

MEDICARE DECISIONS ACCOUNTABILITY ACT OF 2011

MARCH 13, 2012.—Ordered to be printed

Mr. CAMP, from the Committee on Ways and Means,
submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 452]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 452) to repeal the provisions of the Patient Protection and Affordable Care Act providing for the Independent Payment Advisory Board, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

	Page
The Amendment	2
Summary and Background	2
Explanation of the Bill	3
Present Law	3
Reasons for Change	5
Explanation of Provisions	5
Effective Date	5
Votes of the Committee	5
Motion To Report the Bill	6
Votes on Amendments	6
Budget Effects of the Bill	6
Committee Estimate of Budgetary Effects	6
Statement Regarding New Budget Authority and Tax Expenditures Budget Authority	6
Cost Estimate Prepared by the Congressional Budget Office	6
Other Matters To Be Discussed Under the Rules of the House of Representa- tives	10
Committee Oversight Findings and Recommendations	10

Statement of General Performance Goals and Objectives	10
Information Relating to Unfunded Mandates	10
Applicability of House Rule XXI 5(b)	10
Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits	11
Changes in Existing Law Made by the Bill, as Reported	11
Legislation (H.R. 452) as Introduced	47
Amendment in the Nature of a Substitute	49
Minority Views	50

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Medicare Decisions Accountability Act of 2011”.

SEC. 2. REPEAL OF THE INDEPENDENT PAYMENT ADVISORY BOARD.

Effective as of the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), sections 3403 and 10320 of such Act (including the amendments made by such sections, but excluding subsection (d) of section 1899A of the Social Security Act, as added and amended by such sections) are repealed, and any provision of law amended by such sections is hereby restored as if such sections had not been enacted into law.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 452, as ordered reported by the Committee on Ways and Means on March 8, 2012, would repeal Medicare’s Independent Payment Advisory Board (IPAB). To achieve this purpose, the bill amends Section 1899A of the Social Security Act.

B. BACKGROUND AND THE NEED FOR LEGISLATION

On January 26, 2011, Rep. David P. Roe (R–TN) introduced H.R. 452, a bill to repeal provisions of the Patient Protection and Affordable Care Act (P.L. 111–148) providing for the Independent Payment Advisory Board (IPAB). The Committee on Ways and Means received primary referral for the bill because the bill includes Medicare provisions that fall within the jurisdiction of the Committee, including relevant provisions of the Social Security Act (SSA). The Committee has multiple concerns about IPAB, including: IPAB will consist of unelected officials whose primary responsibility will be to cut Medicare spending which could result in restricting access to health care services and/or rationing of care; IPAB will not be accountable to patients, providers, or Congress as it is allowed to operate in private; IPAB is free from judicial review; and IPAB delegates too much power to the Executive Branch.

C. LEGISLATIVE HISTORY

Background

H.R. 452 was introduced on January 26, 2011, and was referred to the Committee on Ways and Means, and in addition to the Committees on Rules, and Energy and Commerce.

Committee action

The Committee on Ways and Means marked up H.R. 452 on March 8, 2012, and ordered the bill, as amended, favorably reported.

Committee hearings

On March 6, 2012, the Subcommittee on Health of the House Committee on Ways and Means held a hearing to specifically examine how IPAB will impact the Medicare program, its beneficiaries, and health care providers.

The Committee also discussed IPAB during a February 28, 2012, hearing with Health and Human Services (HHS) Secretary Kathleen Sebelius on the President's FY13 Budget Proposal, a February 10, 2011, hearing on the Affordable Care Act's (ACA; P.L. 111-148 and 111-152) impact on Medicare and its beneficiaries, and a January 26, 2011, hearing on the ACA's impact on jobs, employers, and the economy.

The Subcommittee on Health also discussed IPAB during a June 22, 2011, hearing on the 2011 Medicare's Trustees Report.

II. EXPLANATION OF THE BILL

REPEAL OF THE INDEPENDENT PAYMENT ADVISORY BOARD

Present law

IPAB was created by Sections 3403 and 10320 of the Patient Protection and Affordable Care Act (P.L. 111-148). Beginning in 2014, IPAB is tasked with making recommendations to cut per capita Medicare spending if such spending exceeds certain economic growth targets.

By April 30, 2013, and each subsequent year, the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) is required to calculate whether the projected growth in average per beneficiary Medicare spending over a five-year period (beginning two years before the year in which the calculation is being made and ending two years after) exceeds projected Medicare spending growth targets. From 2015-2019, the Medicare spending growth targets will be the projected 5-year increase in the average of the urban consumer price index (CPI-U) and medical inflation (CPI-M). Beginning in 2020, the Medicare spending growth target will be GDP +1 percent.

If the Chief Actuary determines that projected Medicare spending growth exceeds the projected spending growth targets, then the Chief Actuary must establish a savings target to rein in Medicare spending in the last year of the five-year period being examined. Savings targets are capped at the *lesser* of a pre-determined percentage (which increases from 0.5 percent of total Medicare spending in 2015 to 1.5 percent in 2018 and beyond) or the actual difference between estimated Medicare spending growth and the spending growth target.

If Medicare per capita spending is projected to outpace the target, IPAB would then recommend Medicare cuts that, if enacted, would meet the savings target identified by the CMS Chief Actuary (IPAB's recommended savings could exceed the savings target). IPAB is prohibited from recommending policies that would ration care (although "ration" is not defined in law), raise beneficiary premiums, increase cost sharing, or otherwise restrict benefits or eligibility.

