

PROTECTING SENIORS ACCESS TO MEDICARE ACT

OCTOBER 31, 2017.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BRADY of Texas, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 849]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 849) to repeal the provisions of the Patient Protection and Affordable Care Act providing for the Independent Payment Advisory Board, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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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 “Protecting Seniors Access to Medicare Act”.

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Care Act (Public Law 111–148), sections 3403 and 10320 of such Act (including the amendments made by such sections) are repealed, and any provision of law amended by such sections is hereby restored as if such sections had not been enacted into law.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. 849, as ordered by the Committee on Ways and Means on October 4, 2017, would repeal Medicare’s Independent Payment Advisory Board (“IPAB”), section 3403 and 10320 of the Patient Protection and Affordable Care Act (“ACA”; P.L. 111–148).

B. BACKGROUND AND NEED FOR LEGISLATION

On February 3, 2017, Representative David P. Roe (R–TN) and Representative Raul Ruiz introduced H.R. 849, a bill to repeal provisions of the ACA providing for 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. 849 was introduced on February 3, 2017, and was referred to the Committee on Ways and Means, and additionally to the Committee on Energy and Commerce and the Committee on Rules.

COMMITTEE HEARINGS

On June 8, 2017, the Committee held a hearing on the Department of Health and Human Services’ (HHS) Fiscal Year 2018 Budget Proposal with Secretary Price, in which IPAB was discussed.

On February 10, 2016, the Committee held a hearing on the HHS Fiscal Year 2017 Budget Proposal with Secretary Burwell, in which IPAB was discussed.

On June 10, 2015, the Committee held a hearing on the Implementation of the Affordable Care Act with Secretary Burwell, in which IPAB was discussed.

On March 12, 2014, the Committee held a hearing on the HHS Fiscal Year 2015 Budget Proposal with Secretary Sebelius, in which IPAB was discussed.

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

On June 22, 2011, the Subcommittee held a hearing on the 2011 Medicare Trustees Report, in which IPAB was discussed.

On February 28, 2012, the Committee held a hearing on the HHS Fiscal Year 2013 Budget Proposal with Secretary Sebelius, in which IPAB was discussed.

On February 10, 2011, the Committee held a hearing on the ACA's impact on Medicare and its beneficiaries.

On January 26, 2011, the Committee held a hearing on the ACA's impact on jobs, employers, and the economy.

COMMITTEE ACTION

The Committee on Ways and Means marked up H.R. 849, the Protecting Seniors' Access to Medicare Act of 2017, on October 4, 2017, and ordered the bill, as amended, favorably reported (with a quorum being present).

II. EXPLANATION OF THE BILL

A. PROTECTING SENIORS' ACCESS TO MEDICARE ACT OF 2017

PRESENT LAW

IPAB was created by Sections 3403 and 10320 of the ACA (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. No board members have been selected to date.

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 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 or exceed the savings target identified by the CMS Chief Actuary. 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.

Due to the projected growth in Medicare spending, the Trustees currently predict that IPAB will be triggered as soon as 2021, compared to the 2016 report that predicted a 2017 trigger date. The Trustees estimate that IPAB will reduce Medicare growth rates for the first time in 2023, by 0.002 percent. In addition, the Trustees project that growth rates will be reduced by similarly small amounts in 2026, 2027, 2028, 2030, 2033, and 2035. However, they project that “IPAB is not triggered beyond 2035 in current law, mostly due to the assumptions about long-range health care cost growth, which is lower than GDP growth.”

IPAB operating funds are drawn from the Medicare trust funds. IPAB was scheduled to receive \$15 million in FY2012 (indexed to inflation in future years). Congress has repeatedly rescinded its funding (FY2012–FY2017), rescinding \$15 million in the Consolidated Appropriations Act of 2017, which policy was most recently retained in the three-month continuing resolution (The Continuing Appropriations Act, 2018 and Supplemental Appropriations for Disaster Relief Requirements Act of 2017).

