Center for Strategic and International Studies (CSIS)

The Imperative of Entitlement Reform and Health Care Cost Control

Moderator:
Former Senator Sam Nunn (D-GA)

Panel One

Featuring:
William H. Frist (R-TN),
Former U.S. Senate Majority Leader;
Donna Shalala,
Former U.S. Secretary of Health and Human Services

Panel Two

Featuring:
John B. Taylor
Former U.S. Under Secretary of the Treasury for International Affairs;
Alice Rivlin,
Former Director of the White House Office of Management and Budget

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SAM NUNN: I think we'll get ready to get started. John Hamre, you want to –

JOHN HAMRE: Yes, indeed, I will give us the invocation. (Laughter.) Welcome, everybody. We're delighted you're here. This is the fourth in a series that we've been hosting. We are – we're partnered with other institutions. And it's a broad-based effort to try to bring a debate to America during a presidential election that seems to be remarkably substance-free. I mean, we've got lots of – lots of anger in the room, but we don't have a lot of conversation knowledge, and that's what we're trying to supplant. And we want to say thank you to all of you for being a part of that, for making it possible for us to do this.

As you will see, this is a slightly modified version of something familiar in Washington, which is a congressional hearing. And we do have members of Congress who are going to be here, and they are going to be participating in dialogue with witnesses to talk about the crucial issues that we face in this country. I want to say a very sincere thank-you to these former members of Congress that still feel compelled by the urgency of the day to take this important role. None of them, you know, finds this a premier thing to do with their time, but they think it's urgent for the country's well-being. And I want to say thank you to all of you.

Senator Nunn, let me turn it over to you, and we'll get this started. (Inaudible.)

MR. NUNN: OK, John. Thank you very much. We welcome everyone here to the fourth, as John said, forum. We call it "Strengthening of America – Our Children's Future." So thank you, John, to you and the entire CSIS team – including particularly Craig Cohen, Andrew Schwartz, Ryan Sickles – for hosting us and doing so much to make these forums a success. I also want to thank Bob Bixby, who heads The Concord Coalition, Jeff Thiebert and – Thiebert and other valuable members of the Concord team who have made this effort possible. Steve Bell – Pete Domenici and Steve have worked together for many years, and Steve is at the Bipartisan Policy Center and has been a big part of this. And Valeria MacPhail on my staff, who reminds me every day that she is the only female keeping all of these males straight in terms of the staff effort right now.

MR. : It only took one.

MR. NUNN: (Chuckles.) That's right. (Laughter.)

This is an effort of a number of organizations who have a variety of perspectives. But the common denominator is that all of us believe that America's current fiscal course is both irresponsible, unsustainable and dangerous. These organization include The Concord Coalition, the Center for Strategic and International Studies, the Bipartisan Policy Center, the American Business Conference, the James A. Baker III Institute of Public Policy at Rice University, the Belfer Center at Harvard University, the Hoover Institute (sic; Institution) at Stanford University – including John Taylor, who is one of our distinguished panelists here today – and the Woodrow Wilson International Center for Scholars – Jane Harman, who has been in two of our hearings – and former CBO director Rudy Penner of the Urban Institute has also been a key adviser. And I see John Endean here from the American Business Conference – John, thank you, and Al West, and all who have helped us here.

These forums are part of a larger effort with many allies. We're working in full cooperation with the Campaign to Fix the Debt, chaired by former New Hampshire Senator Judd Gregg and former Pennsylvania Governor Ed Rendell and led by the Committee for a Responsible Federal Budget's president, Maya MacGuineas. We're also working closely in this quest for fiscal sanity with David Walker's Comeback America Initiative and the Peter G. Peterson Foundation's ongoing and invaluable effort to call attention to the fiscal challenges that threaten our nation's future. Particularly thanks to Pete Peterson and Michael and the Peterson Foundation for their financial support, without which we would not be able to pay our bills. So we're very grateful for that.

Pete Domenici and I are co-chairing these forums with our colleague – colleagues Warren Rudman and Evan Bayh. Evan has joined us today; Warren could not be with us. We've assembled a bipartisan group of 35 former members of the Senate and House who have signed on to this initiative and whose names you can see in your program. Pete and Evan and I are honored to have with us today former Senators Bill Brock and Byron Dorgan and former Representative Bill Frenzel.

We've come together in the heat of an election campaign because of our growing concern that our nation's perilous fiscal position and our growing frustration with the seeming inability of Democrats and Republicans to work together to find solutions. Both sides seem to have a political strategy – not much doubt about that – but their governing strategy is in doubt, to say the least. If this doesn't change, our fiscal woes will deepen, public cynicism will fester and financial markets will grow increasingly alarmed. As we should have learned by now from Europe, markets are comfortable until suddenly they are not, a point made very clearly by two of our first witnesses in the first forum, Bob Rubin and Jim Baker.

Previous forums have examined the financial, the international and the national security implications of our nation's troubling fiscal outlook, the opportunity for pro-growth tax reform and the potential for bipartisan solutions. In these forums we've heard from distinguished speakers such as James Baker, Robert Rubin, Robert Gates, Michael Mullen, Erskine Bowles, Alan Simpson, Marty Feldstein, Larry Summers, Alice Rivlin and of course my co-chair, Pete Domenici. He and Alice chaired a parallel commission – a very important effort – to Simpson-Bowles.

Our focus today is health care and entitlement reform. At today's forum we will hear from Alice Rivlin of the Brookings Institute making her second appearance, which, Alice, demonstrates both your great wisdom and your high threshold for pain. We appreciate you being here for both; as well as John Taylor at the Hoover Institute (sic; Institution). They'll be on our second panel; as well as our first panel, former HHS Secretary Donna Shalala and former Senate majority leader Bill Frist.

There are many parts of the puzzle that must fit together to solve our problems and to get us on a sound course, including tax reform, streamlining our military budget while maintaining our strength and encouraging strong, sustainable economic growth. Congress and the executive branch must also – over the short term, medium term and long term – do a much, much better job

of oversight, keeping track of which programs, including tax preferences, work and weeding out those that do not.

No task, however, is as important as gaining control of our rapid – of the rapid growth of our major entitlement programs, including the three largest ones, Medicare, Medicaid and Social Security. The projected growth of these three programs, which run on autopilot, accounts for the entire projected increase of federal spending as a share of the economy over the coming decades, excluding interest on the debt. And Pete Domenici has a chart, which he may use again today, to demonstrate that pretty clearly.

Let me just make a couple of observations before we turn it over to Pete and our fellow panelists, as well as the people who will be enlightening us today, Donna and Bill Frist. First, these programs we're talking about that are growing so rapidly are very successful and very important programs. They have vastly improved the standard of living among the elderly and disabled in our country. Dismantling these programs is simply not on the agenda.

Second, regardless of how successful these programs have been, they are not on a sound financial footing for the future. In the case of Social Security and Medicare, promised benefits far exceed dedicated sources of income from the payroll tax and beneficiary premiums. Over the next 25 years, the annual costs of Social Security and the major health care entitlements are projected to grow about six to – about – by about 6 percent of the gross domestic product, caused in large part by the blessing – the blessing of increased life expectancy but also by increased medical costs per capita. At some point our nation must recognize that programs that were created when the average life expectancy was 65 must be adjusted when life expectancy moves to 80.

That is why entitlement reform is the central fiscal challenge. During these forums we have, I think, clearly demonstrated the magnitude of the fiscal challenge, why the American people should care about it and why both political parties have to work together to solve it. Today is the last forum for the time being but certainly not the end of our activities. We will issue a report on these programs in the next few weeks, and we will be active in the policy debate when the election season ends and the governing session begins.

I remain optimistic. In the end, I believe that all Americans, regardless of political affiliation, will recognize that this is not just about numbers; it's a moral and generational issue and challenge. I remain optimistic. Winston Churchill famously said, America will always do the right thing after we have tried every other alternative. Fiscally, I hope that we are ending – nearing the end of Churchill's prophecy.

So Pete, with that, I'll turn the mic over to you.

PETE DOMENICI: Well, thank you very much, Sam. And to our fellow members of Congress who are with us today, thank you so much for coming today and for your support in the past, particularly Evan Bayh. You have not – been unable to be with us, but you've been with us as we put this event together. Thank you for that.

Let me say, Senator Nunn, that I want to emphasize how critical the subject that I'm going to talk about is to both federal and state and fiscal challenges, and most importantly, to the American economy. We have one chart with us. It seems to sum it up for me. And for the federal fiscal level, we can see the chart that's before you. Everyone take a look. This is an easy one to remember the problem of your country by calling it the blue line. Some people think that based upon their memory of things and the feeling of things, the blue line is something very healthy, very – it's the kind of thing you want to do.

Well, in this case, you see, the blue line wins. But the problem is that it's winning so much that it loses, we lose, the government – the United States, not the government – the United States loses, because as this one chart sums it up, this is what's happening to the health – government – United States government health care cost, up, up and away, while the other four basic programs of our national government, Social Security, discretionary spending, you can see them there. They're all controllable, but not the health care costs. It's just gone up, up and away. The health care spending rises dramatically.

And the Bipartisan Policy Center recent report, which was authored by Senators Frist, Daschle, myself, notes that several factors are driving this. Sam has alluded to them. I will summarize them. First, health care inflation, although subdued the past few years, there's no doubt that it will reaccelerate as the onslaught of retiring baby boomers further – baby boomers further age and increase their utilization of the health care services. Secondly, baby boomers' demographic means that we are adding about 10,000 Americans each day to Medicare, 10,000 each day. It is estimated that 52 percent of the spending growth in the federal health care programs over the two decades will be due to this demographic tsunami. Did you get it? Obviously it's a big, big event.

So we face a double whammy: more seniors, which we're thrilled about, more costly medical care for each senior, and we did not figure – count on either as we told these people what they would be getting from their government, these wonderful senior citizens. We don't have to hurt them or harm them, but we must reform the program so that the blue line – best way I can put it is if that blue line that you see can be broken, and instead of continuing up, if you can – if you can make it where it turns a bit. And even if it's 10 years out, when it turns, but it's real, then you have begun to solve this problem. You must break that curve, which is upward, and turn it downward.