IPAB's recommendations are due to the President and Congress by January 15th following the year in which the Chief Actuary sets

the savings target. IPAB is prohibited from making its first recommendations before January 15, 2014, and IPAB-related spending reductions cannot be implemented before August 15, 2014. If IPAB does not submit recommendations (e.g., a majority of IPAB members do not vote in favor of a final package to send to Congress and the President that meets the targeted savings), the HHS Secretary would draft a proposal to achieve the necessary cuts (due to the President by January 25th, who would then send to Congress). Similarly, if the Senate fails to confirm the President's IPAB appointees, the HHS Secretary would be responsible for developing the legislation to cut Medicare to achieve the savings target and submitting that plan to the President. The President would then have two days to submit that plan to Congress.

IPAB's recommendations are afforded expedited procedures for consideration by the House and Senate. In years in which IPAB makes recommendations, the Committees of jurisdiction would have until April 1st to report legislation that complies with the spending cuts (either by adopting the IPAB's recommendations in whole or in part) or the IPAB recommendations would be discharged to floor. Congress would have until August 15th to pass such legislation. Congress can change the specific policy recommended by IPAB, but the savings targets must be met.

If Congress does not pass legislation that meets IPAB's savings requirements, the HHS Secretary would implement IPAB's recommendations beginning August 15th of the year in which the IPAB issued such recommendations. If Congress' response to IPAB recommendations is to pass a different collection of Medicare cuts, the President can issue a veto (which requires the standard two-thirds vote to override).

In 2017, Congress can discontinue IPAB via a joint resolution which receives "fast track" treatment in the Senate, so long as the resolution is introduced before February 1st and contains specific language outlined in the Democrats' health care overhaul. Such a repeal would require a three-fifths supermajority vote in both the House and Senate. Repeal efforts in other years would not enjoy the special Senate floor procedures.

IPAB will consist of 15 members appointed by the President and confirmed by the Senate. The President is to "consult" with the Senate Majority and Minority Leaders and with the Speaker and House Minority Leader on 12 of the 15 members (3 to each leader). IPAB members are to have expertise in health finance, actuarial science, health plans, or integrated delivery systems and would consist of physicians or other health professionals, academics, economists, and urban/rural, consumer, and seniors interests. However, the majority of IPAB members cannot be health care providers. IPAB members could generally serve a maximum of two, six-year terms. The HHS Secretary, CMS Administrator, and the Health Resources and Services Administration (HRSA) Administrator will serve as non-voting IPAB members. IPAB receives its operation funding from the Medicare trust funds.

Special exemptions from IPAB-recommended cuts were granted to those providers who, in the ACA, received a cut to their annual base Medicare payment adjustment and a "productivity adjustment" cut. Specifically, providers cannot be cut by the IPAB in years in which they are subject to the productivity cuts and a cut

to their payment update. As such, the hospital and hospice industries are exempt from IPAB cuts until 2019, while clinical laboratories are exempt from IPAB cuts through 2015. Given that a significant sector of the health care industry is exempt from cuts (representing 37 percent of Medicare benefit payments in 2009), other providers such as physicians, nursing homes, home health agencies, Medicare Advantage, and Part D plans would likely bear the brunt of the cuts, at least until 2019.

Reasons for change

The Committee believes that appointing an unelected and unaccountable board to cut Medicare spending will harm beneficiary access to care and force health care providers to limit the number of beneficiaries they will treat or even stop participating in Medicare altogether.

While the statute suggests that IPAB will be prohibited from recommending policies that ration health care, the term “ration” is not defined in the statute, meaning its definition and application would be determined by IPAB members. Further, nothing would preclude IPAB from rationing care by way of driving down reimbursements for treatments and procedures to levels where no provider would provide the care.

The Committee also has significant concerns about the degree of institutional power that will be taken from Congress and provided to IPAB and the Executive Branch. The President controls IPAB appointments, whether considered by Congress or recess appointed. If IPAB is unable to submit a proposal to cut Medicare to Congress, the HHS Secretary submits a proposal instead. Congress has limited ability to override the Medicare cuts proposed by IPAB and HHS, and any override could be vetoed by the President, ensuring that the President’s IPAB or HHS proposal becomes law.

The Committee objects to IPAB’s ability to conduct its proceedings outside of the public domain, as well as its exemption from judicial review. Such authority hinders consideration of beneficiary and provider input while robbing them of any recourse through the judicial system or appeal of IPAB decisions.

Explanation of provisions

H.R. 452, as amended, would repeal Section 1899A of the Social Security Act, which contains the IPAB provisions, while leaving in place provisions which provide for expedited consideration of IPAB-related proposals to reduce Medicare spending. Those expedited procedures also created a point of order against a measure repealing them, requiring the House to take additional action to enable consideration of the bill. However, with IPAB repealed, there would be no such proposal for Congress to consider under those expedited procedures.

Effective date

H.R. 452 would become effective on the date of its enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made con-

cerning the votes of the Committee on Ways and Means in its consideration of the bill, H.R. 452.

MOTION TO REPORT THE BILL

H.R. 452 was ordered favorably reported, as amended, by a voice vote with a quorum present.

VOTES ON AMENDMENTS

Chairman Camp's amendment in the nature of a substitute was approved by voice vote with a quorum present.

