Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

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# RIVLIN-DOMENICI DEFICIT REDUCTION PLAN IS SUPERIOR TO BOWLES-SIMPSON IN MOST AREAS

## But Health Proposal Is Very Troubling

By James Horney, Paul N. Van de Water, and Robert Greenstein

The Rivlin-Domenici deficit reduction plan, which a commission of the Bipartisan Policy Center unveiled last week, marks a significant improvement over a plan from the co-chairs of President Obama's fiscal commission — with the exception of health care, in which the Rivlin-Domenici plan actually is more problematic.

On November 10, the co-chairs of the President's Commission on Fiscal Responsibility and Reform — former Clinton White House Chief of Staff Erskine Bowles and former Republican Senator Alan Simpson — released a plan for their members to consider. The Center on Budget and Policy Priorities issued a report praising the co-chairs both for moving the budget debate beyond exaggerated claims about savings from steps like eliminating earmarks and for recognizing that any serious deficit reduction plan must involve revenue increases as well as spending reductions. The Center noted, however, that the proposal has serious shortcomings and falls well short of a balanced and appropriate plan to put the budget on a sustainable path.[1] We concluded that as the commission continues working to see if it can reach agreement on a plan to formally recommend to the President and Congress, which would require approval by 14 of its 18 members, it should make major improvements to the Bowles-Simpson plan in a number of key areas.

Then, on November 17, a commission of the Bipartisan Policy Center that was co-chaired by former Clinton Office of Management and Budget Director Alice Rivlin and former Republican Senate Budget Committee Chair Pete Domenici released its own deficit reduction plan.[2] The plan helps show how the President's commission could improve the Bowles-Simpson plan in various respects. The plan from the Rivlin-Domenici commission, composed of former elected officials and budget experts from both parties, marks a distinct improvement over Bowles-Simpson in five of the six key areas that the Center identified as especially problematic in Bowles-Simpson.

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[1] James Horney, Paul Van de Water, and Robert Greenstein, "Bowles-Simpson Plan Commendably Puts Everything on the Table But Has Major Deficiencies Because it Lacks an Appropriate Balance Between Program Cuts and Revenue Increases," Center on Budget and Policy Priorities, November 16, 2010.

[2] Debt Reduction Task Force, "Restoring America's Future," Bipartisan Policy Center, November 2010.

Unfortunately, in the remaining key area — health care — the Rivlin-Domenici provisions are actually more problematic than those in Bowles-Simpson. Both plans include proposals that could impair access to adequate health care for millions of lower-income and elderly people who rely on Medicare or Medicaid, or who will become eligible for premium subsidies under the health reform law.

## Five Key Areas in Which Rivlin-Domenici is Superior to Bowles-Simpson

The Rivlin-Domenici proposal is significantly better designed than the Bowles-Simpsons plan in five important areas:

- **It does *not* adopt the unrealistic and arbitrary goal set by Bowles-Simpson of holding spending and revenues to 21 percent of GDP**. A goal of limiting total federal expenditures in future decades to 21 percent of the Gross Domestic Product — the average over the last 40 years — ignores the reality that it will not be possible to meet crucial national needs in coming decades without spending more than in the past.[3]

    - The aging of the population and increases in per-person costs throughout the U.S. health care system (in both the public and private sectors) will increase the cost of meeting longstanding federal commitments to seniors, low-income children and adults, and people with disabilities, thereby driving up costs for Medicare, Medicaid, and Social Security.

    - The federal government's responsibilities have grown significantly over the last decade. They include homeland security (on which the nation spent little in the decades before the September 11 attacks), medical and other assistance to the large numbers of veterans of the Iraq and Afghanistan wars, helping states fulfill education requirements imposed by the No Child Left Behind Act, the Medicare prescription drug benefit enacted in 2003, and the provisions of the health reform law that extend insurance coverage to tens of millions of Americans who otherwise would be uninsured (the health reform legislation *reduced* the deficit, but *increased* federal spending).

    - Spending for interest on the federal government's debt also will be substantially higher in coming decades than it was over the last 40 years, in large part because of the increase in debt resulting from the wars in Iraq and Afghanistan, the large Bush-era tax cuts, and the current severe economic downturn.

    The Rivlin-Domenici commission report accepts the reality that the world and federal responsibilities have changed, and that it will not be possible to meet national needs in coming decades and hold spending to the level deemed appropriate in the past. It proposes major program changes to reduce spending well below what it will be if policies remain unchanged, but it accepts that total federal spending will have to be above 21 percent of

[3] Paul N. Van de Water, "Federal Spending Target of 21 Percent of GDP Not Appropriate Benchmark for Deficit Reduction Efforts," Center on Budget and Policy Priorities, July 28, 2010.