The escalating costs are not confined just to federal programs. Each and every American faces a reality of health care cost increases, and they affect various plans, which you no longer can continue – which, no longer will work, just like the federal government's programs that we have before us. The increasing of public cost transfers into the private sector, hurt businesses, hurt competitiveness and potential employment.

Now, finding a way to finance our health care system is urgent and necessary. We've got to bend the health care cost curve, as I indicated. We need health care and economic policy leaders to work together. They can't be off talking aside and talking on some way to solve something that the other kind – other's not looking at.

The Bipartisan Policy Center study that I mentioned has begun to look at alternative policies that might contain the growth of health care spending in this country. There are – there is a program; there is proposal, but we're looking at more and better ones to see if we can have more to offer as Congress in the not-too-distant future, hopefully, begins to try to solve this problem.

We've made promises as elected officials to Medicare and Medicaid, to military retirees and others. We cannot keep those promises without reforming tax and program policies that impact the health care sector. We hope our Health Care Cost Containment Initiative will inform needed policies and policy changes that will benefit both the public and the private health care sector in addressing these escalating costs.

So Mr. Chairman, it's been my privilege to work on this. I'm hoping that from it those who must solve our country's problems in the not-too-distant future will understand that the list of organizations that you as our co-chairman announced when you were talking about who's with us, when the list grows by the day, if they find out – if there are groups in America that find out this is going on, they want to join.

Why is it that everybody tells us this has to be done? Why is it that so many groups that represent America's interest and have millions of members, why is it that they want to join in fixing it, and yet we continue to wait, not knowing when the axe will fall, but knowing from our experts that it would not be a good day for America if, in fact, our sovereign dollar was truly put in jeopardy? That could indeed happen.

Thank you very much.

MR. NUNN: Thank you very much, Pete.

Evan, do you have any observations here?

EVAN BAYH: Well, just a – just a couple, Sam. First, to you and Pete, I want to thank you for your leadership. I wish Warren all the best. He's been a good friend.

I'd say it's an honor to be with our panelists today. Senator Frist, for a period of years, was the leader of the other political party, but he's still my friend, and someone I could work with and was always a voice for reason, so Bill, it's great to be with you again here today.

I first met Donna Shalala when I was a humble governor from my state of Indiana and she was the secretary of education, and just performed outstandingly in that capacity. And I've admired from a distance, Donna, the work you've been doing at the University of Miami. As a matter of fact, I think I can say I agree with Donna Shalala on almost everything, with the possible exception of who we'll be rooting for in the Miami-Notre Dame game this weekend, so – (laughter) – forgive me for that but, you know, football loyalties are parochial.

And to all of you, I want to thank you for being here, because ultimately this is going to be a job for the American people. As Harry Truman once famously said, in the United States,

it's not the politicians that run the country. In the United States, it's the people. The politicians, we're just the hired help.

So it's important through forums like this to get out the word about the importance of tackling this issue and to educate the American people about the best way to go about it. Promoting economic growth, first and foremost, is something that would do wonders to solve our fiscal problems. Secondly, looking intelligently at the tax base, how to organize that efficiently to promote investment, job creation and also pay for our national defense, servicing the debt and the other things, the other obligations that we have to meet. And finally, the issue of spending. As the lines that Pete was referring to show, domestic discretionary spending is pretty much under control. Military spending will be coming down as a consequence of unwinding the conflicts in Iraq and Afghanistan. Social Security is politically very difficult, sometimes referred to as the third rail of American politics, but not conceptually that hard. And I would anticipate that that would be among the things that will be recommended.

The hardest part is the topic for our panels today, and that's what to do about that blue line that Pete referred to that is just going up, part of which is to be expected, and not altogether a bad thing. Our population is aging, as my colleagues have pointed out. There are advancements in medical technology and treating people. That's a good thing.

But it can't continue to go two or three times the rate of inflation as far as that line extends without eventually gobbling everything else up. Oh, and by the way, some of the most obvious areas of savings have already been utilized for other initiatives our government has recently adopted, making the challenge even more difficult.

So we're really here today to – the final thing I'd say, Sam, is just to conclude by saying – there is – I think it's a Chinese proverb that says that the real test of statesmanship is someone who plants a tree in whose shade they will never rest. Many of the solutions we're here today to discuss and hopefully put into place will only bear fruit 10, 20, 30 years from now. But in so doing, we'll strengthen our country and enrich our children's lives. And to me, that is a true test of statesmanship. And Sam and Pete, I want to thank you for meeting that test today.

MR. NUNN: Thank you very much, Evan. And we appreciate your being part of this group from the very beginning, and your leadership.

Bill Brock – and have any opening comments?

WILLIAM EMERSON "BILL" BROCK III: Maybe less than a minute.

When Evan and others talked about the American people being the boss, they have to know what the problem is. There's nobody telling them. There's no serious debate at the national level about debt. And it's eating us up.

And if you look at the solutions – if in fact entitlements are taking every single dollar of federal revenue every year, entitlements take it all, what's left are all the discretionary – federal employees, national security, health, education – all those have to be funded by debt. So

anybody that tells you we can cut our way to stability – I started to say, may be smoking something strange, but – (laughter) – it's irresponsible.

If you look at the alternative and say, maybe we can solve this by taxes – to solve it by taxes, you'd have to raise taxes 50 percent on every living American. It's irresponsible to say we can solve it by taxes.

All of this has to be part of the whole – everybody's going to have to take a piece of the pain. Somebody has to tell us the truth. That's, I hope, what we can contribute to it, because if we don't kick-start this campaign and tell the American people the problem, they're not going to know. And when we try to solve it next year they're going to be screaming, oh, you didn't tell us that. Well, we didn't, and that's our fault.

MR. BAYH: Sam, can I correct something? I just said – I don't want people to think I'm completely senile yet. I was thinking about Donna's tenure at Miami and previous to that at Wisconsin – of course, she was secretary of HHS, not secretary of education, Donna, so – you'd make a great secretary of education, by the way – (laughter) – but you know, maybe that's your next career.

MR. NUNN: Thank you, Evan.

Warren?

WARREN RUDMAN: Sam, thank you very much. I'll take only one minute. You have, I think – and Evan quoted the Chinese proverb and Churchill; let me quote Garrison Keillor – (laughter) – who said: We were raised by people who taught us that life is an enormous struggle. And if at some point you should feel really happy, be patient, it'll pass. (Laughter.) And it reminds me kind of of the somber mood of this subject. To solve this will be painful. Not to solve it will be very painful and very destructive to this country's economic future. It is not overstating it at all to say that our economic future is now at stake.

So thank you, Sam, and Pete, and the rest of you who have convened us, as well.

MR. NUNN: Thank you.

Bill?

MR. : Thank you, Mr. Chairman. Thanks to everybody; look forward to hearing from these great witnesses.

MR. NUNN: OK, let me give a very brief introduction of both of our witnesses. And both of them have had so many achievements I could go on forever, but I will make it very abbreviated.

Dr. Donna Shalala became professor of political science and president of the University of Miami on June 1 of 2001; has had more than 30 years of experience as an accomplished scholar, teacher and administrator. In 1993, Bill Clinton – President Bill Clinton appointed Donna U.S. secretary of health and human services, HHS, where she served for eight years, becoming the longest-serving HHS secretary in U.S. history. At the end of her tenure as HHS secretary, The Washington Post described her as, quote, "one of the most successful governmental managers of modern times;" end quote. President Shalala has more than four dozen honorary degrees and a host of other honors.

In 2008, President Bush presented her with the Presidential Medal of Freedom, the nation's highest civilian award. And in 2010, she also received the Nelson Mandela Award for Health and Human Rights. Donna, we're delighted to have you.

And let me give Bill a brief introduction, and then we'll go from Donna to Bill with their statements.

Bill Frist is both a nationally recognized heart and lung transplant surgeon and former U.S. Senate majority leader. Senator and Dr. Bill Frist is uniquely qualified to join us today to discuss health care policy issues such as cost control. At the Bipartisan Policy Center, Senator Frist along with Senators Tom Daschle and Pete Domenici and Dr. Alice Rivlin, leads the Health Care Cost Containment Initiative, which will be seeking approaches to contain health care cost growth on a system-wide basis while enhancing health care quality and value.

Senator Frist represented Tennessee in the U.S. Senate for 12 years, where he served on both health and finance committees responsible for health legislation; he was elected majority leader of the Senate in 2003. Dr. Frist's latest book, "A Heart to Serve: The Passion to Bring Health, Hope and Healing," discusses how his family shaped his values, his arduous path to leadership and service to others through heart transplantation, his jump to serving a larger community through the political world and his commitment to global health and communities around the world.

Bill Frist is continuing to be fully focused and fully engaged and dedicated to the many important facets, challenges and opportunities of our health care field as well as many other fields. So Bill, we're delighted to have you and Donna.

Pete, do you want to say a word?

MR. DOMENICI: Well, if I didn't say a word about Bill he would wonder if I had changed my mind and decided that I didn't care a lot about him anymore; that would be a terrible thing.

So I just want to say – Sam and fellow members, I remember – you know, I remind you often that I'm kind of losing my memory a bit, but this one, I don't know why I remember it – but he was standing on the floor of the Senate and he looked like he wanted to go somewhere. And I said, what's – what – where are you going, Bill? And he said, I'm going to the White House. I said, now; it's middle of the afternoon. Yeah, he said, somebody else is going to

manage here, nothing much going on; I'm going to the White House. What for? He said, I'm going to see the president. What for? He said, I'm going to talk about the president of the United States supporting the largest program to save human lives that has ever been initiated. And I said, you are? Yes.

Well, I learned shortly afterwards that that afternoon yielded the program that our then-president initiated for the HIV treatment, where there was a new breakthrough. And the only country that could afford to pay for it and save millions of lives was the United States of America. And the president was President Bush. And that afternoon, he started a talk which ended up with that program being adopted.