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill, H.R. 452, as reported:

The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO), which is included below.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states H.R. 452, as reported, would increase direct spending by \$3.1 billion over the 2013–2022 period.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the Congressional Budget Office (CBO), the following statement by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 8, 2012.

Hon. DAVE CAMP,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 452, the Medicare Decisions Accountability Act of 2011.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

H.R. 452—Medicare Decisions Accountability Act of 2011

Summary: H.R. 452 would repeal the provisions of the Affordable Care Act (ACA) that established the Independent Payment Advisory Board (IPAB) and created a process by which that Board (or the Secretary of the Department of Health and Human Services)

would be required under certain circumstances to modify the Medicare program to achieve certain specified savings.

CBO estimates that enacting H.R. 452 would not have any budgetary impact in 2012 but would increase direct spending by \$3.1 billion over the 2013–2022 period. That estimate is extremely uncertain because it is not clear whether the mechanism for spending reductions under the IPAB authority will be triggered under current law over the next 10 years. However, it is possible that such authority would be triggered in one or more of those years; thus, repealing the IPAB provision of the ACA could result in higher spending for the Medicare program than would occur under current law. CBO’s estimate represents the expected value of a broad range of possible effects of repealing the provision over that period.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the bill would not affect revenues.

H.R. 452 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 452 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By fiscal year, in millions of dollars—												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012– 2017	2012– 2022
CHANGES IN DIRECT SPENDING													
Estimated Budget													
Authority	0	–14	–14	–14	–14	–15	475	1,095	384	414	824	–71	3,121
Estimated Outlays	0	–6	–10	–14	–14	–15	475	1,095	384	414	824	–59	3,133

Basis of estimate: H.R. 452 would repeal the provisions of the ACA that created the Independent Payment Advisory Board. Assuming enactment near the beginning of fiscal year 2013, CBO estimates that the bill would reduce direct spending by \$59 million over the 2013–2017 period, but would increase direct spending, on an expected-value basis, after 2017. On balance, CBO estimates that enacting H.R. 452 would lead to a net increase in direct spending of \$3,133 million over the 2013–2022 period.

ADMINISTRATIVE COSTS

The Congress appropriated \$15 million for the IPAB in the ACA for fiscal year 2012, along with a formula for increasing that amount in subsequent years by the percentage increase in the consumer price index for all urban consumers (CPI-U). (However, \$10 million of the \$15 million provided for 2012 was subsequently rescinded.) Funds appropriated in authorizing legislation are considered direct spending, because the availability of those funds is not contingent on future appropriation acts.

CBO estimates that net funding for IPAB administrative costs will total \$149 million over the 2013–2022 period, and that outlays will total \$137 million through 2022. Those amounts take into account that about 10 percent of the funds provided for the IPAB will be offset by changes in receipts from Medicare Part B premiums. For example, the estimated gross funding for 2013 under current law is \$15 million, and about \$1 million in additional Part B pre-

miums will be collected, resulting in an estimated net change in budget authority of \$14 million for next year.

In total, CBO estimates that enacting H.R. 452 would reduce net direct spending for administrative costs by \$137 million over the 2013–2022 period.

NET SPENDING FOR MEDICARE BENEFITS

Under current law, the Independent Payment Advisory Board has the obligation to reduce Medicare spending—beginning in 2015—relative to what otherwise would occur if the rate of growth in spending per beneficiary is projected to exceed a target rate that is based on inflation (for 2015 to 2019) or growth in the economy (for 2020 and subsequent years). Each year, beginning in the spring of 2013, the law requires the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) to project two numbers, each of which is a five-year moving average for the period ending two years in the future:

- The rate of change in net Medicare spending per beneficiary (that is, gross Medicare spending less enrollees’ payments for premiums), and
- The rate of change in an economic measure—which is the average of the CPI–U and CPI–M¹ for five-year periods ending in 2015 through 2019, and GDP per capita plus 1 percentage point for five-year periods ending in 2020 and subsequent years.

The Chief Actuary of CMS will compare those two values, and if the spending measure is larger than the economic measure, the difference will be used to determine the IPAB’s savings target for the last year of the five-year period.

CBO’s current estimates of Medicare spending and its current economic projections result in an IPAB spending measure that is below the economic measure in each target year through 2022 (that is, in the last year of each five-year period):

	2015	2016	2017	2018	2019	2020	2021	2022
Spending Measure	1.7%	1.7%	1.5%	2.7%	3.1%	3.6%	3.9%	4.2%
Economic Measure	2.8%	2.8%	2.9%	3.0%	3.2%	5.2%	4.9%	4.7%
Difference	–1.1%	–1.1%	–1.4%	–0.3%	–0.1%	–1.6%	–1.0%	–0.5%

The point estimates in CBO’s baseline projections, therefore, result in a projected savings target of zero in every year through 2022.

The IPAB mechanism, however, is essentially a one-sided bet: The resulting target can be only zero or savings; the IPAB cannot be instructed to increase spending. So, variations in those measures might lead to additional savings but could not lead to added costs.²

In fact, the difference between the spending measure and the economic measure in each year that the Chief Actuary makes an IPAB determination will probably not be equal to the difference

¹The CPI–U is the consumer price index for all urban consumers and the CPI–M is the medical care category of the CPI–U. The medical care category is one of eight major expenditure groups that make up the CPI–U (see <http://www.bls.gov/cpi/cpifact4.htm>).

