health care professionals will be called on to develop and administer humane methods for feeding striking detainees while providing general medical care under trying prison conditions. Second, health care professionals must also continue to scrutinize the behavior of public officials, cognizant of the medical interests of their patients and the collective interests of their community. Force-feeding should be rare, the product of serious but ultimately unsuccessful negotiations with strikers.

These are not easy straits to navigate. Armed conflict and other public emergencies pit personal, professional, and public interests against one another. Medical professionals, like other citizens in a thriving democracy, must simultaneously sustain the efforts of war and contain them.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Failure to Launch? The Independent Payment Advisory Board's Uncertain Prospects

Jonathan Oberlander, Ph.D., and Marisa Morrison, B.A.

Controversy has followed the Independent Payment Advisory Board (IPAB) since its inception. The Affordable Care Act (ACA) established the IPAB as a 15-member, nonelected board. Among other duties, the IPAB is empowered to recommend changes to Medicare if projected per-beneficiary spending growth exceeds specified targets. Congress must consider Medicare reforms proposed by the board under special legislative rules, including limits on debate, which are designed to ensure speedy action. If Congress does not enact legislation containing those proposals or alternative policies that achieve the same savings, the IPAB's recommendations are to be implemented by the secretary of health and human services. Other rules make it difficult for Congress to override these procedures (supermajorities are required) or eliminate the board altogether (the ACA allows Congress to do so only in 2017 through a supermajority vote).[1-3]

In 2010, Obama administration officials hailed the IPAB as "the most important institutional change" in the ACA and a crucial component of health care cost containment.[4] The IPAB enjoys strong support among many health policy analysts who are attracted to the vision of a nonpartisan board insulated from political pressures that can formulate more rational and coherent Medicare policy.[5] The IPAB's supporters also praise it as a fail-safe ensuring that growth in Medicare spending is moderated, regardless of congressional inaction. President Obama has proposed strengthening the board's role by lowering the Medicare spending targets that would trigger IPAB action.

The IPAB's critics see it in a very different light. Because the board is prohibited by law from making recommendations that raise revenues, increase cost sharing of Medicare beneficiaries, or restrict benefits and eligibility, it is expected to focus on savings from medical providers. A broad coalition of health care industry groups, fearful that the board's proposals will result in reduced Medicare payments, fiercely opposes the IPAB. In addition, Republicans view it as an instrument of rationing and bureaucratic intrusion into medicine. In the 2012 vice-presidential debate, Congressman Paul Ryan (R-WI) warned that the IPAB would be "in charge of cutting Medicare each and every year in ways that will lead to denied care for current seniors." House Republicans have voted to repeal the IPAB and the entire ACA, though those measures have not cleared the Democratic-majority Senate. In January 2013, the GOP adopted a House

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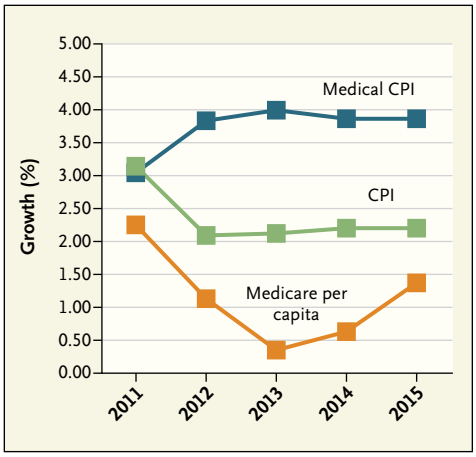

Projected Growth in Medicare Per Capita Spending, the Consumer Price Index (CPI), and the Medical CPI, 2011–2015.

Data are from the Office of the Actuary, Centers for Medicare and Medicaid Services, 2013.

rule declaring that the IPAB "shall not apply" in the current Congress, thereby rejecting the special procedures that the ACA had established for congressional consideration of IPAB recommendations.

Given the political storm surrounding the IPAB, it is ironic that the first major milestone in the board's operation passed with scant public notice. On April 30, the chief actuary of the Centers for Medicare and Medicaid Services released a report projecting Medicare spending growth during 2011–2015. (The ACA requires the actuary to release such a 5-year forecast annually as the first stage of the IPAB process.) According to the report, per-person Medicare spending will grow at an average rate of 1.15% during that period, far below the target growth rate set by the ACA — the average of the Consumer Price Index (CPI) and the Medical CPI (see graph). Indeed, the rate of increase in Medicare expenditures per enrollee has slowed since 2006, and the ACA is expected to further restrain that rate. One consequence of gradual spending growth is that the IPAB will not be required to propose reductions in Medicare reimbursement. If low Medicare spending growth persists in the near term, then the most controversial feature of the IPAB — congressional consideration of IPAB proposals under expedited procedures — will not come into play.