I thought maybe everybody ought to know, in spite of the things – in addition to the things Sam talked about, he did just little things like causing the United States of America to do what I just described. It's – he does little things like that, kind of – in a timely – and manner that many of us don't quite understand, but he sure gets them done. Thanks, Sam. Thank you, Bill.

MR. NUNN: Thanks, Pete. Thank you both for being here.

Donna, we'll let you lead off, if that's OK.

DONNA SHALALA: (Off mic) – and I said we're going to be here – (audio break). Of course, it's an honor to be here with all of you. I was very wary of coming with an election going on, but Alice Rivlin prevailed on me, as she often has. I run a billion dollar-plus academic health system, so I spend most of my time down in the weeds of health care, not in the broader policy issues. So I thought this would be fun, to deal with some of the broader issues.

Budget experts though here in D.C. could do all the analysis that they want, but as you have carefully pointed out, each of you, you'll not achieve what we all want if we don't integrate the health policy much better in the political community into whatever our discussions are. This is a different beast than some of the other areas for discussion.

And I worry about the public. They continue to react very negatively to what they perceive as budget-driven set of reforms, particularly to the health care system. They don't trust Washington, they don't think Medicare is the reason for the deficit. No matter how much we talk to them about the driving cost of health care, they're very wary of everything that we've been proposing.

And interestingly, for now, Medicare is growing at below GDP per capita growth rates and us – as such, earlier cuts will be very hard to come by. This is not to say that we don't need to do significantly more and to really get our house in order for the next 10 to 20 years. But we have to be careful of front-loaded, excessively large, poorly-designed, budget-driven health policy, which has the potential to hurt the economy and patience and undermine our real desire to reform a much-needed-to-be-reformed health care delivery system. And more than anything, I do believe the health care system needs to be reformed.

The bipartisan policy report and the 13 major cost containment recommendations are very significant because it's one of the first times that they've been summarized together. But each of those recommendations have their own politics. In fact, I teach the politics of health care. And each of those recommendations, I could do my 50-minute lecture on the stakeholders and the very complicated politics that surround each one of those.

So as we work our way through, we have to be both careful and, I think – (audio break) – discussion about what we can do with health care to try to contain costs over a very long time, and in the process, make the delivery of health care more seamless, of higher quality, with much better outcomes. That's the point. We want a better health care system at the end of the day, not a weaker health care system at the end of the day. We spend a lot of money on health care, and we know that. But it can't just be the federal government and it can't just be Congress. As your own reports point out, the states have a significant role here. I just finished chairing for the Institute of Medicine a report on the future of nursing. The fact is, there are serious state restraints in this country, as the report pointed out, on health care providers. They invest significantly in training nurses, physicians' assistants and other professionals, pharmacists, and then don't let them work up to their training level. They restrain what they can do in the health care system.

Unless we see health care as a team sport, we're not going to get this job done.

So without going through all the cost-sharing or the value-oriented benefit designs that both Bill and I (tend ?) to discuss, let me – let me make one final point. And actually, Senator, you gave me the opening. The great running backs at Notre Dame and at the University of Miami are patient. They wait until the holes open up. That also describes the political system when it's most successful in the United States. It sees the holes and it makes the holes.

And we have to take advantage of what is an opportunity of a lifetime to reform the health care system over a period of time, but make sure that all of the stakeholders are at the table with us in the redesign of a system that needs to fundamentally be redesigned – whether it's eliminating fee-for-service, or allowing health care providers to work together as teams or controlling the costs of chronic illness, or eliminating the very heavy costs that all of us bear at the end of life while not diminishing or reducing the values that we have in this country.

Thank you very much.

MR. NUNN (?): Thank you very much, Donna. Bill?

DR. FRIST: Thank you, and it's great to be with everybody and to be back in town here. And I hope the next few minutes can reflect, in the question and discussion, a little bit about what the real world is like. And I say that part in jest, but I think it is a very important issue because much, much of the discussion here misses the dynamic of how health care is actually delivered. (Audio break.)

And Donna mentioned that she is, in essence, on the front line, sort of in the weeds, but unless you are there, which most of Washington is not, the real magic of what a doctor-patient

relationship or a nurse-patient relationship is all about – the integration of being able to respond with science but do it in a way of artistry and understanding of how you change behavior, which is a cultural element which it's hard to get to when you're looking just at budgetary issues. The importance of innovation – and I look at my own world, where I've done hundreds of heart and lung transplants – I've used artificial hearts, I've used lasers, I've done thousands of operations, I've written 20,000 prescriptions over time. All of that never gets really reflected in the discussions here. And it really did not in the development of the Affordable Care Act.

And – you know, obviously I'm exaggerating a little bit, but to me, the genius of what we're going to have to address, which Washington probably isn't going to want to – we'll approach it from the budget end because we got to, but Washington and – and you see it play out in the presidential races – in all likelihood, they're not going to want to come back and address the macro health care issues.

The federal outlays that we just looked at – and the focus will be on Medicare for good reason, but that's a $550 billion program of a $2 ½ trillion health care system that has this genius and magic and dynamism and artistry that affects all of us in a very intimate way. And you really can't dissociate them. And that's why we can't look at it just as a budgetary issue, which from the greatness of America – which depends on the debt, which depends on the annual deficits, which depends on entitlements, and the only entitlement that really matters, if you really look at what's underlying that chart that Pete showed, is Medicare, the one that's going to be increasing over the next 75 years. And that depends on the value equation. And the value equation in its numerator has outcomes, it has results, has healing, has health, has prevention, but in the denominator is the dollar sign. Per dollar invested.

And the Affordable Care Act did not do that. We can put all the demonstration projects – it didn't. It's an insurance bill, it's an access bill, it's a fairness bill, it's an equity bill, it is a moral imperative bill – and that's good stuff, and it's important stuff, but the central organizing principle of that bill did not focus on cost. Did not focus on the denominator of the equation itself. And yet, that's what we have to do. To (march out ?) greatness of America, entitlements, deficit – or debt, deficit, entitlement – Medicare is where the action is. And I just hope that we can address it.

The budgetary approach to it is a good one. It really comes down to what Pete – what Senator Domenici said. We have a doubling of the number of seniors coming in over the next 25 years, so we got more people that we got to take care of. The per capita cost is going up. It's going up for all the people in health care, we know, but that particular group is going up because of chronic diseases most of them have. And almost everybody will have, 99 percent will – (audio break) – have some sort of chronic – (audio break) – twice as many. The per capita cost is going up – and we'll come back to that in discussion. And then what Pete didn't mention is that we have fewer people paying in. We just don't have – we used to have 5-to-1 and 4-to-1 and 3-to-1 workers paying in. So we just – the equation does not work.

So then we have to decide how to – how to fix it, because it has to be fixed. And the fixing it, it can't just be caps, can't just be GDP plus a half percent, 1 percent. It's going to be part of it, but the organic part of it, the system, the system delivery, where the technology and the

innovation and the prevention and giving birth and disability and fighting autism and Alzheimer's is exploding, and obesity, which is tripling our costs, which wasn't a problem three – all that's got to be addressed, and has to be done through delivery systems. And the preservation of innovation and creativity and delivery. America has been great, and we're proud of it. And I love it. I was in London two days ago and I just love comparing America to anywhere in the world in terms of innovation.

And the innovation itself has been in medical imaging with the MRIs and PET scans. It's been in artificial hearts. It's been – nobody had done lung transplants when I started my training and then I ended up doing them routinely every week. I mean, it's unbelievable. All of that innovation we do need to protect over time, but it does cost money as we go forward. So we have to be careful to protect it.

Washington said, well, we put $50 billion in NIH. That's good, but 70 (billion dollars) to $80 billion comes out of the big, bad pharmaceutical companies and the big, bad device companies. Let's just tax them more. Seventy (billion dollars) to $80 billion of research – much more – (inaudible) – comes there and another $20 billion comes out of universities and private foundations and the like. And it's the integration of these models that we've got to protect over time.

Let me just close off – because the BP's say – the Bipartisan Policy committee – put out a good – (audio break) – that does affect the larger back-row issue of health care if you're not going to be covering people at age 65, you're going to move it up, but also the population part of that equation you can look at in terms of maybe not focusing on all of them, maybe do a little more means testing like we did in the Medicare Modernization Act, maybe focus on those with chronic disease and non-chronic disease. So there's a lot you can do in the equation.

But it's cost equals population plus unit serviced – how many – how many services you do – times the cost of the service and then you had to add administration. And that's the equation: population – well, cost equals population times number of services, cost of each of those services plus administration. And then you just have to go down each one of those and see how complex it is, but how you can't just put a single cap – or, if you put a single cap, you're going to have to look at the intertwining of that relationship.

And I hope that we'll have an opportunity to do that over the course of the next couple of hours and look at a number of those issues. But if you look at it in that way, you do exactly what Donna said. In the population, what do you do? Can we take care of everybody with the same level of care or do you need to focus? You move over and you look at the services – well, Washington basically says, get rid of fee for service. That's good, but it's too simple.

MS. SHALALA: And too hard.

DR. FRIST: It's hard, but it's getting easier. But it's just too simple. You got to –

MR. NUNN: What are you talking about? What –

DR. FRIST: Fee for service. (Inaudible) – basically people will say if you get rid of fee for service and go to, you know, population help, all of which is very good, it will take up. But that's not what's necessarily driving the number of services. All of a sudden – as a doctor, I come in and I see somebody with prostate cancer and I've got six different ways that can treat that, all driven by technology – unbelievable technology. The outcome is the same. But technology drives the number of services that I can offer an individual coming in.

The number of service is driven by the American culture. I was in London two days ago and I was talking to patients there and they said we just don't expect to have the very best all the time. And we don't expect to have chemotherapy at the end of life. But our American expectations, culture – well, that's not a medical system, a health care system, that's a change in culture, that's a change in behavior.

We got to start thinking about Facebook and social networking actually how do you change culture itself? If you move over to the cost per service – that the number of services – to the cost per service, again heart transplants just cost a lot of money; putting seeds in the prostrate just costs a lot of money today. And then, of course, if you move over to administration people say that's easy to cut – (audio break) – by productivity, that's part of administrative costs. So it's too simplistic to say just medical loss ratio.