²For a discussion of CBO’s longstanding approach to estimating one-sided bets, see <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/15xx/doc1589/onesided.pdf>.

that CBO currently projects. If the Chief Actuary ends up projecting some combination of a higher spending measure or a lower economic measure than CBO currently projects, the savings target for the IPAB mechanism could exceed zero.

Because of the one-sided nature of the budgetary impact of variations in the spending and economic measures that determine IPAB's savings target, it is important to consider the probabilities associated with such variations when assessing the effects of possible changes in law. To assess the probability of the IPAB mechanism being triggered, CBO analyzed the technical component of changes in its recent baseline projections of Medicare spending.³ We concluded that there is a roughly two-thirds chance that the amount of spending in five years will differ from the agency's current projection by less than 2-percent as a result of technical factors.⁴ (Thus, there is a one-third chance that the amount of spending in five years would differ by more than 2 percent as a result of such factors.) The uncertainty regarding the five-year moving average of the rate of growth in net Medicare spending per beneficiary is approximately one-fifth of the uncertainty concerning the amount of Medicare spending in the fifth year.

To produce estimates for proposed legislative changes to the IPAB mechanism that take into account the probabilities of variations in the relevant measures, CBO applies that probability distribution to its point estimates of the five-year moving average of net Medicare spending per beneficiary to calculate an expected value for the IPAB's savings target under both current law and with the proposed change in law. CBO applies a *de minimis* rule that the target will be zero if the expected value of the savings target is less than 0.05 percent.

The use of probability-based estimates for changes to the IPAB mechanism does not affect the presentation of the effects of that mechanism in CBO's baseline. The baseline reflects the agency's current best judgment of the likely level of spending under current law; if the IPAB mechanism is triggered, that outcome probably will result from spending that exceeds CBO's current projections.

Following the above logic, repeal of the IPAB mechanism would have a budgetary cost. After application of the *de minimis* rule (for estimated effects that round to 0.0 percent), the expected value of the IPAB's savings target would be zero in 2015, 2016, 2017, 2020, and 2021 (but not in 2018, 2019, and 2022, when the expected value of the savings target would be between 0.1 percent and 0.2 percent of projected net Medicare spending). In addition, CBO anticipates that, if the IPAB mechanism was triggered, some of the savings in the target year would compound and produce savings in subsequent years. As a result, CBO estimates that repealing the IPAB mechanism would increase expected Medicare spending each year from 2018 through 2022, with the expected value of the net

³ CBO characterizes the components of changes in baseline projections as technical, economic, and legislative. This analysis of variability in projections focuses on the technical component—which largely represents unanticipated changes in the utilization of health care services—because the economic component is expected to have similar, and largely offsetting, effects on the spending and economic measures whose difference determines the IPAB's savings targets. The analysis excludes the legislative component of changes in CBO's baseline projections because the baseline reflects current law and does not anticipate future legislative changes.

⁴ The total uncertainty around CBO's projections of Medicare spending—taking into account the economic and legislative components of changes in those projections—would be considerably larger.

increase in Medicare spending for benefits totaling about \$3.3 billion over that five-year period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table. (Enacting H.R. 452 would not affect revenues.)

	By fiscal year, in millions of dollars—													2012– 2017	2012– 2022
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022				
	NET INCREASE OR DECREASE (–) IN THE DEFICIT														
Statutory Pay-As-You-Go Impact	0	–6	–10	–14	–14	–15	475	1,095	384	414	824	–59	3,133		

Intergovernmental and private-sector impact: H.R. 452 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Previous estimate: On March 7, 2012, CBO transmitted a cost estimate for H.R. 452 as ordered reported by the House Committee on Energy and Commerce on March 6, 2012. The two versions of the bill are identical, as are the two CBO cost estimates.

Estimate prepared by: Federal Costs: Tom Bradley; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Jimmy Jin.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE OF REPRESENTATIVES

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee concluded that it was appropriate and timely to enact the sections included in the bill, as reported.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee states that the primary purpose of H.R. 452, as reported, is to protect Medicare beneficiaries and strengthen the Medicare program.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Act of 1995 (P.L. 104–4).

The Committee has determined H.R. 452, as reported, contains no intergovernmental or private-sector mandates.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Clause 5(b) of rule XXI of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined

by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the sections of the bill, and states that H.R. 452, as reported does not involve any Federal income tax rate increases within the meaning of the rule.

E. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets and existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

* * * * *

Subtitle E—Ensuring Medicare Sustainability

* * * * *

[SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

[(a) BOARD.—

[(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

[“INDEPENDENT MEDICARE ADVISORY BOARD

[“SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the ‘Independent Medicare Advisory Board’.

[“(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

[(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as ‘a determination year’) the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as ‘an implementation year’);

[(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to

develop and submit during the first year following the determination year (in this section referred to as ‘a proposal year’) a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

[(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

[(c) BOARD PROPOSALS.—

[(1) DEVELOPMENT.—

[(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

[(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board’s recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

[(2) PROPOSALS.—

[(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

[(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

[(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

[(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

[(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a).

[(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

[(vi) The proposal shall only include recommendations related to the Medicare program.

[(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

[(i) give priority to recommendations that extend Medicare solvency;

[(ii) include recommendations that—

[(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

[(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

[(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

【“(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

【“(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates; and

【“(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX.

【“(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

【“(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

【“(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary’s review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

【“(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

【“(3) TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT.—

【“(A) IN GENERAL.—

【“(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall transmit a proposal under this section to the President on January 15 of each year (beginning with 2014).