GDP in the decades ahead. *Under the Rivlin-Domenici plan, total spending will equal approximately 23 percent of GDP in 2020 and rise to somewhat higher levels in later years*; *revenues will equal about 21.5 percent of GDP in 2020 and also be somewhat higher in subsequent years*.[4] (Under the Rivlin-Domenici plan, the budget would not be balanced, but the deficit would be reduced to such an extent that the debt-to-GDP ratio would be brought down from the approximately 70 percent of GDP projected for the end of this year to 52 percent of GDP in 2030 and 2040.[5] Most budget analysts agree that the crucial fiscal policy goal is not to balance the budget but rather to stabilize the debt as a share of GDP at a tolerable level,[6] which the Rivlin-Domenici plan would do.)

- **It has a much better balance between spending cuts and revenue increases.** The Bowles-Simpson proposal achieves roughly *two-thirds* of its deficit reduction through program cuts and just one-third through increased revenues. According to the Bipartisan Policy Center task force report, the Rivlin-Domenici plan achieves a much more even balance, securing roughly half of its proposed savings from program cuts and half from revenue increases. About 54 percent of its savings over the 2012-2020 period and about 52 percent over the 2012-2040 period would come from increased revenues.[7] (It should be noted that the Rivlin-Domenici plan measures savings in discretionary spending from a baseline that has higher levels of discretionary spending than the baseline that Bowles and Simpson use.[8]) As a result of achieving more of the proposed deficit reduction through revenue increases, the Rivlin-Domenici plan is able to reduce the deficit in 2020 to the same level as Bowles and Simpson *without* budget cuts that threaten as much harm as the cuts that Bowles and Simpson have advanced.

- **It proposes to achieve Social Security solvency through a better balanced of benefit cuts and revenue increases.** The Social Security component of the Bowles-Simpson plan is heavily weighted toward benefit cuts. The benefit reductions are wide ranging and would affect nearly all beneficiaries, except for some with very low earnings. Indeed, the benefit reductions that Bowles and Simpson propose account for about *two-thirds* of the plan's Social

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[4] One reason that revenues would rise relative to GDP after 2020 under the Rivlin-Domenici plan is the plan's proposal to phase out the tax exclusion for employer-provided health insurance premiums. The exclusion would be phased out over ten years starting in 2018, which would produce increasing revenue over this period. In addition, under current law, the cost of the employer exclusion will rise faster over time than GDP, so the savings from eliminating the exclusion continue to grow over time.

[5] Reducing deficits to slightly less than 3 percent of GDP by the middle of this decade would stabilize the debt-to-GDP ratio at whatever level it would have reached by that point. The Rivlin-Domenici plan brings deficits down *well below* 3 percent of GDP — to 1.2 percent of GDP in 2015 and 1.5 percent of GDP in 2020 — thereby reducing the debt-to-GDP ratio.

[6] For a discussion of stabilizing the debt-to-GDP ratio as the appropriate fiscal goal, see National Academy of Sciences and National Academy of Public Administration, "Choosing the Nation's Fiscal Future," January 2010, p. 50.

[7] These calculations of the share of spending savings for both plans exclude reductions in net interest payments, since those reductions are the result of both spending cuts and revenue increases.

[8] The Rivlin-Domenici baseline assumes discretionary funding will grow from the 2011 level at the rate of GDP. The Bowles-Simpson baseline assumes discretionary spending at the levels proposed by the President in his fiscal year 2011 budget. If the Rivlin-Domenici savings were calculated from the Bowles-Simpson baseline, the share of savings attributed to spending cuts would be significantly smaller than one-half; sufficient detail is not available on the plan to allow a precise calculation.

Security financing improvements over the next 75 years — and about *four-fifths* of the improvement in the 75th year. The Rivlin-Domenici plan is much better balanced. Benefits cuts represent less than half of the improvement in solvency over 75 years and about half of the improvement in the 75th year.

Through changes in the retirement age or the benefit formula, both plans would reduce basic Social Security benefits for future beneficiaries. Both plans also include an increase in the minimum benefit for long-time low-wage earners. But the more balanced approach in the Rivlin-Domenici plan allows them to propose smaller reductions for beneficiaries who are in the middle of the earnings spectrum. Under the Bowles-Simpson plan, the benefit in retirement for a person who has been a medium earner (someone earning about $43,000 in today's terms) would be cut by 15 percent below the currently scheduled amount in 2050. Under the Rivlin-Domenici plan, the reduction would be 9 percent. This difference is important because the benefits for middle earners are already modest — just $1,397 a month ($16,764 a year) for a lifelong medium earner retiring at age 65 in 2010. This benefit is only about 55 percent above the poverty line and barely more than what researchers reckon is a "no-frills, bare-bones" budget for retirees.[9] The typical retiree does not have significant income from other sources.