Anyway, the cost issue is there. The equation is simple. It is the greatness of America that focuses on Medicare and that's the significance, I think, of this discussion today.

MR. NUNN: Thank you, Bill. One of the things that's frustrating, I think, is to read that the other industrial countries basically spend a lot less per capita portion of GNP than we do. Two questions on that. Number one, is that accurate in your view and do they get better or worse results? Do we get better results for the amount we spend? Either of you.

MS. SHALALA: Well, there – we have completely different systems. They spend – other countries of the world spend a lot less on pharmaceuticals, for example, because they negotiate for bigger populations and they've been doing that for a very long period of time – it's been more central. We have a much more fragmented system. So we spend 2.3 percent, I think, more on pharmaceuticals than other countries.

On other kinds of health care professionals, we simply – we do pay our people more. Our professionals make more money than other professionals in other countries. There's no question about that. They're either salaried –

DR. FRIST: And that's a good thing.

MS. SHALALA: And that's – our people consider that a very good thing.

DR. FRIST: Our doctors get paid more – (inaudible) – that's good thing.

MS. SHALALA: Our doctors certainly get paid more than they do in other countries. Do they get better health outcomes? The evidence is yes, but some of that is because they have

more homogeneous populations. So it's a tricky measure. But do other countries – most of the rest of the world has more centralized systems, they pay less for all of the services, they're more tough-minded about specialists and people getting to specialists, they put more money on the front end for primary care. So there are a number of explanations for why that takes place, and Bill has –

DR. FRIST: Let me – let me jump in, because this is a great – a great thing because The New York Times always opens with that. So I'm glad you opened with it, it's important. United States of America spends twice as much per capita either in absolute terms or its percentage of GDP than any of the OECD – the other comparable countries on average. Spends twice as much, our outcomes are much, much less, and therefore we need – whatever you want to put: universal health care, socialized medicine, "Nixoncare," "Clintoncare," whatever. That's what they always say: We need more universal insurance.

That's always what it is. So everybody should be thinking right now, well, how do you answer that? Is that right? To answer your question, number one, if you got cancer, you want to go to nowhere else but the United States of America. And right now, there's probably a 30 percent chance you're going to die of cancer. If you have heart disease – if you have significant heart disease you're not going to want to go to any other country than America. If you have a heart attack right now or a stroke right now, you want to be in America today. And there's probably a 35 percent chance you're going to die of heart disease.

But if you look at mortality and how long you're going to live, you don't want to be in the United States. You want to be 26 other countries. (Laughter.) And if you're going to have a baby, you don't want to be in the United – on average – you don't want to be in the United States. You want to go to 30 other countries to have that baby. So to answer your question: yes and no. But if you use how long you live, it's right. We spend twice as much, our outcomes are much, much worse than the average – (inaudible) – countries in infant mortality.

So then you say – and this is probably the most important thing I'll say today – then you'll say, why? And Donna started to list them but it's pretty easy actually. Take any endpoint you want – and you can put cost in there, you can put how long you live and you can put infant mortality. We're going to put how long you live because it's easy and that's the one that The New York Times is quoting. What determines how long you live today?

If you take 600 of the sort of macrostudies out there and you put them together -- and you can do the same thing globally and you can do it here in the United States – how long you live, which is the outcome that you're referring to, is driven by what? Genetics? Human genome project – very successful project, by the way, public-private partnership. Finished on time, under – started 1990 and we finished at $3 billion. Put in return, $1 invested $147 out – unbelievable project.

But genetics, there's about 30 percent determination – say 100 percent is your overall determination, genetics is 30 percent. Socioeconomic – how rich you are, where you live – very important. Three subway stops here from Washington, D.C. is a 12 year difference in how long

you live. From where we're sitting right now, three subway stops; the difference in mortality, how long you live, is 12 years. Something's wrong.

But as an independent variable, how rich you are is only about 15 percent – 30 percent genetics, 15 percent socioeconomic. The environment – the bigger environment, pollution and all, about 6 percent overall. The insurance – the Affordable Care Act, "Nixoncare," "Romneycare," all of that is only about 15 percent. Who your doctor is, what hospital you go to is only about 15 percent of how long you live. Pretty interesting, because The New York Times basically said, spend twice as much, outcomes so poor, therefore we need different insurance.

Not where the action is. The action is – 40 percent of how long you live is in behavior. And behavior is K through 12 education. Behavior is obesity. Behavior is wearing seat belts. Behavior is whether or not you smoke. Thus, the opening paragraph is right. But if we're going to address how long you live or health care costs, what you need to do is address that 15 percent of hospitals, insurance, Affordable Care Act, all that other stuff, who your doctor is, where they train – do that. But you've got to look at the 40 percent change in behavior, and you've got to link those two. And in policy you've got to link the two if you want to change outcome. And you put everything else in there, and that's going to be the secret: Are we in Washington smart enough to have that overall 55 percent impact?

MS. SHALALA: Well, and what Bill's pointing out is there are things we could do in health care to get better outcomes that are low-tech, that are not high-tech. We've put an enormous investment in high-tech, but there is a lot we could do. If we get people to exercise, eat right and not to smoke, we'd have plenty of money to drive down that piece and do the kinds of changes that we're suggesting in the health care system.

MR. : Thank you very much.

Pete.

MR. : Well, I don't know if the rest of you who are entitled to ask – I don't know if the rest of you entitled to ask questions are as confused as I am, but I've heard my great friend explain, this and I'm confounded. I just want to ask, how do we apply those various things that you've gone through, that, number one – and we'll do that in a moment.

And number two, we speak of reforming the delivery system. And most of the time you start when you – with fee-for-service, when you're talking about reforming the system. You talk about what do you do for – about fee-for-service, and I think we're at a stage where most people think we shouldn't have fee-for-service continue on indefinitely, that there ought to be some substitute, partial or otherwise, system, and I wanted to ask you that.

And third part of it is this: We do have a system that is rather old that has been – (inaudible) – it has come back to life now, where we talk about paying the recipient a stipend and they then get to buy their own insurance. What's the name of that?

DR. FRIST (?): In Medicare, it's premium support or defined contribution instead of defined benefits, just like what we did with (patients ?). Some people call them vouchers.

MR. : Both of you, vouchers – (laughter).

DR. FRIST (?): But not in Washington. Yeah.

MR. : Can both of you talk about those three a little bit, the ones that I just mentioned to you? How do you apply that – the kinds of things you talked about, Doctor and – Shalala? How do you apply them? And my last question is the one you just heard about the changing of a system. Could you talk about it, please?

DR. FRIST: Do you want to start or do you want me to start?

MS. SHALALA: Well, I – why don't you go ahead?

DR. FRIST: Yeah, well, I think the first is, I think you have to go back to my – if you go look at costs, not access and insurance and equities – because government's pretty good at collecting money and distributing and spending. We do our taxes, and we do that pretty well. We like – or Washington likes – and I'd like to think that when I was here that we were pretty smart at running things, and we just don't do a good job at running things. The private sector does a better job, markets do a better job. Markets may not have the equity issues – (audio break) – fairness issues quite as much, especially in health care, because this – the inequity in knowledge – the doctor has more knowledge than the patient. Now, that's changing now that we have our iPads and iPhones and all, as we come through. But the economics – so conceptually, people are going to disagree about what I just said, but I think government has to have that larger framework that addresses the big issues, as you show on your slide, the budgeting, the responsibility, the equity, justice, moral imperatives, and then recognize that human biology, unlike shopping at a grocery store or probably even military spending, that human biology changes so much, so fast. Things like evidence-based medicine are good if you're treating a thousand patients, but you, that evidence-based medicine might not work because of your genetic code, 3.2 billion bits of information that make you different than anybody else in the room here. So how – can you treat everybody the same coming in?

So how do you do it? Number one, I would say – to your first question, I would say take all that – we're not going to have time for the details – but align incentives around real value itself – the incentive for the hospital around value, the incentive for the nurse around value, for the doctor around value, for the social worker and I would include the patient around value. Value means results, mean outcomes, means health, means wellness. And our whole system, instead of just saying you get paid $30 every time you see a patient or a thousand dollars every time you do a biopsy or $500 every time you do an MRI, which is traditional fee-for-service, clearly that's not going to work. It's not going to work, and that's why we say leave fee-for-service. But I don't want you to leave fee-for-service because I get paid for service. But the sort of what you're buying should be a package. It could be an episode of illness, 30 days before, 30 days after a heart attack. It could be bundling, where you take 10 doctors and say, you give the heart transplant, here's a $100,000 and you figure out how it's going to be distributed. But to do it in Washington, D.C., with 16,000 codes in a fee-for-service system that deal with each of you independently instead of focusing on the heart transplant itself? So to our credit, the government is out there, and we're looking through a demonstration project. But I can tell you, the bundling demonstration project that we do here in Washington will take four or five or six years. The

private sector is already doing it fast and moving, but the private sector doesn't get fed into the Washington dynamic very much as we go through.

Question number two. Let's have one and two fee-for-service. And I think the premium support issue, which we can come back to, which does apply to sort of Medicare, because that's the big debate in Washington – it has – the premium support is the so-called voucher system or it's the system of a defined contribution versus a defined benefit. So instead of promising everybody that no matter what happens we're going to take care, it does give you an actuarial amount of money to what, on average, works today. And you have to have risk-sharing and – or a risk evaluation in there. And that is, I think, a – going to be a big debate here, whether or not to move in that direction. If you do move in that direction, it becomes obviously much easier from a budgetary standpoint than promising everybody everything, 50 million people out there with the highest technology, with six ways to treat everything. Washington's not going to be able to cap that. And to try to that through 15,000 codes is just not going to work.

MS. SHALALA: I agree with Bill. I would take on some other issues. And I'm not sure I'd continue with these demonstrations. The problem is, when you do demonstrations, the political system gets involved. And when you select out – I once tried out competitive bidding demonstrations. We picked the most conservative areas in the country, particularly the members of Congress had been (yacking ?) us about go out and get competitive bidding. It took them 24 hours to stop us. And so unless you scale up enough –

MR. : You were making me do all those demonstration projects for you – (inaudible).