【“(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

【“(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph;

【“(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year; or

【“(III) for proposal year 2019 and subsequent proposal years, a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in paragraph (8) exceeds the growth rate described in paragraph (6)(A)(i).

【“(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

【“(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

【“(i) the recommendations described in paragraph (2)(A)(i);

【“(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

【“(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

【“(iv) a legislative proposal that implements the recommendations; and

【“(v) other information determined appropriate by the Board.

【“(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Board under paragraph (3)(A)(i) or the Secretary under paragraph (5), the President shall immediately submit such proposal to Congress.

【“(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, to but fails, to submit a proposal to the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

【“(A) such proposal to the President; and

【“(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

【“(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

【“(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the

Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

【“(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

【“(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

【“(B) MEDICARE PER CAPITA GROWTH RATE.—

【“(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

【“(ii) REQUIREMENT.—The projection under clause (i) shall—

【“(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians’ services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

【“(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

【“(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

【“(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

【“(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

【“(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

【“(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

【“(7) SAVINGS REQUIREMENT.—

【“(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

[(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

[(i) the total amount of projected Medicare program spending for the proposal year; and

[(ii) the applicable percent for the implementation year.

[(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

[(i) in the case of—

[(I) implementation year 2015, 0.5 percent;

[(II) implementation year 2016, 1.0 percent;

[(III) implementation year 2017, 1.25 percent;

and

[(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

[(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

[(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.]

* * * * *

[(e) IMPLEMENTATION OF PROPOSAL.—

[(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

[(2) APPLICATION.—

[(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

[(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

[(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

[(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

[(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

[(3) EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the President to Congress pursuant to this section if—

[(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: ‘This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.’; and

[(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

[(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

[(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

[(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.—

[(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

[(A) that is introduced in 2017 by not later than February 1 of such year;

[(B) which does not have a preamble;

[(C) the title of which is as follows: ‘Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act’; and

[(D) the matter after the resolving clause of which is as follows: ‘That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.’

[(2) PROCEDURE.—

[(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

【“(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

【“(C) CONSIDERATION.—

【“(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

【“(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

【“(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

【“(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

【“(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

[(i) The joint resolution of the other House shall not be referred to a committee.

[(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

[(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

[(II) the vote on final passage shall be on the joint resolution of the other House.

[(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

[(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

[(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

[(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

[(i) make any determinations under subsection (c)(6) after May 1, 2017; or

[(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

[(B) the Board shall not submit any proposals or advisory reports to Congress under this section after January 16, 2018; and

[(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

[(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

[(1) MEMBERSHIP.—

[(A) IN GENERAL.—The Board shall be composed of—

[(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

[(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

[(B) QUALIFICATIONS.—

[(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

【“(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

【“(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

【“(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

【“(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

【“(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

【“(i) the majority leader of the Senate concerning the appointment of 3 members;

【“(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

【“(iii) the minority leader of the Senate concerning the appointment of 3 members; and

【“(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

【“(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

【“(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

【“(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member’s predecessor was appointed shall be appointed for the remainder of such term;

【“(C) a member may continue to serve after the expiration of the member’s term until a successor has taken office; and

【“(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

【“(3) CHAIRPERSON.—

【“(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

【“(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

【“(i) the appointment and supervision of personnel employed by the Board;

【“(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

【“(iii) the use and expenditure of funds.

【“(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

【“(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

【“(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

【“(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

【“(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

【“(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

【“(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

【“(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

【“(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

【“(i) POWERS OF THE BOARD.—

【“(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

【“(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

【“(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States in-

formation necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

【“(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

【“(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

【“(6) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

【“(j) PERSONNEL MATTERS.—

【“(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

【“(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

【“(3) STAFF.—

【“(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

【“(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

【“(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

【“(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

【“(k) CONSUMER ADVISORY COUNCIL.—

【“(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

【“(2) MEMBERSHIP.—

【“(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

【“(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

【“(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

【“(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

【“(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

【“(6) APPLICATION OF FACAA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

【“(1) DEFINITIONS.—In this section:

【“(1) BOARD; CHAIRPERSON; MEMBER.—The terms ‘Board’, ‘Chairperson’, and ‘Member’ mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

【“(2) MEDICARE.—The term ‘Medicare’ means the program established under this title, including parts A, B, C, and D.

【“(3) MEDICARE BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

【“(4) MEDICARE PROGRAM SPENDING.—The term ‘Medicare program spending’ means program spending under parts A, B, and D net of premiums.

【“(m) FUNDING.—

【“(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

【“(A) for fiscal year 2012, \$15,000,000; and

【“(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

【“(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.”

【“(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

[(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

[(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

[(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.”.

[(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

[(1) INITIAL STUDY AND REPORT.—

[(A) STUDY.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

[(i) Medicare beneficiary access to providers and items and services;

[(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

[(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

[(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

[(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

[(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

[(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

[(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

[(2) by inserting after paragraph (3) the following:

[(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.”.]

* * * * *

TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * *

Subtitle C—Provisions Relating to Title III

* * * * *

[SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDITIONAL IMPROVEMENTS TO, THE INDEPENDENT MEDICARE ADVISORY BOARD.