- **It proposes more realistic reductions in nondefense discretionary programs**. The Bowles-Simpson plan proposes to cut funding for nondefense discretionary programs in 2015 approximately $100 billion below what the President requested. (A similar reduction is proposed for defense spending.) This represents a cut of a little more than 15 percent below what the President proposed for 2015 in last February's budget (and a little less than 15 percent below the amount appropriated for 2010, adjusted for inflation). Cuts of this size would reduce the ability of the federal government to meet important needs, threatening funding for elementary and secondary education, law enforcement activities, basic scientific and medical research, and the basic operations of government.

  The difficulty of cutting programs enough to get the proposed savings is suggested by the fact that in the "illustrative" list of domestic discretionary cuts that Bowles and Simpson have issued, nearly half of the required savings in nondefense discretionary programs come from measures aimed at the federal workforce — freezing federal employee compensation (on top of proposed mandatory savings from reducing retirement benefits for federal employees), cutting the federal workforce in non-security agencies by 10 percent, and eliminating 250,000 nondefense contractors. As budget experts have noted, it is hard to imagine that all of these cuts could be made without seriously impairing the ability of federal agencies to function effectively.[10] If these steep federal workforce savings were *not* achieved, then cuts in other areas of domestic discretionary spending — like funding for education,

[9] The Department of Health and Human Services defines the 2010 poverty guideline for a one-person household (of any age) in the lower 48 states as $10,830. An "Elder Economic Security Index" developed by Wider Opportunities for Women estimates that a minimal standard of living for an elder person living alone housing in 2006 averaged $15,134 for those in owner-occupied housing and $19,541 for those in rental housing; see http://www.wowonline.org/ourprograms/eesi/documents/NatlEESIIndexFAQs.pdf.

[10] Stan Collender, "The Bowles-Simpson Deficit Reduction Plan Doesn't Add Up," November 11, 2010, http://capitalgainsandgames.com/blog/stan-collender/2036/bowles-simpson-deficit-reduction-plan-doesnt-add.

medical and scientific research, and services for disadvantaged people — would have to be even deeper.

Measured on a comparable basis, the cuts in nondefense discretionary funding proposed by the Rivlin-Domenici task force in 2015 appear to be roughly two-thirds as large as those proposed by Bowles and Simpson. (The dollar amount of savings stated in the materials that the Rivlin-Domenici task force released is larger, but that is because the savings are measured from a baseline that assumes a higher level of funding for discretionary programs than the baseline that Bowles and Simpson use.) Achieving the reductions proposed by Rivlin and Domenici would still be extremely difficult to accomplish without causing harm, but the cuts they endorse are more realistic than what Bowles and Simpson have proposed.

- **It is much less likely than the Bowles-Simpson plan to undercut the economic recovery.** Bowles and Simpson state that a key principle guiding any deficit reduction plan should be "don't disrupt a fragile economic recovery." Nevertheless, their plan proposes to begin implementing policy changes to reduce the deficit (beyond the reduction that will occur automatically as the economy recovers) in 2012, when the Congressional Budget Office projects unemployment will still average 8.4 percent and economic output will still be far below its potential. (CBO projects the gap between actual and potential GDP will not be closed until the end of 2014.) Implementing deficit reduction that soon, as opposed to enacting deficit reduction provisions now that will be implemented *after* the economy is healthy, poses a risk of undercutting the economy.

  The Rivlin-Domenici plan, too, proposes to begin implementing deficit reduction in 2012, but it poses far less risk to the economy because it would first put the economic recovery on a firmer footing by boosting economic activity and job creation in 2011 and 2012 through a one-year Social Security payroll-tax holiday. This estimated $650 billion tax cut would increase the deficit in 2011 and 2012 (because the tax cut would still be in effect in the first quarter of fiscal year 2012), but the boost to economic activity and job creation would produce a more robust economy in which to make the transition to lower long-term deficits.