MS. SHALALA: Yeah.

MR. : -- when you were there. No, yeah, it's interesting.

MS. SHALALA: But unless we scale up, we're not going to get these kinds of changes. The other point I would make is, we need to do the chronic illness issue. That's where a lot of our costs are. So we've got to manage chronic illnesses better. Bill and I have talked at length about the privacy issue in managing chronic illnesses. We almost have to go to third parties because people are afraid that they're going to lose their jobs if they sign up with a manage chronic illness system. So there are a lot of things we can do there.

And finally, we've got to do something about standard of care. We've got get some agreement. We need doctors who are professionals, who have a certain kind of flexibility. But boy, if the alternatives range from millions of dollars to thousands of dollars – and I could tell you example after example. I went to get my ankle looked at, and you know, he suggested an MRI and I said, is that really necessary? And he said, no, you can have an X-ray. Well, the difference in price between the two is dramatic. He just hadn't had anyone that knew the difference in price. So we've got to be very careful about standard of care as well. And only if we bundle payments, I think, or do some of these other kinds of things, will it make a difference. But I do believe that we've got get it to another stage beyond the demonstration stage to be able to put the politics together.

MR. NUNN: Byron (ph)?

BYRON DORGAN (?): Sam, thank you very much. Well, thank you for the ideas and the thoughts that you have. I was just thinking, I just finished a book called "The Measure of a Nation" by Howard Friedman, a scientist, a statistician and a professor at Columbia, that devotes the first quarter of the book to health care. It's one of the most fascinating discussions I've read about health care and the problems and the solutions.

So a quick question. I come from a state that has largely had nonprofit health care. That's changing now. But in the cities in my state and elsewhere, I see – you go down the street and you on the street corner orthopedic center, cancer center, cardiac center, and more and more morphing towards for-profit centers for very specific kinds of things.

And going back to the Atul Guandi (ph) piece some long while ago about overutilization, I always wonder, once you put together a for-profit center with that little brick building in that corner, whether there – whether you are not absolutely required as an investment decision to drive and drive and drive utilization. And to what extent do you think that increases the cost of health care?

MS. SHALALA: Well, it's another example of the fragmentation of health care. And we believe that the fragmentation of health care – so many specialists, a fragmented delivery system – the fact is, if you get cancer in this country, you need physicians following you forever. If they're following you out of a specialty center, there's a whole different cost than if they're following you out of an integrated health care delivery center. But that's part of the fragmentation. The reason those places exist is because the payment system is designed to reinforce them and to produce margins there as opposed to a more integrated system.

DR. FRIST: (Inaudible) – it's a good – it's a big question. And I think that it kind of comes back to, like, government versus nongovernment. We don't have a socialized system. All this debate – socialized system versus not – you know, we are a private system. All these Medicare dollars go through sort of private system, private delivery system. Except for the Veterans Administration, we don't own a hospital. We don't own doctors, even – (inaudible) – to Medicare spending. I want to finish on the spending; I'll come back to the – (inaudible) – bit. But right now about 50 percent of the health care dollar does go through government. But that doesn't mean we're a socialized system, because that money goes through government, but it was delivered actually through a private system.

Before about 1960, when health care, instead of being 18 percent of the GDP, was down around 4 percent of GDP, aging wasn't an issue; obesity wasn't an issue; technology – we didn't have technology. My dad a few pills but didn't have 25 pills. It was mainly aspirin that he could do back in the – even 1960 – (inaudible) – before cardiac surgery. We didn't have all of these option – these alternatives. You could kind of get by, and the sort of not having a bottom line – forget the word – you can be – you can say private; you can say efficiency; you can say market-driven.

And then along about 1965 or 1970 it got to be – health care costs started going up – allocation of resources, third-party reimbursement. We had Medicare and Medicaid come in. And then all of a sudden health care became a big business. And with that, who runs businesses well? Government – (audio break) – basically you can't go out and get good managers. You

can't go out and get good accountants. You can get somebody volunteering some time after hours. But to think about life-and-death decisions, high technology, sophisticated allocation, 68 cost centers in a single clinic coming in – a nonprofit doing that well – they just didn't.

And therefore you had an industry that really exploded by bringing in professional accountants and professional managers and people who – doctors want to practice medicine; they don't want to be back there running a small business. They used to – (inaudible) – now we're coming back to it, as you pointed out. And therefore you had this explosion. And with that you have inefficiencies, as you do in any market. But the competition of the for-profit motive in health care through the '60s and '70s and '80s all of a sudden meant the nonprofit, inefficient hospitals – and I'll use hospitals as an example – or clinics simply couldn't stay in business without hiring professional management, without that sort of competition.

So hospitals – you may have had just a narrow 10 percent for-profit, some not very good and some good – but as they professionalized, the other 90 percent of the nonprofit. So every one of your nonprofit hospitals in your state are today professionally run by professionals; without the competition, without the marketplace, they are not there. And you pull the CEO of any of your hospitals aside – he says, I'm in a profit-making business. You can't run it without that sort of bottom – that bottom line.

Now the question needs to be applied is where's the innovation going to be? To think that the acute-care model of a hospital, of a delivery system, is going to work in a field of understanding the personalization of health care, the expense of health care – it's just not. It's going to move to the outpatient. Where we've innovated in imaging, we've innovated in drugs, we've innovated in patents, we've innovated with Ph.D.s and Nobel laureates and – or Nobel Prize winners in the science – where we have failed in America is innovation in our delivery system. We are still an acute-care model, little emphasis on wellness, little on prevention – wait till you get sick, and we can cure it with a heart transplant instead of prevention up front.

Now, why is that? And why do we have a problem with Medicare, unlike London, where I – or England, where I was yesterday, is because the government there is taking care of you from the time you are born to the time that you die. And therefore they can put more money into primary care earlier on or into prevention and wellness, because they know 30 to 40 years later, there's – the payback is going to be there. And our insurance companies here, where everybody's switching every two to three years, has very little incentive, unless you regulate it, to come in and invest early on. And so our Medicare program has to be smart on prevention and wellness. Is that too late when we come back to chronic disease? You develop your heart failure before you're 65 in many cases, so we've – going to have to work it into our private insurance system much, much earlier.

I think most of the innovation today – and this is going to answer your question pretty directly – is coming from the for-profit – not just for-profit sector, but the competition and markets that were originally driven by the for-profit sector – that that is where – they have a bottom line, and a nonprofit group does not, and that competition is set up. If you look at how you start focusing on chronic disease management today, University of Miami can probably do a pretty good job, and Guy – (inaudible) – everybody focuses on Guy Singer, Mayo – (inaudible) –

they can do it, but that's a little tiny – of the $2.7 trillion, that's a trillion dollars. What about the other $2.6 trillion that are out there?

MS. SHALALA: But –

DR. FRIST: And most of – most of that innovation – you got to be fast. You do have to have access to capital. You have to be measured. You have to play by the rules. And that's where I think most of the innovation's going to come from.

MS. SHALALA: No. I agree with that, but fundamentally our system is designed to reward procedure. We make our money on hospital beds – I mean, we're waiting for the outpatient to start making money for us. But we're making our money on the hospital beds, on the institutional care and on doing more for the patient. As long as that system continues to exist, you can give us all the IT in the world; our incentive is to get our margins out of doing more to the patient.

MR. NUNN: I'm going to have to – just because we've got another panel – we could – this is fascinating; we could go on forever. But I'm going to – Evan, I'm going to give you the last question for this panel. And then our two Bills, I will let you ask the questions to the second panel.

MR. : (Off mic.)

MR. BAYH: Thank you, Sam. I'll be real brief here. My formative experience in public life was as a governor, and so I've got a healthy appreciation for the role that states play as sort of laboratories of experimentation. And Bill, you were just talking about your familiarity with other systems. So my question is very simply, for the two of you, looking at the 50 states, is there one out there that's trying some good things that we ought to look at as possibly a model? Or how about – how about the other countries? Is there one you think's getting it more right than not right that we might look to as possibly for some guidance, because they've actually been doing these things?

MS. SHALALA: Well, I think lots of the states are doing something that's interesting and innovative, whether it's the use – whether it's trying to get control of Medicaid costs by using a combination of IT and other health care providers to manage the process better – I mean, there are lots of things going on out there. Each state has to put together its own pieces and look where it's – (inaudible). Here's what I can tell you: When states have transferred their Medicaid systems to the private sector, those private-sector companies are getting pretty good margins. That tells us something about the management of the Medicaid system. Now, are they giving less care as a result of that? In some cases they are; in some cases they aren't.

So Bill's fundamental point about – we've got to learn how to measure outcome value; so no matter what the organization is, whether we do it through the private sector or manage it ourselves, we've got to make sure that we're getting quality for our money. But I think that there are a number of states, including Indiana, that – and Florida, that are trying some different kinds

of things. There are a number of states that are trying things in mental health, for example, Senator Domenici. So there's a lot of experimentation going on.

One of the things we have to do is make sure we don't restrain the secretary from doing more with waivers and trying out new things. The Democrats are as bad as the Republicans on this, from this point of view. They're so worried that she's going to give away the store for the dual eligibles, the Medicaid-Medicare types; and the Republicans have similar worries about competitive pricing and some other kinds of things. So I think we need to let the secretary work with the governors and work through some of these alternatives so that we continue to experiment at that level. But we've got to learn how to measure outcomes at the same time.

DR. FRIST: Yeah, I – and I agree. I love the states, and nobody's smart enough for – to lick this. Is – it is – part of it goes back to human biology. We just constantly – our – we're just evolving so quickly. In science, we're learning to treat. We – the cost of health care is so big because we do a lot of overtreatment, this fee for service. more you do, but that's, again, an oversimplifcation. I don't Washington to think if we get rid of fee for service, everything's going to be OK.