[(a) IN GENERAL.—Section 1899A of the Social Security Act, as added by section 3403, is amended—

[(1) in subsection (c)—

[(A) in paragraph (1)(B), by adding at the end the following new sentence: “In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.”;

[(B) in paragraph (2)(A)—

[(i) in clause (iv), by inserting “or the full premium subsidy under section 1860D–14(a)” before the period at the end of the last sentence; and

[(ii) by adding at the end the following new clause:

[(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.”;

[(C) in paragraph (2)(B)—

[(i) in clause (v), by striking “and” at the end;

[(ii) in clause (vi), by striking the period at the end and inserting “; and”; and

[(iii) by adding at the end the following new clause:

[(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.];

[(D) in paragraph (3)—

[(i) in the heading, by striking “TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT” and inserting “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”];

[(ii) in subparagraph (A)(i), by striking “transmit a proposal under this section to the President” and insert “submit a proposal under this section to Congress and the President”; and

[(iii) in subparagraph (A)(ii)—

[(I) in subclause (I), by inserting “or” at the end;

[(II) in subclause (II), by striking “; or” and inserting a period; and

[(III) by striking subclause (III);

[(E) in paragraph (4)—

[(i) by striking “the Board under paragraph (3)(A)(i) or”; and

[(ii) by striking “immediately” and inserting “within 2 days”];

[(F) in paragraph (5)—

[(i) by striking “to but” and inserting “but”; and

[(ii) by inserting “Congress and” after “submit a proposal to”; and

[(G) in paragraph (6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A, B, and D)”];

[(2) in subsection (d)—

[(A) in paragraph (1)(A)—

[(i) by inserting “the Board or” after “a proposal is submitted by”; and

[(ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”; and

[(B) in paragraph (2)(A), by inserting “the Board or” after “a proposal is submitted by”];

[(3) in subsection (e)—

[(A) in paragraph (1), by inserting “the Board or” after “a proposal submitted by”; and

[(B) in paragraph (3)—

[(i) by striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting “EXCEPTIONS.—

[(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or”];

[(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and

[(iii) by adding at the end the following new subparagraph:

[(B) LIMITED ADDITIONAL EXCEPTION.—

[(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—

[(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

[(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).

[(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

[(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—

[(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

[(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).”;

[(4) in subsection (f)(3)(B)—

[(A) by striking “or advisory reports to Congress” and inserting “, advisory reports, or advisory recommendations”;

and

[(B) by inserting “or produce the public report under subsection (n)” after “this section”; and

[(5) by adding at the end the following new subsections:

[(n) ANNUAL PUBLIC REPORT.—

[(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

[(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

[(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks

and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

【“(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

【“(C) Epidemiological shifts and demographic changes.

【“(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

【“(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

【“(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

【“(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

【“(A) that the Secretary or other Federal agencies can implement administratively;

【“(B) that may require legislation to be enacted by Congress in order to be implemented;

【“(C) that may require legislation to be enacted by State or local governments in order to be implemented;

【“(D) that private sector entities can voluntarily implement; and

【“(E) with respect to other areas determined appropriate by the Board.

【“(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

【“(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.”.

【(b) NAME CHANGE.—Any reference in the provisions of, or amendments made by, section 3403 to the “Independent Medicare Advisory Board” shall be deemed to be a reference to the “Independent Payment Advisory Board”.

【(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall preclude the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsection (a)(4).】

* * * * *

SOCIAL SECURITY ACT

* * * * *

**TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND
DISABLED**

* * * * *

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) * * *

(b) DUTIES.—

(1) * * *

* * * * *

[(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.]

[(5) (4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission’s agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.]

[(6) (5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.]

[(7) (6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term “appropriate committees of Congress” means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.]

[(8) (7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.]

[(9) (8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.]

* * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * *

[INDEPENDENT MEDICARE ADVISORY BOARD

[SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the “Independent Medicare Advisory Board”.

[(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

[(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as “a determination year”) the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as “an implementation year”);

[(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as “a proposal year”) a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

[(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

[(c) BOARD PROPOSALS.—

[(1) DEVELOPMENT.—

[(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

[(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board’s recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d). In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.

[(2) PROPOSALS.—

[(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

[(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B)

for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

[(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

[(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

[(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D-15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D-13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D-13(a) or the full premium subsidy under section 1860D-14(a).

[(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

[(vi) The proposal shall only include recommendations related to the Medicare program.

[(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.

[(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

[(i) give priority to recommendations that extend Medicare solvency;

[(ii) include recommendations that—

[(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

[(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

[(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

[(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

[(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates;

[(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX; and

[(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.

[(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

[(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

[(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary's review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

[(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

[(3) SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT.—

[(A) IN GENERAL.—

[(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall submit a proposal under this section to Congress and the President on January 15 of each year (beginning with 2014).

[(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

[(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph; or

[(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year.

[(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

[(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

[(i) the recommendations described in paragraph (2)(A)(i);

[(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

[(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

[(iv) a legislative proposal that implements the recommendations; and

[(v) other information determined appropriate by the Board.

[(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Secretary under paragraph (5), the President shall within 2 days submit such proposal to Congress.

[(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, but fails, to submit a proposal to Congress and the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

[(A) such proposal to the President; and

[(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

[(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

[(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

[(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

[(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

[(B) MEDICARE PER CAPITA GROWTH RATE.—

[(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending (calculated as the sum of per capita spending under each of parts A, B, and D).

