. | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO.
MCELHINEY Gary Layne	USMC - 11	[redacted]3796

4.a. GRADE, RATE OR RANK	4.b. PAY GRADE	5. DATE OF BIRTH (YYMMDD)	6. RESERVE OBLIG. TERM. DATE
Master Gunnery Sergeant	E-9	54[redacted]	Year 00 Month 00 Day 00

7.a. PLACE OF ENTRY INTO ACTIVE DUTY	7.b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
MCRSC Nashville, TN	[redacted]

8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	8.b. STATION WHERE SEPARATED
2dMaintBn 2dFSSG PSC BOX 20127 CLNC 28542	Same as block 8a RUC 27121

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
CMC (MMSB - 20) RUC 36005	Amount: $ 200,000 ☐ None

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.)

3529 - Motor Transport Maintenance Chief (17 years 8 months)
3531 - Motor Vehicle Operator (3 years 10 months)

12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
a. Date Entered AD This Period	72	04	04
b. Separation Date This Period	95	09	30
c. Net Active Service This Period	23	05	27
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	00	14
f. Foreign Service	00	02	24
g. Sea Service	00	09	01
h. Effective Date of Pay Grade	93	10	01

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

Good Conduct Medal (8th Awd)
National Defense Service Medal (2d Awd)
Sea Service Deployment Ribbon (5th Awd)
Meritorious Mast
Letter of Appreciation
Navy Artic Service Ribbon

14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed)

Advance Auto Mechanic Maintenance Leadership Course 2-TQ 76 (7611)
Advance Auto Maintenance NCO Leadership Course 14 weeks (7609)
Motor Transportation SNCO Leadership Course 16 weeks (7709)

15.a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS' EDUCATIONAL ASSISTANCE PROGRAM	Yes	No	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes	No	16. DAYS ACCRUED LEAVE PAID
		X		X		RLB 0.0 SLB 0.0

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION ☐ Yes ☒ No

18. REMARKS

Good Conduct Medal Period Commences - 930404
Item 13 cont - Navy Achievement Medal, Meritorious Unit Commendation, Armed Forces Expeditionary Medal, Pistol Expert Badge (2d Awd), Rifle Sharpshooter Badge, Navy Commendation Medal
Item 14 cont - Marine Intergrated Maintenance Management Supervisor (8509), Fire Truck 01I Maintenance Course (8603)
"Extent of service was at the request and for the convenience of the government."

19.a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code)	19.b. NEAREST RELATIVE (Name and address - include Zip Code)
[redacted]	Larry Mcelhiney - Brother Same as block 19a

20. MEMBER REQUESTS COPY 6 BE SENT TO TN DIR. OF VET AFFAIRS ☒ Yes ☐ No

21. SIGNATURE OF MEMBER BEING SEPARATED	22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and signature)
Gary L McElhiney	J. K. DANIELS, CW02 USMC [signature]

DD Form 214, NOV 88 S/N 0102-LF-006-5500 Previous editions are obsolete. MEMBER - 1

RECEIVED
DEC 8 1995
Mail Unit
VARO
Montgomery, AL
22

Exhibit F

CAUTION NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD SAFEGUARD IT | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1 NAME *(Last, First Middle)*: TUKES Willie Lee Jr

2 DEPARTMENT, COMPONENT AND BRANCH: USMC-II

3 SOCIAL SECURITY NUMBER: [redacted] 3293

4a GRADE, RATE OR RANK: MGySgt

b PAY GRADE: E-9

5 DATE OF BIRTH *(YYYYMMDD)*: 1963[redacted]

6 RESERVE OBLIGATION TERMINATION DATE *(YYYYMMDD)*: 00000000

7a PLACE OF ENTRY INTO ACTIVE DUTY: MEPS Atlanta GA

b [redacted] **AT TIME OF ENTRY** *(City and state or complete address if known)*

8a LAST DUTY ASSIGNMENT AND MAJOR COMMAND: 2dTankBn 2dMarDiv CamLej NC 28542

b STATION WHERE SEPARATED: MCB IPAC CamLej NC 28542 (RUC 45020)

9 COMMAND TO WHICH TRANSFERRED: CMC (MMSB 20)

10 SGLI COVERAGE NONE — AMOUNT $ 400,000

11 PRIMARY SPECIALTY *(List number title and years and months in specialty List additional specialty numbers and titles involving periods of one or more years)*

2149 Ordnance Vehicle Maintenance Chief 8 years 9 months
0411 Maintenance Management Specialist 3 years
2145 Tracked Vehicle Repairman - 6 years 2 months
2146 Main Battle Tank (MBT) Repairer/Technician 6 years 8 months
0911 Drill Instructor - 5 years 1 month