## Rivlin-Domenici Health Care Proposal Has Serious Shortcomings

Although superior in other areas, the Rivlin-Domenici proposal is even more troubling than the Bowles-Simpson plan with respect to health care. Rivlin and Domenici propose $756 billion in health care budget cuts over the next ten years. Included in their plan is a tax on sweetened beverages, whose consumption contributes significantly to obesity.[11] Setting aside this sound tax proposal, Rivlin and Domenici propose reducing health care spending by $600 billion over ten years — considerably more than the $482 billion in reductions proposed by Bowles and Simpson. Three proposals, in particular, would likely result in harm to tens of millions of vulnerable Medicare and Medicaid beneficiaries.

[11] Chuck Marr and Gillian Brunet, *Taxing High-Sugar Soft Drinks Could Help Pay for Health Reform*, Center on Budget and Policy Priorities, May 27, 2009, http://www.cbpp.org/files/5-27-09health2.pdf.

*Substantially Increasing Medicare Premiums and Cost Sharing.* The Rivlin-Domenici proposal would raise Medicare Part B premiums by *40 percent* for most beneficiaries. In 2010 terms, that represents an increase of about $500 a year. (The increase would be phased in over five years starting in 2012.) The proposal would also increase cost-sharing charges (deductibles and co-insurance), but it would place a limit (sometimes called a "catastrophic cap") on the total amount of cost-sharing that a beneficiary would have to pay in any year. Overall, many beneficiaries would have to pay hundreds of dollars a year more. Beneficiaries with incomes under $10,830 (for a single individual) would be protected.[12] But beneficiaries above that level would face higher out-of-pocket costs, which almost certainly would deter use of some needed health care by people with small incomes — a group that includes many elderly widows and frail people with chronic health conditions. Moreover, because the Rivlin-Domenici deficit reduction plan includes reductions in Social Security benefits, as well, Medicare beneficiaries — whose median income today is only about $23,000 — would have less income available with which to pay the substantially higher Medicare premiums and cost-sharing charges they would face.

*Converting Medicare into a Premium Support System.* Starting in 2018, the Rivlin-Domenici plan would effectively provide a voucher to Medicare beneficiaries, which they would use to help pay the costs of enrolling either in traditional fee-for-service Medicare or a competing private insurance plan. The voucher, however, would be set to grow only at the rate of growth of GDP per capita plus 1 percent, which would likely fail to keep pace with rising Medicare costs (and rising cost throughout the U.S. health care system). This means that a beneficiary who wished to remain in traditional Medicare would have to pay a higher premium to cover the difference between the cost of that coverage and the voucher amount.

Alternatively, a beneficiary could choose to enroll in a competing private health plan that had a lower premium because it held down costs by being more efficient, using a more limited network of providers, imposing better utilization management, or through other action. Plans with limited networks, however, might not be suitable for people in poorer health, those in rural areas, those with restricted mobility, or beneficiaries in nursing homes. Furthermore, if private plans were given leeway to construct their provider networks and to design their benefit packages in ways to attract healthier-than-average beneficiaries and deter sicker ones, as private Medicare Advantage plans have done, traditional Medicare would likely end up with sicker enrollees and higher costs. ("Risk adjustment" mechanisms are imperfect and likely would not fully compensate for such differences in enrollee pools.) If this occurred, costs per beneficiary in traditional Medicare would mount, and it could become increasingly unsustainable over time.

To avoid this outcome, it may be possible *in theory* to structure a premium support system to assure that traditional Medicare and the private plans compete on a level playing field and that private plans do not enroll healthier beneficiaries, on average. Traditional Medicare would need authority to offer an integrated benefit package, including drug and supplemental coverage, and to update that package in response to changes in the health care system and the insurance market.[13] In

[12] Medicaid pays the Medicare premium and cost-sharing charges for Medicare beneficiaries with incomes below the poverty line ($10,830 for an individual and $14,570 for a couple in 2010). Medicare beneficiaries with incomes between 100 percent and 135 percent of poverty ($14,620 for an individual) are eligible for assistance with their Medicare premiums, but not with cost-sharing charges.

[13] It appears that the revised cost-sharing structure in the proposal applies only to Part A (hospital insurance) and Part B (supplementary medical insurance), not Part D (prescription drugs).

addition, the private plans would have to be subject to substantial regulation; it would be necessary to limit those plans to offering standardized benefit packages (to ensure that benefit packages were not designed to deter sicker individuals) and to preclude them from offering additional services designed to entice healthier enrollees. *In practice,* securing congressional approval for legislation allowing or requiring such regulation would be extremely difficult, as would monitoring and enforcing such regulations adequately and effectively.