You know, we can go into that, and I'll participate in those debates, but it's very important to do, because human nature is we – if that's the way you're getting paid, you just do more of it. But we have this overuse and we have this underuse, which we've got to address, and it's prevention and it's wellness and it's obesity. It's catching this stuff before it becomes a heart transplant, which I love doing, but I don't want to do that many. And then there's the misuse, which is just the misallocation, the waste, the 20 (percent) to 30 percent we're just not treating appropriately with the medicines and with the technology that is there.

The delivery system – if Washington comes in and basically says, we can deliver health care, well, we know the system. It's just false. We can't. And – but a lot of people like to think we can. And therefore – and the Affordable Care Act did this. It basically said, we don't have the answer. We don't want a socialized system. We don't want to own hospitals and own doctors and all that. And it pushes a lot down to the states.

These state exchanges, that – you can either like them or not, but what it means, we're going to have 50 laboratories out there taking state-of-the-art – more – the states are more nimble than the federal government, because the governors can come in, and with – you know, just close things down the next day, or they can open up and with that – and so we have 50 laboratories out there that are going to have markets where a huge number of people will be able to go in and get information about their health care plan, about outcomes, about what it costs, about transparency, and that's what markets are.

Where is that going to come up? Not the federal government, but it's going to come from 50 states out there and 50 governors. And all health care is, in essence, local, but this intermediate government level.

There's – and one last thing, just because: dual eligibles. Washington wants to treat everybody the same. You just can't do it. Can't – 300 million people with the same policy.

You just can't do it. We don't have the money to do it. It's too expensive to – 5 percent of people, 1 out of 20 people, so there are probably five people in here, or maybe it's six people in here, are responsible for 60 percent of all health care spending, these six people right here.

The secret to all of this – (inaudible) – but to say, seven people in here are responsible for, say, for 50 percent of all health care spending in the country. So if I want to address your line, all I need to do is find those seven people in this room, and basically I can manage you state-of-the-art – I'm going to spend full time on you. Instead of trying to spend time on everybody, I can forget about everybody else if I can identify these seven people.

How do we do it? It can be done. It just – one thing: there is a billion patient years of medical records, clinical claims data that is in Medicare, say, 30 million people times 50 years or however long it's been, so whatever they come to is – but there's a billion patient years of information. Why can't – well, it's not "we" anymore, but why can't the government come in and take that data and look at it to be able to predict who these six or seven people are, seniors? And if we focus on those seven people, you can forget about the – all this other stuff and the 16,000 codes and all of that.

Conceptually, that's the sort of thinking that we can do today that we couldn't do when Donna was in charge or when I was majority leader six years ago, because we didn't have the know-how. We didn't have the analytics. We didn't have this stuff. And if the federal government basically said, let's take that data, let's analyze it, let's focus, let's target, all these other problems kind of go away that we're trying to micromanage.

MS. SHALALA: And Senator, I think we're saying the states could do a lot. They also could do tort reform, because that's a state-based issue, and they certainly can do something about scope of practice. So as we talk about who does what, we've got to hold the states accountable at the same time, because they've got – they've got a big stake in this, as the – (audio break) –

MR. NUNN: I want to thank both of you. Fascinating discussion. Lot of creativity here. Good ideas. Thank you. (Applause.)

Our next two witnesses, if they would come up, John Taylor and Alice Rivlin. And I'm going to give you both again a very brief introduction. Alice and John, thank you both for being here. Let me – I'm not sure who's going to go first. I'll leave it up to you all.

But John, Dr. John B. Taylor, is the Mary and Robert Raymond professor of economics at Stanford University and a George P. Shultz senior fellow in economics at the Hoover Institute. He is director of the Stanford Introductory Economics Center. John's academic fields of expertise are macroeconomics, monetary economics and international economics.

John is well-known for his research on the foundations of modern monetary theory and policy, which has been utilized by central banks and financial market analysts around the world. From 2001 to 2005, he served as undersecretary of Treasury for International Affairs. John also served as a member of President George H.W. Bush's Council of Economic Advisers and as a

senior economist on President Ford's and President Carter's Council of Economic Advisers. John was recently awarded a Manhattan Institute's prestigious – high prize for his new book, "First Principles: Five Keys to Restoring America's Prosperity." John, we're delighted to have you here.

And Alice Rivlin, this is your second appearance, and Alice has helped us plan this series, which we are very grateful for. Dr. Rivlin is a senior fellow in the Economic Studies program at Brookings and a visiting professor at the Public Policy Institute of Georgetown University.

Alice served as vice chair of the Federal Reserve Board, 1996 to '99. She was director of the White House Office of Management and Budget in the first Clinton administration. Alice was the founding director of the Congressional Budget Office, 1975 to 1983. She was named one of the greatest public servants of the last 25 years by the Council for Excellence in Government in 2008, and I certainly concur with that judgment.

In February 2010, Dr. Rivlin was named by President Obama to the Commission on Fiscal Responsibility and Reform, the Simpson-Bowles commission. She also co-chaired with former Senator Pete Domenici, our co-chair here for these forums, the Bipartisan Policy Center's task force on debt reduction. Again, I could go on and on, but John and Alice, we're delighted to have you.

JOHN TAYLOR: Thank you very much, Senator. Thanks.

MR. DOMENICI: John, before you proceed, might I say, Alice, you understand that I could have introduced you had I really worked on him, but he wanted to keep the symmetry, and I said go ahead. And I don't know anything about Alice – (laughter) – Dr. Rivlin anyway. (Laughter.)

MR. TAYLOR: Thank you very much Senator, both senators, for all your doing, and for other people here. Appreciate your all coming, and it's a pleasure and honor to be here on the panel with Alice Rivlin.

I am going to refer to a few charts. I remember in the first panel I wrote this down. Bob (Rudman ?) says that we must be sure that the substantive effects are fully understood of what we're talking about, and sometimes the best way to do that is with a few charts.

So this chart to me is one that really we ought to just think about – (audio break) – do it. And unfortunately, there has been absolutely no improvement in that line. The only thing that CBO has done in their analysis is stopped the explosion by saying, we can't go above 250 percent anymore. So the red line, their most recent projection, just stops it, says they don't want to look at the bad news. Well, that's obviously not the way to end this.

This growing debt is the problem – the focus of this whole initiative and forum, but it is intimately related to another problem in our country, and that is our very slow growth of the

economy. We've had a combination of slow economic growth and exploding deficit and debt, and they're related.

So if I could – if you could take a look at this next chart, it illustrates this. It's a busy – (audio break) – in the future. And that's with those projections of CBO now and what they could be if we just raise growth a half a percent or even a percent.

Now, our growth in the debt is one of the reasons we're not recovering. I mean, even now it is important to think about our children's future, but it's right now, us – our children, as they're existing today, our grandchildren as they're existing today. This low economic growth is causing high unemployment, and the high debt is one of the reasons for that. So they're intimately related.

Senator Domenici's chart showed at the beginning the main reason for the explosion of the debt is spending, and the main reason for the increase in spending is the increase in health care spending by the federal government. That's shown in chart three, if you look at that briefly. It doesn't say anything more than Senator Domenici's chart showed, but you can see as you go into the future here and look at health care and Social Security as a share of GDP, what's driving this is health care.

And so we need to contain spending, and we need to contain health care spending. And the simplest way to think about it is to keep the growth, roughly speaking, at GDP. It may sound like a big-picture way to think about it, but that's ultimately what we have to do, and there's different ways to do that.

So if you could look at the next chart with me, this is to me the most important chart to look at to understand what's going on, to really fully understand the difficulty of this whole deal we're in. This is simply the ratio of federal spending to GDP. GDP is a good measure of our capability of supporting government spending, so it's a natural denominator. It goes only back to 2000, and it's projected out to 2020.

The blue line is our history. It shows to me an incredible surge in federal spending as a share of our GDP. Back in 2000, it was 18.2 percent of GDP, in 2007, 19.7 percent of GDP, heading up there to 25 percent in the recession. And it's come down to just about 24 (percent).

And then you go beyond the blue line, you'll see really what we're debating about here. This is really the whole nature of where we are going forward. And I've drawn in a few lines here to illustrate. The top line, the red line, is the proposal of the administration for the budget last year, February 2011. So as drawn, it really didn't do very much to deal with this, as I see, spending problem, spending binge.

The sort of teal-colored line is labeled Simpson-Bowles. That's really what Simpson-Bowles proposed as a share of GDP, so it's substantially lower than what the administration proposed about the same time. That was December 2010. The administration was February 2011.

The green line is my proposal. This came from an op-ed that George Shultz, my colleague, former Treasury secretary, knows a lot about these things, Gary Becker, Nobel Prize winner. We draw – drew this line. We called it a pro-growth budget, because it really, it seems to me, gets the opportunity we have to get rid of this debt explosion.

And then finally, if you look at the black line right below the red line, that's where we are now. That's CBO. That's their projection, excluding, by the way, the sequester. It's basically just the projection of what they think will happen, their so-called alternative fiscal scenario.

So if you look at this chart with me, I think there's several very important points to draw, and I'll just conclude with those. Number one, the problem here is really just undoing something that's had – happened very recently. If you'd like to think about the goal, the red line, all that – sorry, the green line – the goal of the green line, all that does is bring us back to where we were in 2007. That shouldn't be so hard. If you – if you were talking to a family that – their debt was in terrible shape, and all they had to do is get their spending back to where it was before they ran into the debt problems, and especially if it was only a few years ago when times really weren't so bad, they may say, hey, this is good news; I can make this adjustment relatively easy. That seems to me what's attractive about simply benchmarking back to where you were recently.

Second thing is this is a very gradual decline. In fact, all of those are pretty gradual, even the green one. This – (inaudible) – should be – shouldn't be disruptive to the economy. In fact, simulations of models that we've down show this is – actually will increase economic growth. It's not like an austerity-type of concern that you should be worried about. I think that's a very – it's a very gradual decline, much more gradual than the rapid increase.

Third thing I would observe, and this is a very important point, all of these ideas require that we contain health care spending to have it grow not much more than GDP. In fact, I don't think there's much disagreement about that idea going down the road. The disagreement is how you do it. And we heard some of the discussion, Senator Frist and – describing the premium support and overall totals.