In other words, because Medicare spending growth has moderated, the IPAB will not be as important as either its supporters or its detractors have claimed. It's much more likely to be irrelevant than to become the centerpiece of cost containment. Now the IPAB's ability to move forward at all is in doubt. Its members — the board is to comprise health policy experts, physicians and other health professionals, employers, third-party payers, and consumer representatives — are supposed to be nominated by the President for Senate confirmation in consultation with both Democratic and Republican congressional leaders. Among the 15 members nominated by the President, 6 are to be chosen in consultation with Republican House and Senate leaders, and Democratic House and Senate leaders are to provide input on 6 additional nominees.

Yet 3 years after the ACA's enactment, the IPAB still has no members. Secretary of Health and Human Services Kathleen Sebelius described "active discussions" about IPAB nominees in February 2012 and said last month that the administration was "consulting" Congress regarding "potential members." But President Obama has not yet nominated anyone for the IPAB, and Republican congressional leaders have refused to provide any recommendations for appointees. Even if Democrats settle on nominees, the controversy surrounding the IPAB will make their Senate confirmations, which are subject to filibuster, extraordinarily difficult. Presidents historically have made appointments when the Senate is in recess, and President Obama conceivably could fill some IPAB slots in this manner. But recess appointments are temporary, lasting only until the end of the next congressional session. Moreover, in January 2013, the U.S. Court of Appeals for the District of Columbia issued a ruling severely restricting the President's constitutional authority to make such appointments. The Obama administration is appealing that decision to the Supreme Court; meanwhile, in May, another federal appeals court echoed the D.C. Circuit's narrow interpretation of recess-appointment power. Even if the legal obstacles are circumvented, relying on recess appointments could undermine the IPAB's theoretically nonpartisan character. However, if no members are appointed, the power to recommend changes to Medicare when spending targets are exceeded does not disappear: it reverts to the secretary of health and human services.

Since Medicare spending is currently not projected to exceed the ACA's targets, there is no need for the administration to appoint members now. Yet the difficulties in launching the IPAB point to a more fundamental problem. The board's appeal lies largely in its aspiration to remove politics from Medicare — to create a policymaking process that is informed by experts and insulated from electoral pressures, interest-group demands, financial

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considerations, and partisan divisions. But given Congress's extreme partisan and ideological polarization, the ongoing fight over the ACA, the legacy of mythic "death panels," and recriminations over Medicare reform, the IPAB's rough start should not be surprising. This is not the sort of political environment in which an independent board charged with making controversial decisions about one of America's most popular social programs is likely to thrive. These dynamics are unlikely to recede soon, which means that the IPAB is stuck in purgatory, neither operational nor canceled — an institution designed to be above politics that cannot escape the political binds holding it back.

The longer-term picture is, as always, cloudier. Perhaps President Obama will pursue recess appointments. A new president and Congress could, in 2017 and beyond, unshackle the IPAB in response to deficit pressures and the search for Medicare savings. And if Medicare spending growth accelerates, the IPAB's role could expand. Yet a new president could also refuse to appoint any members or enforce the spending targets, and Congress could repeal the IPAB in 2017. The IPAB's demise would, in that scenario, deal a symbolic blow to health care reform and cost containment. But the impact on Medicare expenditures and national health spending would be negligible. For all the hype, the Congressional Budget Office currently forecasts no savings from the IPAB over the next decade.

Regardless of the IPAB's future, one thing is clear: rather than removing politics from Medicare, the board's difficult early journey has underscored just how entrenched politics are in health care policy.

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The Gross Domestic Product and Health Care Spending

Victor R. Fuchs, Ph.D.

How much will the United States spend on health care during the next decade or two? The answer matters greatly to physicians, federal and state governments, businesses, and the general public. The answer will determine the type and extent of care that physicians can provide to their patients, as well as the amount of physicians' take-home pay. It will also determine how much everyone else can consume or invest in other goods and services. Unfortunately, forecasting health care spending is extremely difficult. Future spending depends in part on developments within the health care sector and in part on developments in the economy as a whole. The former include changes in the prevalence of health problems such as obesity, infectious diseases, and dementia, as well as changes in medical technology such as new drugs, imaging devices, and surgical procedures. The economy as a whole includes variables such as the unemployment rate, trends in average wages, and prices of securities and housing.

The 2013 Economic Report of the President takes an optimistic view of future national health care expenditures, which is based on the slowdown in the rate of growth of those expenditures in recent years.[1] Like most commentators, the report notes that one possible explanation is the recent recession, but it argues that this was not a major factor relative to improved efficiency in hospitals and physician groups, payment reforms, and early responses to the Affordable Care Act. If the United States is entering a new era of modest growth in health care spending, the current pressure for radical changes in funding, modes of payment, organization, and delivery of care would abate. On the other hand, if the current slowdown is primarily attributable to the most severe recession since the

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