[(ii) REQUIREMENT.—The projection under clause (i) shall—

[(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

[(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

[(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated

as the projected 5-year average (ending with such year) percentage increase in—

[(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

[(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

[(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

[(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

[(7) SAVINGS REQUIREMENT.—

[(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

[(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

[(i) the total amount of projected Medicare program spending for the proposal year; and

[(ii) the applicable percent for the implementation year.

[(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

[(i) in the case of—

[(I) implementation year 2015, 0.5 percent;

[(II) implementation year 2016, 1.0 percent;

[(III) implementation year 2017, 1.25 percent;

and

[(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

[(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

[(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.]

* * * * *

[(e) IMPLEMENTATION OF PROPOSAL.—

[(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal sub-

mitted by the Board or the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

[(2) APPLICATION.—

[(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

[(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

[(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

[(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

[(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

[(3) EXCEPTIONS.—

[(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or the President to Congress pursuant to this section if—

[(i) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: “This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.”; and

[(ii) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

[(B) LIMITED ADDITIONAL EXCEPTION.—

[(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—

[(1) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

[(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).

[(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

[(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—

[(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

[(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).

[(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

[(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

[(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.—

[(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

[(A) that is introduced in 2017 by not later than February 1 of such year;

[(B) which does not have a preamble;

[(C) the title of which is as follows: “Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act”; and

[(D) the matter after the resolving clause of which is as follows: “That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.”

[(2) PROCEDURE.—

[(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the

House of Representatives and the Committee on Finance of the Senate.

[(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

[(C) CONSIDERATION.—

[(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

[(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

[(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

[(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

[(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House

a joint resolution described in paragraph (1), then the following procedures shall apply:

[(i) The joint resolution of the other House shall not be referred to a committee.

[(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

[(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

[(II) the vote on final passage shall be on the joint resolution of the other House.

[(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

[(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

[(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

[(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

[(i) make any determinations under subsection (c)(6) after May 1, 2017; or

[(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

[(B) the Board shall not submit any proposals, advisory reports, or advisory recommendations under this section or produce the public report under subsection (n) after January 16, 2018; and

[(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

[(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

[(1) MEMBERSHIP.—

[(A) IN GENERAL.—The Board shall be composed of—

[(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

[(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

[(B) QUALIFICATIONS.—

[(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation,

and a balance between urban and rural representatives.

[(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

[(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

[(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

[(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

[(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

[(i) the majority leader of the Senate concerning the appointment of 3 members;

[(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

[(iii) the minority leader of the Senate concerning the appointment of 3 members; and

[(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

[(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

[(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

[(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

[(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

[(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

[(3) CHAIRPERSON.—

[(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

[(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

[(i) the appointment and supervision of personnel employed by the Board;

[(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

[(iii) the use and expenditure of funds.

[(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

[(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

[(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

[(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

[(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

[(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

[(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

[(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

[(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

[(i) POWERS OF THE BOARD.—

[(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

[(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

[(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States in-

formation necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

[(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

[(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

[(6) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

[(j) PERSONNEL MATTERS.—

[(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

[(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

[(3) STAFF.—

[(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

[(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

[(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

[(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

[(k) CONSUMER ADVISORY COUNCIL.—

[(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

[(2) MEMBERSHIP.—

[(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

[(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

[(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

[(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

[(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

[(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

[(l) DEFINITIONS.—In this section:

[(1) BOARD; CHAIRPERSON; MEMBER.—The terms “Board”, “Chairperson”, and “Member” mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

[(2) MEDICARE.—The term “Medicare” means the program established under this title, including parts A, B, C, and D.

[(3) MEDICARE BENEFICIARY.—The term “Medicare beneficiary” means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

[(4) MEDICARE PROGRAM SPENDING.—The term “Medicare program spending” means program spending under parts A, B, and D net of premiums.

[(m) FUNDING.—

[(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

[(A) for fiscal year 2012, \$15,000,000; and

[(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

[(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

[(n) ANNUAL PUBLIC REPORT.—

[(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, pa-

tient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

[(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

[(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

[(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

[(C) Epidemiological shifts and demographic changes.

[(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

[(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

[(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

[(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

[(A) that the Secretary or other Federal agencies can implement administratively;

[(B) that may require legislation to be enacted by Congress in order to be implemented;

[(C) that may require legislation to be enacted by State or local governments in order to be implemented;

[(D) that private sector entities can voluntarily implement; and

[(E) with respect to other areas determined appropriate by the Board.

[(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

[(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.]

* * * * *

SECTION 207 OF TITLE 18, UNITED STATES CODE

§ 207. Restrictions on former officers, employees, and elected officials of the executive and legislative branches

(a) * * *

* * * * *

(c) ONE-YEAR RESTRICTIONS ON CERTAIN SENIOR PERSONNEL OF THE EXECUTIVE BRANCH AND INDEPENDENT AGENCIES.—

(1) * * *

* * * * *

[(3) MEMBERS OF THE INDEPENDENT PAYMENT ADVISORY BOARD.—

[(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Payment Advisory Board under section 1899A.

[(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Payment Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.]