12 RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a DATE ENTERED AD THIS PERIOD	1981	09	14
b SEPARATION DATE THIS PERIOD	2011	09	30
c NET ACTIVE SERVICE THIS PERIOD	30	00	17
d TOTAL PRIOR ACTIVE SERVICE	00	00	00
e TOTAL PRIOR INACTIVE SERVICE	00	10	13
f FOREIGN SERVICE	03	00	21
g SEA SERVICE	00	00	00
h EFFECTIVE DATE OF PAY GRADE	2006	05	01

13 DECORATIONS MEDALS BADGES CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED *(All periods of service)*

Meritorious Service Medal Marine Corps Good Conduct Medal (10th Awd), Bronze Star Medal, Navy and Marine Corps Commendation Medal (4th Awd), Combat Action Ribbon (Kuwait) Navy and Marine Corps Achievement Medal (2d Awd), Iraq Campaign Medal (w/2 Bronze Service Stars), Sea Service Deployment Ribbon (6th Awd) Global War on Terrorism Service Medal Global War on Terrorism Expeditionary Medal (Kuwait), National Defense Service Medal (2d

14 MILITARY EDUCATION *(Course title number of weeks and month and year completed)*

Ordnance Vehicle Technician crs (GBT) 1996 M1A1 Tank Turret Mechanic crs (GBP) 1992 M1A1 Tank System Mechanic crs (GBN) 1992 Tank System Technician crs (GBG) 1990, Drill Instructor crs (81E) 1986, Green Belt crs (MMD) 2002 Gray Belt crs (MMC) 2002, Tan Belt crs (MMB) 2002

15a MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS EDUCATIONAL ASSISTANCE PROGRAM: X YES

b HIGH SCHOOL GRADUATE OR EQUIVALENT: X YES

16 DAYS ACCRUED LEAVE PAID: RLB 60 0 SLB 0 0

17 MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION: X NO

18 REMARKS

45020-2011-3805
Good Conduct Medal period commences 20110914 Delayed Entry Program (19801031-19810913) SNM did not contribute to the MGIB
Item 13 CONT Marine Corps Drill Instructor Ribbon (2d Awd), Southwest Asia Service Medal (3rd Awd), Kuwait Liberation Medal (Kuwait), Kuwait Liberation Medal (Saudi Arabia), Navy Unit Commendation (2d Awd), Navy Meritorious Unit Commendation, Letter of Appreciation, Meritorious Mast (x3), Rifle Qualification Badge (Marksman) Pistol Qualification Badge (Sharpshooter)
Subject to active duty recall by Service Secretary

The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non Federal agency for verification purposes and to determine eligibility for and/or continued compliance with the requirements of a Federal benefit program.

19a MAILING ADDRESS AFTER SEPARATION *(Include ZIP Code)*: [redacted]

b NEAREST RELATIVE *(Name and address - include ZIP Code)*: Jacqueline Y Tukes (Spouse) Same as Block 19a

20 MEMBER REQUESTS COPY 6 BE SENT TO NC **DIRECTOR OF VETERANS AFFAIRS**: X YES

21 SIGNATURE OF MEMBER BEING SEPARATED: Willie

22 OFFICIAL AUTHORIZED TO SIGN *(Type name grade title and signature)*: D J STRASSER, SSGT, PERSCHF, USMC

SPECIAL ADDITIONAL INFORMATION *(For use by authorized agencies only)*

23 TYPE OF SEPARATION: Retired

24 CHARACTER OF SERVICE *(include upgrades)*: Honorable

25 SEPARATION AUTHORITY: MARCORSEPMAN PAR 2003

26 SEPARATION CODE: RBCD

27 REENTRY CODE: RE-2B

28 NARRATIVE REASON FOR SEPARATION: MAXIMUM SERVICE OR TIME IN GRADE

29 DATES OF TIME LOST DURING THIS PERIOD *(YYYYMMDD)*: None

30 MEMBER REQUESTS COPY 4 *(Initials)*

DD FORM 214, FEB 2000 | PREVIOUS EDITION IS OBSOLETE | SERVICE - 8

Exhibit G

Table 3

Allan Wayne Howard
Offset - Veterans Benefits Administration Payments

Effective Date	Reason(s)	Entitlement	Total	Net Award	Combined Rating	Dep. Status & Entitlement Code
12/1/2024	Cost of Living Adjustment		$ 3,831.30	$ 3,831.30	100%	V
12/1/2023	Cost of Living Adjustment		3,737.85	3,737.85	100%	V
10/1/2023	Compensation Rating Adjustment		3,621.95	3,621.95	100%	V
12/1/2022	Cost of Living Adjustment		731.86	731.86	40%	V
12/1/2021	Cost of Living Adjustment		673.28	673.28	40%	V
12/1/2020	Cost of Living Adjustment		635.77	635.77	40%	V
12/1/2019	Cost of Living Adjustment		627.61	627.61	40%	V
12/1/2018	Cost of Living Adjustment		617.73	617.73	40%	V
12/1/2017	Cost of Living Adjustment		600.90	600.90	40%	V
4/1/2017	Compensation Rating Adjustment		589.12	589.12	40%	V
12/1/2016	Cost of Living Adjustment		133.57	133.57	10%	V
12/1/2014	Cost of Living Adjustment		133.17	133.17	10%	V
1/1/2014	Cost of Living Adjustment		130.94	130.94	10%	V
12/1/2013	Cost of Living Adjustment		130.94	130.94	10%	V
12/1/2012	Cost of Living Adjustment		129.00	129.00	10%	V