This – if you look at the proposals of the administration, the proposals of the House, proposals in this campaign, all of them have health care spending, Medicare spending in particular, being contained substantially. The difference is how do you do it. Do you do it with a premium support, which to me, as an economist, is decentralizing the decisions to the doctors, to the patients, to the insurance companies, where prices and quantities and qualities are determined there, or do you have it decided at the center? And whatever you want to do it, don't think of one as more draconian than the other.

And the last thing I'll mention is all of these – while it looks bad, they're coming down, they're – nothing's coming down. All of these are increases in total spending. So if we just look at the last chart, chart five, that's just taking those shares of GDP numbers and translating them back into the actual dollars that must be spent and appropriated or part of the entitlement system – (audio break) – should we – we should be focusing on.

Thank you very much.

MR. NUNN: Thank you very much, John. Alice?

ALICE RIVLIN: Thank you, Mr. Chairman. (Audio break.) I'm not going to give you any more charts, because I think John has done it. I don't have anything to add to that set of charts.

I think that having me and John Taylor together is an interesting illustration of where economists can – where economists differ on some things, but more especially, where they do not. There is a lot of mythology about our profession, and people say, oh, economists never agree; they disagree on – even on the facts and even more on the projections.

I don't think that's really true with respect to this particular problem. (Audio break) – sustainable, that the spending drivers are Medicare and Medicaid and other health care, and to a lesser extent, Social Security. And we know the reasons for that: the demography, the increasing number of seniors and the rising cost of health care.

We know that for those reasons, federal spending is on track to grow faster than the economy can grow and faster than revenues will grow at any set of tax rate. And that creates a widening wedge of borrowing that will drive up the debt-to-GDP ratio, will eventually drive it off the charts, although the CBO has decided not to let it do that. (Chuckles.)

That will make it more expensive for our country to borrow and eventually impossible to borrow the amounts that we will need to. It will mean spikes in interest rates, slower growth and perhaps a really prolonged recession or depression. And we all agree that growth is the key. We must have higher growth to regain prosperity and our leadership in the world.

So there's not a lot to argue about in terms of those facts. One big uncertainty is how fast do we have to move. When do we hit a catastrophe or a moment in which we can't put it off any longer? Now, frankly, nobody knows. John and I are among those who say we can't afford to wait to – because it'll be too late if we find out. We better get a move on. Some of you may have seen Paul Krugman's – (audio break) – that we need to get there. Now, John's not an extremist; he's not a big anti-government person or a libertarian. But he does believe strongly in limited government and predictable rules. He believes limited government and predictable rules are much better for growth than larger government and more intervention, right?

Now, I'm not an extremist either, but I would tend to move a little slower to the sustainable track than I think John would, because I think the principal cause of the slow recovery is the depth and severity of the recession caused by the cataclysmic financial and housing market crash. We shouldn't have had that, but we did, and we're in a very deep hole. So I would favor more actions to help people get back on their feet than I suspect John would. And that also leads me to believe that going over the fiscal cliff – which some people are saying, well, let's just do it – would throw the economy into a new downturn. So I would favor getting back on a fiscally sustainable track fairly slow, but that doesn't mean putting it off like Paul Krugman would. It means legislate now, but legislate it in a way that means we get back on the track fairly slowly.

The bigger difference, I think, is over the role of government. I suspect I would favor a stronger safety net and a somewhat more activist government than John would, and that reflects the differences in the larger population. That difference affects the mix of spending and revenue changes that are desirable to get onto a sustainable track. It turns on how we cope with this avalanche – tsunami, as Pete called it – of seniors that are affecting our budget. John, in his very excellent book that I commend to you, suggests that maybe going back to the 19 ½ percent, approximately, of GDP that we were spending in 2007 could be considered some kind of a norm, because that was before the financial crash and the Great Recession.

But I would point out that whatever past year we take as a norm – or better, whatever collection of services we think ought to be provided by the government – providing that same services is probably going to take more spending in the future than it took in 2007 or in some – in some other pre-crisis year just because of what we've been talking about. We will be dealing with this much larger number of seniors – more than half, again, very quickly, and almost twice as many in Social Security and Medicare in three decades than we have now. I doubt that we can or that we should cut back on the rest of government enough to accommodate that big a demographic shift. If we did, it would risk reducing the investments in education and science and infrastructure that we need for growth.

Now, those are differences, and they're widely reflected in the – in the public at large, but let me come back to what we agree on. I think we can agree that whatever the size or role of government we think is appropriate, we need to pay for it. And that means getting back on this track that will come close to balancing the budget or at least will allow us to reduce the ratio of the debt to our economy by not having a deficit that is larger than the economy – than the rate of growth of the economy.

And secondly, I think we could agree that whatever we decide government ought to do, we need to do it efficiently and in a way that interferes as little as possible with growth. And that's an argument for a more pro-growth health system and a more pro-growth tax system. So let me just finish – (audio break) – specifics. First, we do need to put Social Security back on a firm foundation for the future. It is really stupid to wait to do that. We need to assure people currently in the labor force and entering into it that Social Security will be there for them and they can plan around it. I am fully with John on predictability on this thing.

Now, here we may have some different emphasis across the population, again, over how – what ratio of spending cut and revenue increase would be appropriate, but a bipartisan compromise means some of each. You can raise the retirement age a little bit far in the future; you can index it to longevity, as Pete and I did in our report, rather than raising the age. We can – you can raise the taxable wage base gradually, improve the measure of the CPI. None of these changes need be very large, but we ought to do them now and just get on with it.

And finally, we need to use, as we've been talking about, the federal health programs to move the whole health system toward greater efficiency: less waste, more incentives linked to outcomes and value, as this previous panel said, rather than to higher volumes of services. The election has escalated the rhetoric and made the differences seem, I think, much bigger than they

really are. Actually, I suspect we're quite close to a workable set of compromises here. With respect to Medicare, we've talked about the premium support model and the Affordable Care Act model, which is more of – discover what works well and what incentives work well, and put them in by regulation. Pete and I, in our report, said, why don't we do both? Keep fee-for-service Medicare for anybody who wants to be in it, and keep improving it along the lines that we have talked about, but offer people a choice as well. That seems to me a good compromise.

Whatever we do here, the differences are not so great. We are not arguing about whether incentives should be for value rather than quantity. And we're not even arguing, as John just pointed out, about the rate of growth. Everybody thinks, can't grow the Medicare spending or the whole health care system much faster than the GDP. So the bottom line is, the differences are real across the political spectrum, but compromise is essential. And the one thing we can't afford is gridlock. We can't afford to do nothing, because everything gets worse if we do. Thank you.

MR. NUNN: Thank you, Alice and John, for very compelling testimony. I wish we could put you two in a room and – you know, and feed you well until you – well, maybe not feed you so well –

MS. RIVLIN: Not too well. (Chuckles.)

MR. NUNN: – until you came to an agreement and just pronounce it as being the answer. But let me just ask one question. We got the fiscal cliff coming up; I think both of you agree that that would be a disaster. If the lame duck session were to move in a direction of substituting Domenici-Rivlin, legislatively drawn, or Simpson-Bowles or some combination of those two – instead of kicking the can down the road, change cans and have Domenici-Rivlin or Simpson-Bowles as the new can so that they have six months or three months or whatever to change it if they want to. But if we go over the cliff, we go over to a softer landing, not a disaster. If that counterproposal were to come up in the lame duck, what would you – I'll ask both of you, what would you think about it as an alternative to where we are now, a new default position?

MS. RIVLIN: (Chuckles.) We certainly need a better default position than we had in the – in the fiscal cliff. We want one that will put us back on a track to sustainability and that, whatever you might think about this particular solution, is a lot better than doing nothing. And that's not true of the fiscal cliff; it's probably worse than doing for – at least for a little while because it could throw us into recession right away. So I think that's a reasonable idea. Not going to be an easy idea to get across to your former colleagues, however.

MR. TAYLOR: I would say one of the problems with just doing, say, Simpson-Bowles as currently – as written down back in December 2010, is it actually also has a very large, immediate tax increase, if you take it literally. And so, in fact, it's not much different than the fiscal cliff tax increase in terms of percentage of GDP. So that would have to be looked at very carefully, I think, on this – on the tax side.

On the spending side, actually, as – and my charts illustrate I think a very interesting coincidence, perhaps, and that is for fiscal year 2013 the Simpson-Bowles spending as a share of GDP is actually to – it's very close to what the House budget has for 2013; it's very close to the green line in my chart. It may be something people could agree on for 2013. And that's not a – that's not a small item, because the 2013 budget is – it's already past due, of course, but that's got to be dealt with in the lame duck.

And so I would think that may be a possibility. Tax reform itself is extraordinary (sic) complex, and it's not something that's going to be decided in a lame duck period. So I could imagine agreeing to – at least until the overall parameters of the 2013 budget – people understand it, they've talked about it; it wouldn't be a surprise to the members, they could I think deal with it in the lame duck – and then in fact maybe even have the instructions to the committees for the out-years follow the same spending line – which is also in my picture; it's actually a flat line. And then in the first six months or whatever of the new session after the inauguration people hammer out the rest of this – they hammer out the tax reform, they hammer out how much of the tax will reform will be, if you like, revenue-neutral, and how much will generate additional static revenues.

So I think that's a possibility. And again, primarily because of this almost-coincidence that, as stated back in 2010, Simpson-Bowles is quite close to what I think would work for 2013.

MR. NUNN: Is – (audio break) –

MS. RIVLIN: In our plan, Pete and I thought we needed some more stimulus up front – (audio break) – you don't want to go to too austere a budget right away, and it just seems to me the European experience has proved that. And I think John will probably argue with that.

MR. NUNN: Bill Brock.

MR. BROCK: There are a lot of people that would argue the – part of the problem we have today is the degree of uncertainty that affects business decisions, investments and so forth – regulatory questions, tax questions, spending questions. And I think it's fair to say that unless we have some at least additional certainty about where government policy might lead – (audio break) – side with that, any tangible commitments on the tax side – maybe just in gross revenue numbers, or whatever it is, that you might not address that certainty.