IPAB’s recommendations are due to the President and Congress by January 15 following the year in which the Chief Actuary sets the savings target. IPAB was prohibited from making its first recommendations before January 15, 2014, and IPAB-related spending reductions could not 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 by January 25 to the President, who would then send the proposal to Congress). Similarly, if the Senate fails to confirm the President’s IPAB appointees, the HHS Secretary would be solely responsible for developing the legislation to cut Medicare to achieve the savings target and for 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 1 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 15 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 15 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 could have discontinued IPAB via a joint resolution which receives “fast track” treatment in the Senate, so long as the resolution had been introduced before February 1 and contained specific language outlined in the Democrats’ health care overhaul. Such a repeal would have required a three-fifths supermajority vote in both the House and Senate. Repeal efforts in other years will not enjoy these 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 per 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 experts in 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 operational 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 were 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 any 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. 849, as amended, would repeal section 3403 and 10320 of the ACA, including the amendments made by these sections. Beginning in 2014, the IPAB is tasked with making recommendations to cut per capita Medicare spending if such spending exceeds certain economic growth targets. The Secretary of HHS is directed to implement the Board's proposals automatically unless Congress affirmatively acts to alter the Board's proposals or to discontinue the automatic implementation of such proposals. Under the proposed legislation, the IPAB would be repealed.

EFFECTIVE DATE

H.R. 849 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 statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 849, the Protecting Seniors' Access to Medicare Act of 2017, on October 4, 2017.

The Chairman's amendment in the nature of a substitute was adopted by a voice vote (with a quorum being present).

The vote on Mr. Reichert's motion to table Mr. Doggett's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas to 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	.....	.....
Ms. Black	X	.....	.....	Ms. Sánchez .....	.....	X	.....
Mr. Reed .....	.....	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO) .....	.....	.....	.....	

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

The vote on the amendment offered by Mr. Doggett to the amendment in the nature of a substitute to H.R. 849, which would prevent the repeal of the Independent Payment Advisory Board if CMS found that Medicare prescription drug spending was growing faster than the rate of inflation, was not agreed to by a roll call vote of 22 nays to 15 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	Mr. Neal	X	.....	.....
Mr. Johnson	X	.....	Mr. Levin	X	.....	.....
Mr. Nunes	X	.....	Mr. Lewis	X	.....	.....
Mr. Tiberi	X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert	X	.....	Mr. Thompson	X	.....	.....
Mr. Roskam	X	.....	Mr. Larson	X	.....	.....
Mr. Buchanan	X	.....	Mr. Blumenauer	X	.....	.....
Mr. Smith (NE)	X	.....	Mr. Kind	X	.....	.....
Ms. Jenkins	X	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen	X	.....	Mr. Crowley	X	.....	.....
Mr. Marchant	X	.....	Mr. Davis .....	.....	.....	.....
Ms. Black	X	.....	Ms. Sánchez	X	.....	.....
Mr. Reed	Mr. Higgins	X	.....	.....
Mr. Kelly	X	.....	Ms. Sewell	X	.....	.....
Mr. Renacci	X	.....	Ms. DelBene	X	.....	.....
Mr. Meehan	X	.....	Ms. Chu	X	.....	.....
Ms. Noem	X	.....			
Mr. Holding	X	.....			
Mr. Smith (MO)				
Mr. Rice	X	.....			
Mr. Schweikert	X	.....			
Ms. Walorski	X	.....			
Mr. Curbelo	X	.....			
Mr. Bishop	X	.....			

H.R. 849 was ordered favorably reported to the House of Representatives as amended by a roll call vote of 24 yeas to 13 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....
Ms. Jenkins	X	.....	.....	Mr. Pascrell	X	.....	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	.....	.....
Ms. Black	X	.....	.....	Ms. Sánchez	X	.....	.....
Mr. Reed .....	.....	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)							
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						

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 bill, H.R. 849, 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 that H.R. 849, as reported, would increase direct spending by \$17.5 billion over the 2017–2026 period. The Committee states further that the bill involves no new or increased tax expenditures.

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 CBO, the following statement by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 27, 2017.

Hon. KEVIN BRADY,
*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. 849, the Protecting Seniors' Access to Medicare Act.

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

Sincerely,

KEITH HALL
Director.

Enclosure.

H.R. 849—Protecting Seniors' Access to Medicare Act

Summary: H.R. 849 would repeal the provisions of the Affordable Care Act (ACA) that established the Independent Payment Advisory Board (IPAB) and that created a process by which the 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 specified savings.

CBO estimates that enacting H.R. 849 would increase direct spending by \$17.5 billion over the 2018–2027 period. That estimate is extremely uncertain because it is not clear whether the mechanism for spending reductions under the IPAB authority will be invoked under current law for most of the next ten years. Under CBO’s current baseline projections such authority is projected to be invoked in 2023, 2025, and 2027. However, given the uncertainty that surrounds those projections, it is possible that such authority would be invoked in other years. Taking into account that possibility, CBO estimates that repealing the IPAB provision of the ACA would probably result in higher spending for the Medicare program over the 2022 through 2027 period than would occur under current law. CBO’s estimate represents the expected value of a broad range of possible effects from repealing IPAB provisions.