Diagnostic Code	Diagnosis Description	Percentage	Effective Date	Rating Decision
7715	Non-Hodgkin's Lymphoma	100%	9/25/2023	Service Connected
7802	Secondary Scars Due to SC Renal Cell Carcinoma	0%	9/25/2023	Service Connected
7500	Renal Cell Carcinoma Status-Post Right Nephrectomy	30%	3/14/2017	Service Connected
7805	Right Flank Scar	0%	3/14/2017	Service Connected
6260	Tinnitus	10%	9/11/2009	Service Connected
6100	Bilateral Hearing Loss	0%	9/11/2009	Service Connected

Table 3

Jefferson Michael Criswell
Offset - Veterans Benefits Administration Payments

Effective Date	Reason(s)	Entitlement	Total	Net Award	Combined Rating	Dep Status & Entitlement Code
12/1/2024	Cost of Living Adjustment	Disability Compensation - Vietnam Era	$ 4,181	$ 4,181	100%	V-S; K-1*
12/1/2023	Cost of Living Adjustment	Disability Compensation - Vietnam Era	4,079	4,079	100%	V-S; K-1
12/1/2022	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,953	3,953	100%	V-S; K-1
12/1/2021	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,636	3,636	100%	V-S; K-1
11/1/2021	Special Monthly Compensation Adjustment	Disability Compensation - Vietnam Era	3,434	3,434	100%	V-S; K-1
12/1/2020	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,809	3,809	SMC 48 S*	V-S; K-1
12/1/2019	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,760	3,760	SMC 48 S	V-S; K-1
12/1/2018	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,701	3,701	SMC 48 S	V-S; K-1
12/1/2017	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,600	3,600	SMC 48 S	V-S; K-1
9/1/2017	Special Monthly Compensation Adjustment	Disability Compensation - Vietnam Era	3,530	3,530	SMC 48 S	V-S; K-1
12/1/2016	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,182	3,182	100%	V-S; K-1
7/1/2015	Special Monthly Compensation Adjustment	Disability Compensation - Vietnam Era	3,172	3,172	100%	V-S; K-1
12/1/2014	Cost of Living Adjustment	Disability Compensation - Vietnam Era	3,069	3,069	100%	V-S
7/18/2014	School Child Adjustment	Disability Compensation - Vietnam Era	3,018	3,018	100%	V-S

Table 3

Jefferson Michael Criswell
Offset - Veterans Benefits Administration Payments

4/1/2014	Compensation Rating Adjustment	Disability Compensation - Vietnam Era	3,273	3,273	100%	V-S-2P
1/1/2014	Cost of Living Adjustment	Disability Compensation - Vietnam Era	1,028	1,028	50%	V-S-2P
12/1/2013	Cost of Living Adjustment	Disability Compensation - Vietnam Era	1,030	1,030	50%	V-S-2P
12/1/2012	Cost of Living Adjustment	Disability Compensation - Vietnam Era	1,014	1,014	50%	V-S-2P
11/1/2012	Compensation Rating Adjustment	Disability Compensation - Vietnam Era	998	998	50%	V-S-2P
2/1/2012	Original Award	Disability Compensation - Vietnam Era	509	509	30%	V-S-2P

*SMC 48 S and K-1 are special monthly compensation rates as defined by the U.S. Department of Veterans Affairs

Diagnostic Code	Diagnosis Description	Percentage	Effective Date	Rating Decision
7528	Bladder Cancer with Residuals, Urinary Incontinence and Frequency	20%	11/1/2021	Service Connected
9434	Unspecified Depressive Disorder with Anxious Stress	100%	8/21/2017	Service Connected
7599-7522	Erectile Dysfunction	0%	6/3/2015	Service Connected
7528	Bladder Cancer with Residuals, Urinary Incontinence and Frequency	100%	4/1/2014	Service Connected
7528	Bladder Cancer with Residuals, Urinary Incontinence and Frequency	100%	3/4/2014	Service Connected
9434	Unspecified Depressive Disorder with Anxious Stress	30%	10/10/2012	Service Connected
6260	Tinnitus	10%	1/11/2012	Service Connected
6100	Hearing Loss	0%	1/11/2012	Service Connected
9434	Unspecified Depressive Disorder with Anxious Stress	30%	1/11/2012	Service Connected
7528	Bladder Cancer with Residuals, Urinary Incontinence and Frequency	20%	1/11/2012	Service Connected