And I guess the worry that I have is that we've – (inaudible) – on the – (inaudible). We're worried about Social Security but we're the revenue stream to fund it. I – (audio break) – that's palpably dishonest, and so we keep doing these on a temporary basis and we – (audio break).

MR. TAYLOR: (Audio break) – off a – of course, it wasn't – didn't come from outer space; it was created by government. And in a way, it's the same kind of policy uncertainty that we've been getting more and more of. They have – more and more provisions in the tax code are expiring each year. And it just so happened these are all coming on the same date so people can see it, but it's been happening for a while.

An answer to your question, what's the best way to – (audio break) – in the last couple years at least. So the budget proposed in – (audio break) – that's so damaging.

So it seems to me that if you can give the confidence that we're bringing those down – and I – there's not much disagreement that those should come down; it's a message of how far should the – should you stop at Simpson-Bowles or should you – (audio break) –

MS. RIVLIN: (Audio break) – have a bipartisan solution that can't be overturned from – we're not going to have elections saying, do it this way or don't do it – (audio break) – Bowles line on John's chart was somewhere between the president's budget and his own. And it's because it was a compromise – (audio break) – exactly that.

MR. NUNN: Thank you.

Bill Frenzel?

MR. FRENZEL: (Audio break) – the debt within 10 years – (audio break) –

MR. TAYLOR: (Audio break) – multiplies the debt within 10 years that we make these changes, there's no question about it. (Audio break) – be 40, 50 percent, and we have been pretty successful on that – (audio break) –

MS. RIVLIN: I agree on – (audio break). And we're probably getting some help – this goes back to the health care discussion – we're getting some help from what's going on out there in the health sector already because it does appear that the growth of health care costs is slowing – and partly because people are doing sensible things, both publicly and privately, and in many states. So I don't think that's impossible, but we do have to make sure that we don't let the debt grow faster than the GDP. It's got to grow slower.

MR. : (Off mic) – whether there needs to be some sort of special discipline after the stabilization of the debt so that we have a relatively balanced budget over a cycle?

MR. : Well, this has to do with budget rules and various kinds of constraints on spending. I think that certainly the recent experience shows that we have trouble keeping spending under control. So I would like to see some kind of – and I'm a – as Alice said, I'm a real proponent of rules and predictability. So if there was some way to enforce – and I would say on the spending side, there's other ways to do it, and I would say on the spending side is enforce some kind of a long-term goal of what you'd like the federal government to be spending as a share of GDP. I focus on the share of GDP so much. I know it already gets into the arithmetic, which is confusing to people. But it seems to me that the way to think about this, and I would encourage somehow you do that.

MS. : I think the essence of the challenge is, how do you bring the entitlements into the budgeting process. And they're not now. Someone referred to automatic pilot. The budget is – the appropriations, the discretionary spending is not the source of our problem. We know

how to control that. The problem is mandatory or entitlement spending, which has been outside the regular budgetary process. It's got to be inside.

Now, that doesn't mean that you review Social Security and Medicare every year, but you've got to set a sustainable track and then review it periodically, like every five years the Congress comes back to this, say, have we gotten off the track and what do we want to do about it?

MR. NUNN: Pete.

MR. DOMENICI: Well, obviously we're finishing our event this afternoon, and I don't want to let the occasion pass without thanking you for putting this idea together and asking me to help and for all those that joined. I think in a short period of time we were able to amass a terrific record that, in essence, shows less disagreements for the biggest problem America has ever had outside of the second world war, shows less disagreement among the economists and among the experts than almost any major issue we've had. Today we have two economists – we'll put you in as an economist, Alice; you've been all kind of things – and we know where John fits. We have differences. But look, for the biggest problem we've got, the differences could obviously be solved. (Inaudible) – said the two of you, you go solve them and how much time do you want? And he said, are you serious? We can do anything we want with the code? And we said, yes, you'd probably say, give us a week. And I'm just saying what I think – a week and some good staff.

We – (audio break) – economics, one of whom – (inaudible) – was with him, was –

MR. : Larry Summers and Marty Feldstein.

MR. DOMENICI: -- Marty Feldstein is known as the Republican from Harvard on taxes. And by the time they were finished, there is no question they could have agreed on a revenue package without question, the two of them. Take them a little bit of time because one thinks we can cap them, the other one thinks we ought to go ahead and do away with most of the tax expenditures.

Look at the issue of health care. We've had two witnesses from very different parties, very different issues, one could think different sides and positions, that they would sit down, if given the time and the opportunity and solved the Medicare problem in a couple of weeks and present it to somebody based upon the fact that it isn't the size of the problem. The fact of the matter is, they know it must be solved and they're close enough together to get it solved. I've been in the Senate on issues that were much more debatable than this, and they were small issues. Here we've got the biggest fiscal issue and the disagreements are the smallest that I – are less than I ever anticipated we would be on this particular day in the evolution of these – of these – of these issues.

Let me just make sure that I've got this straight from both of you. It becomes quite obvious that it isn't enough to talk about do you need revenues, are you going to get revenues, do you need entitlements reformed – not cut, but reformed – and then performed in the out-years, not tomorrow, next – not next week, not even next year – maybe 10 years from now they start to change in terms of what you get.

But the issue that overwhelms all of this is that the American economy is not growing and it doesn't make too much sense to – let's strike that. It doesn't seem to me to be a valid approach to close these sessions without asking the two of you, am I correct when I assume that the debt and its continued growth as a – in relationship to our gross domestic product is an inhibitor to growth in the American economy? And if so, is it a major inhibitor?

And if that answer is yes, then obviously when we speak of debt we can simultaneously speak of growth. You got to – can't have this much debt and it growing this fast if you want the economy to grow. But that was my assessment after certain stipulation. What would you say about that, John?

MR. TAYLOR: Well, I would – I would agree. It's a detriment to growth, a growing debt. And that's why it's so important to solve it. And we want to get growth faster now, not – we got to get growth faster for our children and grandchildren, but right now. And I think we can do that in this gradual way. And it would be a benefit to the economy. It would remove some of this uncertainty. It would create more opportunity for the private sector. So I would – I would start with it right now.

MR. DOMENICI: Well, John, let me tell you my last question. We're just 40-some days away from an election. And I'm not going to dip myself into this campaign with the statement I'm going to make next, but it's pretty obvious to me that we hear more talk about who creates jobs – and I would assume growth creates jobs, I didn't add that – is that correct? He's nodding so we can add that to my assessment. (Laughter.) You get jobs from growth. Without growth, you don't get jobs. And, Alice, you agree with that. Is that correct?

MS. RIVLIN: Oh, yes, sir.

MR. DOMENICI: Now, the point of it – the point of it is, if that's the case and we're out here running for president and we're talking all the time about who's creating jobs but nobody's talking about the budget. And we are assuming the budget's one of the most important things that will bring us jobs or lose us jobs, as the case may be.

Alice, would you address my issues and see if I was on base or not in your opinion?

MS. RIVLIN: Oh, I agree with you. I think that the campaign so far has been really not focused on the big, substantive issues. There've been a lot of words about jobs and debt, but what we need is a serious debate between the candidates as what would you actually do to create jobs and what would you do to stabilize the debt and bring it down? And we have not had serious addressing of those two issues and we should.

MR. NUNN: Thank you very much, Pete. Evan, let me give you the last question or word, whatever the case may be.

MR. BAYH: Well, thank you both again. Just very quickly, it seems to me we've been fortunate in one respect, and that is that interest rates have been historically very, very low at a time when our debt burden has been increasing. At some point, the interest rate picture is likely

to change – when we have a resumption of growth or the fed starts unwinding the programs that they've put into place or what have you.

If you could just take a minute each and just share with us how much bigger the challenge will be if we wait until interest rates start going up and servicing our debt becomes that much heavier? Conversely, if we act more quickly – let's say in the next 6 months or so – to put into place a long-term path to dealing with this, what might be the dampening effect in the future when interest rates do start going – how much would that ameliorate the eventual rise of interest rates, if we have a long-term strategy in place for getting the deficit under control?

MR. TAYLOR: Well, very briefly, I think it would be an enormous benefit in terms of the very high risks right now of rapidly rising rates down the road with this gigantic debt, and also remember the Fed has purchased a lot of the debt already, and that will have to go back out into the system. To me, it's a major risk and uncertainty in the future, and it's another reason why if we deal with this now, we'll reduce – that risk is still going to be there, but we can reduce it substantially. And I think that should be added to the reasons. Thank you.

MS. RIVLIN: You started by saying fortunately we have been able to borrow all this money to low interest rates. I would suggest that it's been a very mixed blessing. (Audio break) – we could go much higher than they were even then. It would mean that we were devoting a very large proportion of our – of our revenue to pay – to servicing the debt, because you've got to pay off the top. You – then you do whatever the government is supposed to do.

So we were actually worried about that at the beginning of the Clinton administration. It was one of the reasons that Clinton focused so heavily on the debt reduction, with the help of a Republican Congress, I should say here, eventually, not in the first two years. But the – we were genuinely worried that the debt service was going to explode, meaning that the debt – you'd have to raise taxes just to pay the interest on the debt. Now, we're not there now, because the interest rates are so low, but we could get back to that.

MR. NUNN: OK, to my fellow colleagues, thank you very much for participating. We will continue to work on this issue. To CSIS, thank you again. Concord Coalition and Bob and your group, thank you. And Pete, to the Bipartisan Policy Center, to our witnesses here, we are very grateful to you.

We're going to continue to work on this. We're going to have some kind of report in the next few weeks. There's a larger effort going on that we will be part of called Fix the Debt. It's going to be very active after the election, the post – the lame-duck session and so forth and thereafter. So this is going to be a continuing challenge.

Alice, really grateful to you. Terrific. John, thank you so much. We appreciate it and all of your team out at Stanford, those – tremendous work. I've been a firsthand witness to that, so it's a great pleasure to be here, and we appreciate Hoover being part of this effort.

So thanks to you all. (Applause.)

(END)