Moreover, even in the unlikely event that sufficient features could be incorporated into a premium support system to provide a truly level playing field, the Rivlin-Domenici premium-support proposal would still be highly problematic. Because the vouchers that it would provide to purchase coverage would fail to keep pace with rising health care costs, beneficiaries — whether they enrolled in traditional Medicare *or* in private plans — would likely pay steadily higher premiums and cost-sharing charges, and receive increasingly less comprehensive benefits, over time. Beneficiaries who were sufficiently affluent could afford to pay the higher charges directly or to buy supplemental health coverage that would fill in the coverage gaps. But beneficiaries of modest means would have difficulty, especially since their Social Security benefits also would be reduced. The ultimate result would likely be to create a two-tier health care system, in which elderly and disabled people with enough money get full access to needed treatments and medical advances, but those of lesser means find the latest medical innovations to be out of reach.

*Capping Medicaid Growth.* The Rivlin-Domenici plan proposes to reduce "the amount by which growth in Medicaid costs exceeds the growth of GDP…by 1 percent per year." It does not explain clearly how it would meet this target. The task force's report suggests ending the current Medicaid financing structure, under which the federal government picks up a fixed percentage of a state's Medicaid costs. Instead, the federal government would take over all of the costs of certain aspects of Medicaid, with states responsible for all of the costs of other aspects. Since this reallocation of responsibilities is supposed to be implemented "in a budget-neutral manner," however, it is hard to see how it would help achieve the target, unless funding for the federal portion of Medicaid were capped and reduced below the levels needed to cover increases in health care costs. The task force's report also states that "[o]ther approaches are possible and should be explored."

Reducing federal funding for Medicaid in this manner would shift significant costs and risks to states, low-income beneficiaries, and health care providers. States would either have to increase their own contributions to Medicaid or, as is more likely, offset the losses in federal funding by exercising the greater flexibility they would be given under a reallocation of responsibilities. For example, they might cap Medicaid enrollment and impose waiting lists (which they cannot do today), significantly scale back eligibility for millions of children, parents, seniors or people with disabilities (which would push most of the affected individuals into the ranks of the uninsured), or cut covered health services significantly (which would cause many of those affected to become underinsured).

The risks would likely be greatest for poor people with severe disabilities, who often need an extensive array of health services. Many states likely would curtail benefits such as mental health services and therapies, a number of which are critically needed by people with disabilities and children with special health care needs. States also could significantly raise cost sharing (Medicaid does not charge premiums and requires only modest co-payments.) But an extensive body of research shows that even modest cost-sharing deters the use of needed care by people with low incomes.

Furthermore, states likely would have no choice but to reduce provider payment rates further, even though Medicaid already pays providers much lower rates than Medicare or private health insurance. Provider reimbursement cuts almost certainly would drive more providers out of Medicaid, reducing beneficiaries' access to health care. Provider cuts also would place additional pressures on safety-net providers, who already will have to care for increasing numbers of uninsured or underinsured people if Medicaid eligibility has been cut back, Medicaid enrollment capped, or Medicaid benefits significantly reduced.

The proposed cuts in Medicaid would also threaten the viability of the recently enacted health reform law. About half of the uninsured people who will gain coverage under the Affordable Care Act are supposed to receive it through Medicaid. Substantial cuts in federal financing for state Medicaid programs are incompatible with the health reform law's mandated expansion of Medicaid coverage; Medicaid eligibility cutbacks or enrollment caps also would be incompatible with the new law. In addition, if Medicaid is to cover 16 million new beneficiaries as the health reform law envisions, it will need to attract *more* health care providers; but cuts in already-low Medicaid provider rates will result in *fewer* providers participating.

The bottom line is that it will be impossible to achieve the magnitude of savings in Medicare and Medicaid proposed by the Rivlin-Domenici task force (or by Bowles and Simpson) without doing serious harm to many of the most vulnerable people in the nation, unless the growth in private health spending (that is, in health care costs *systemwide*) also is slowed. This is a point that health care experts from across the political spectrum have made for some time.

Growth in federal health care costs is *not* driven by factors that are unique to Medicare, Medicaid, and other public programs. To the contrary, for the past 30 years, per-beneficiary spending in Medicare and Medicaid has grown at rates nearly identical to those for the overall health care system. Attempting to force very large additional cuts in federal health programs like Medicare and Medicaid beyond those included in the health reform law *without* comparable measures to restrain the growth of private-sector health-care costs would seriously impair the access of Medicare and Medicaid beneficiaries to doctors and hospitals. This is an area in which the Rivlin-Domenici plan joins the Bowles-Simpson plan in needing substantial improvement.