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

CBO estimates that enacting H.R. 849 would increase net direct spending and on-budget deficits by more than \$5 billion in one or more of the four consecutive 10-year periods beginning in 2028.

H.R. 849 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. 849 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By fiscal year, in millions of dollars—												
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018– 2022	2018– 2027	
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	0	0	0	800	220	5,160	1,560	6,600	3,150	800	17,490	
Estimated Outlays	0	0	0	0	800	220	5,160	1,560	6,600	3,150	800	17,490	

Basis of estimate: H.R. 849 would repeal the provisions of the ACA that created IPAB. CBO estimates that enacting the bill would lead to a net increase in direct spending of \$17.5 billion over the 2018–2027 period.

Background

Under current law, IPAB 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. For 2015 through 2019, that target rate is based on inflation; for 2020 and subsequent years, it is based on growth in the economy. Each year, 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.

In general, 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. However, current law prohibits modifications designed to achieve the savings target in two consecutive years if the Chief Actuary determines that the rate of growth in Medicare spending per beneficiary is below the rate of growth in national health expenditures per capita. In general, CBO expects that modifications designed to achieve the savings target would not be implemented in consecutive years.

CBO's current estimates of Medicare spending and its current economic projections result in an estimated IPAB spending measure that is above the economic measure in 2023 and each subsequent year through 2027. However, because of the limitation on making modifications in consecutive years, CBO's baseline projections include the assumption that modifications to the Medicare program designed to achieve the savings target would be implemented in 2023, 2025, and 2027. In addition, CBO anticipates that some of the savings from program modifications made to hit the savings target generated by the IPAB mechanism will compound and produce savings in subsequent years. Under current law, CBO projects that actions taken to achieve the IPAB spending target will reduce Medicare spending by \$15 billion over the 2018–2027 period.²

Estimated effects of H.R. 849 over the 2018–2027 period

The IPAB mechanism is essentially a one-sided bet: either modifications to achieve a savings target are required (resulting in savings) or they are not (resulting in no change).³ IPAB cannot be instructed to increase spending. So, variations in those measures might lead to additional savings but could not lead to added costs. Because of the one-sided nature of the budgetary impact of variations in the spending and economic measures that determine IPAB's savings target, CBO must consider the probabilities associated with such variations when assessing the budgetary effects of possible changes in law.

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 IPAB's savings target under both current law and under

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 www.bls.gov/cpi/questions-and-answers.htm#Question_7).

²CBO's baseline projections result in a projected savings target of 0.1 percent for 2019. However, the 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Trustees Report) determined that the target growth rate will not be exceeded for 2019. CBO views the Trustees Report as a final action that sets the savings target for 2019 to zero.

³For a discussion of CBO's longstanding approach to estimating one-sided bets, see www.cbo.gov/sites/default/files/cbofiles/ftpdocs/15xx/doc1589/onesided.pdf.

the proposal. 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.⁴

Under that probability-based approach, and after applying the de minimis rule (for estimated effects that round to 0.0 percent), CBO estimates that the expected value of IPAB’s savings target would be zero for 2018 through 2021. For 2022 through 2028, the expected value of the savings target would be between 0.1 percent and 0.7 percent of projected net Medicare spending. As a result, CBO estimates that repealing the IPAB mechanism would increase expected Medicare spending each year from 2022 through 2027, with the expected value of the net increase in Medicare spending for benefits totaling \$17.5 billion over that 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. 849 would not affect revenues.

	By fiscal year, in millions of dollars—											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018–2022	2018–2027
NET INCREASE OR DECREASE (–) IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	0	0	0	0	800	220	5,160	1,560	6,600	3,150	800	17,490

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 849 would increase net direct spending and on-budget deficits by more than \$5 billion in one or more of the four consecutive 10-year periods beginning in 2028.

Intergovernmental and private-sector impact S: H.R. 849 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal costs: Lori Housman; Impact on State, local, and tribal governments: Amy Petz; Impact on the private sector: Amy Petz.

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

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

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee made findings and recommendations that are reflected in this report.

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 advises that the bill does

⁴A further discussion of this methodology can be found in CBO’s estimate for H.R. 452, the Medicare Decisions Accountability Act of 2011, www.cbo.gov/sites/default/files/112th-congress-2011-2012/costestimate/hr45220120.pdf.

not authorize funding, so no statement of general performance goals and objectives is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. 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.

E. DUPLICATION OF FEDERAL PROGRAMS

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Pub. L. No. 95-220, as amended by Pub. L. No. 98-169).

F. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings:

The Committee advises that the bill requires no directed rulemakings within the meaning of such section.

VI. 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, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

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). 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 Con-

sumer 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 implementa-

tion 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.

[(d) CONGRESSIONAL CONSIDERATION.—

[(1) INTRODUCTION.—

[(A) IN GENERAL.—On the day on which a proposal is submitted by the Board or the President to the House of Representatives and the Senate under subsection (c)(3)(A)(i) or subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

[(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

[(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

[(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

[(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

[(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is submitted by the Board or the President to Congress under this section, 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 may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

【“(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of subparagraph (A), the 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 provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

【“(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

【“(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

【“(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

【“(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

【“(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

【“(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

【“(4) EXPEDITED PROCEDURE.—

【“(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

【“(B) AMENDMENT.—

【“(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and

debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

【“(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

【“(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

【“(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

【“(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

【“(C) CONSIDERATION BY THE OTHER HOUSE.—

【“(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

【“(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

【“(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

【“(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

【“(iii) AFTER PASSAGE.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

【“(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

【“(v) LIMITATION.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

【“(I) is related only to the program under this title; and

【“(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(D) SENATE LIMITS ON DEBATE.—

【“(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

【“(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

【“(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

【“(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

【“(E) CONSIDERATION IN CONFERENCE.—

【“(i) IN GENERAL.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

【“(ii) TIME LIMITATION.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition

thereto shall be controlled by the minority leader or such leader's designee.

【“(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

【“(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

【“(I) is related only to the program under this title; and

【“(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(F) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

【“(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

【“(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

【“(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

【“(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 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—

[(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) 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 information 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 FACCA.—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.

【“(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.”

【(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.”.]

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

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Subtitle C—Provisions Relating to Title III

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[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 “SUB-

MISSION 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

[(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).]

* * * * *

VII. ADDITIONAL VIEWS

Under current law, the Independent Payment Advisory Board (IPAB) is intended to be a back stop mechanism to address health care costs, in the event the other delivery system reforms of the Affordable Care Act (ACA) did not yield anticipated outcomes in improving care and lowering costs. To date, however, the new delivery reform initiatives in the ACA have brought success. Medicare spending growth has slowed and as a result, the Congressional Budget Office currently estimates that the Independent Payment Advisory Board (IPAB) mechanism will not even be triggered until after 2021.

While some Democrats support the repeal of the IPAB because it may be viewed as an infringement on Congressional authority, given IPAB isn't expected to be triggered for some years, the need for immediate action is not at all clear.

As Republican efforts to repeal the Affordable Care Act failed earlier this year, the timing of this IPAB effort appears to be a return to the Republicans' piecemeal attempt to dismantle the health reform. The Affordable Care Act, which slowed Medicare spending growth, extended solvency, and lowered beneficiary cost-sharing, all while improving benefits, should be improved upon by Congress, not torn down piece by piece through bills such as H.R. 849.

It is also important, regardless of how IPAB is viewed, to set the record straight on what IPAB does and does not do. It is not a "rationing board" as Republicans have claimed. The statute specifically prohibits sending recommendations to Congress that would harm seniors by increasing their out-of-pocket costs or cutting their benefits. In fact, it is the Republican ACA repeal efforts that would have cut nearly a trillion dollars from Medicaid and Medicare, which would have truly led to rationing in the country.

During the markup Democrats raised questions about how Republicans propose to offset the cost of this bill. While CBO estimates that IPAB's mechanism will not be triggered until after 2021, due to the vagaries of CBO scoring, they estimate the ten-year cost of repeal at over \$17.5 billion.

Democrats are concerned that Republicans would offset the \$17.5 billion cost of IPAB repeal with actual and immediate cuts to Medicare benefits, increased costs for Medicare beneficiaries, or cuts to other health priorities that would cause coverage loss.

Despite assertions otherwise, the IPAB appointees must have no conflict of interest helping ensure that sound policy not special interests are guiding recommendations. Once the IPAB recommendations are submitted to the Congress, the Committees of jurisdiction, including the Committee on Ways and Means, may modify the recommendations as may the full House and full Senate under fast-track procedures, so long as the spending targets themselves are not breached. (The House or Senate could also reject the spending

targets, but would face additional procedural hurdles to do so.) The IPAB's recommendations are limited to matters affecting Medicare and IPAB is prohibited from making recommendations that ration care; change eligibility; increase cost-sharing, premiums, or taxes; or reduce benefits.

In conclusion, we are concerned with the process, lack of transparency on offsets, and rhetoric surrounding this legislation.

RICHARD E. NEAL,
Ranking Member.