* * * * *

112TH CONGRESS
1ST SESSION

H. R. 452

To repeal the provisions of the Patient Protection and Affordable Care Act providing for the Independent Payment Advisory Board.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 26, 2011

Mr. ROE of Tennessee (for himself, Mr. BURGESS, Mr. POSEY, Mrs. BLACKBURN, Mr. PAUL, Mr. WESTMORELAND, Mr. LAMBORN, Mr. JONES, Mr. LONG, Mr. SESSIONS, Mr. CRAWFORD, Mr. ROONEY, Mr. DUNCAN of Tennessee, Mr. GARY G. MILLER of California, Mr. NUNNELEE, Mr. FRELINGHUYSEN, Mr. HUNTER, Mr. CONAWAY, Mr. HALL, Mr. BROUN of Georgia, Mr. COFFMAN of Colorado, Mr. COBLE, Mr. THOMPSON of Pennsylvania, and Mr. ROHRBACHER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Rules and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To repeal the provisions of the Patient Protection and Affordable Care Act providing for the Independent Payment Advisory Board.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Decisions
5 Accountability Act of 2011”.

1 **SEC. 2. REPEAL OF THE INDEPENDENT PAYMENT ADVI-**
2 **SORY BOARD.**

3 Effective as of the enactment of the Patient Protec-
4 tion and Affordable Care Act (Public Law 111–148), sec-
5 tions 3403 and 10320 of such Act (including the amend-
6 ments made by such sections) are repealed, and any provi-
7 sion of law amended by such sections is hereby restored
8 as if such sections had not been enacted into law.

○

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 452
OFFERED BY MR. CAMP OF MICHIGAN**

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Medicare Decisions
3 Accountability Act of 2011”.

4 **SEC. 2. REPEAL OF THE INDEPENDENT PAYMENT ADVI-
5 SORY BOARD.**

6 Effective as of the enactment of the Patient Protec-
7 tion and Affordable Care Act (Public Law 111-148), sec-
8 tions 3403 and 10320 of such Act (including the amend-
9 ments made by such sections, but excluding subsection (d)
10 of section 1899A of the Social Security Act, as added and
11 amended by such sections) are repealed, and any provision
12 of law amended by such sections is hereby restored as if
13 such sections had not been enacted into law.



MINORITY VIEWS TO H.R. 452, THE “MEDICARE DECISIONS
ACCOUNTABILITY ACT”

We, the undersigned Members of the Committee on Ways and Means, question the timing and political motivations behind H.R. 452, the “Medicare Decisions Accountability Act”. Thanks to the remarkable steps made in the Affordable Care Act to slow spending growth and strengthen Medicare’s finances, the Congressional Budget Office currently estimates that the Independent Payment Advisory Board (IPAB) mechanism will not even be triggered until sometime after 2022. More specifically, CBO states that, “CBO’s current estimates of Medicare spending and its current economic projections result in an IPAB spending measure that is below the economic measure in each target year through 2022 (that is, in the last year of each five-year period).”¹

	2015	2016	2017	2018	2019	2020	2021	2022
Spending Projection	1.7%	1.7%	1.5%	2.7%	3.1%	3.6%	3.9%	4.2%
Target Growth Rate	2.8%	2.8%	2.9%	3.0%	3.2%	5.2%	4.9%	4.7%
Difference	-1.1%	-1.1%	-1.4%	-0.3%	-0.1%	-1.6%	-1.0%	-0.5%

Thus, we see no urgency to this vote at this time, as was pointed out by Democratic Members during the markup. Given the lack of time sensitivity to this issue, we assume the Republican Majority is raising this bill now merely as a political ploy to continue their piecemeal attempt to dismantle the health reform law, and hold a floor vote on an ACA repeal bill during the two-year anniversary of the law. We believe this time is better spent touting the good work of the Affordable Care Act, which slowed Medicare spending growth, extended solvency, and lowered beneficiary cost-sharing, all while improving benefits. The ACA is something to be celebrated as we look toward its two year anniversary.

During the markup we also raised questions about how Republicans plan to offset the cost of this bill. While CBO estimates that IPAB’s mechanism will not be triggered until sometime after 2022, due to the vagaries of CBO scoring, they estimate the ten-year cost of repeal at \$3.1 billion. It is our understanding that a floor vote will occur the week of March 19th—less than two weeks from our Committee mark-up, with Congress in recess most of that time. Despite this short timetable, the Republican Majority refused to shed any light on their planned offset. We asked whether the offset will cut Medicare benefits, raise cost-sharing, or undermine coverage for those who will receive new assistance in 2014. Again, the Republican Majority refused to answer any of these questions.

¹ Congressional Budget Office, “H.R. 452: Medicare Decisions Accountability Act of 2011, as ordered reported by the House Committee on Ways and Means on March 8, 2012,” March 8, 2012.

We have many times criticized our Republican Majority for their attempts to repeal ACA in whole or in part without articulating their vision to replace. However, in this instance, their intentions are clear. House Republicans voted as part of last year's budget—and we anticipate a similar plan to be announced later this month—to end the guarantee of Medicare. They want to end the Medicare program and turn it into an underfunded voucher program that would greatly shift costs to Medicare beneficiaries and let private insurers be the sole deciders of what benefits will be covered. Their desire to repeal IPAB is not due to a sincere interest in protecting the program, but rather to score political points against the ACA. We wholeheartedly reject their dangerous vision for Medicare's future and stand united in support of the Affordable Care Act's guarantee of affordable, quality health care for all.

SANDER LEVIN.
CHARLES B. RANGEL.
FORTNEY PETE STARK.
JIM MCDERMOTT.
JOHN LEWIS.
RICHARD E. NEAL.
XAVIER BECERRA.
MIKE THOMPSON.
JOHN B. LARSON.
EARL BLUMENAUER.
RON KIND.
JOSEPH CROWLEY.

