

MEDICARE DECISIONS ACCOUNTABILITY ACT OF 2011

MARCH 16, 2012.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 452]

[Including cost estimate of the Congressional Budget Office]

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

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AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

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

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

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but excluding subsection (d) of section 1899A of the Social Security Act, as added and amended by such sections) are repealed, and any provision of law amended by such sections is hereby restored as if such sections had not been enacted into law.

PURPOSE AND SUMMARY

The purpose of H.R. 452, the “Medicare Decisions Accountability Act of 2011” is to repeal section 3403 and section 10320 of the Patient Protection and Affordable Care Act (PPACA), which establish the Independent Payment Advisory Board (IPAB).

BACKGROUND AND NEED FOR LEGISLATION

According to PPACA, section 3403 establishes a 15-member board to “reduce the per capita rate of growth in Medicare spending.”¹

By April 30 of each year, beginning in 2013, the Centers for Medicare and Medicaid Services (CMS) Actuary’s Office will project whether Medicare’s per-capita spending growth rate in the following two years will exceed a targeted rate. Initially, the targeted rate of spending growth will be based on the projected five-year average percentage increase in the Consumer Price Index for all urban consumers (CPIu) and the Consumer Price Index for all urban consumers for medical care (CPIm).

Beginning with the 2018 Determination Year, the target will be set at the nominal gross domestic product per capita, plus 1.0 percent (President Obama’s FY 2013 budget proposes that this be changed to GDP plus 0.5%).² If future Medicare spending is expected to exceed the targets, the board will propose recommendations to Congress and the President to reduce the growth rate. The board’s first set of recommendations would be proposed on January 15, 2014.

By September 1 of each Determination Year, the Board submits a draft of its proposal for review to the Secretary of the Department of Health and Human Services (Secretary) and to Medicare Patient Advisory Commission (MedPAC) for consultation. The board transmits its annual proposal to Congress and the President on January 15 of each Proposal Year, beginning 2014. The proposal is referred to the House Committees on Energy and Commerce and Ways and Means and the Senate Finance Committee. The committees must report an implementing bill or legislation that achieves at least the same level of targeted reductions in Medicare spending growth as contained in the IPAB plan. Unless both houses of Con-

¹ Section 3403, Patient Protection and Affordable Care Act (Public Law 11–148).

² FY 2013, Budget in Brief, U.S. Dept. of Health and Human Services; p. 55.

gress agrees to legislation that achieves the same reductions in spending, the Secretary automatically implements the board's proposals on August 15 of the Proposal Year and the recommendations that relate to payment rate changes that take effect on a fiscal year basis take effect on October 1 of the Proposal Year. Recommendations relating to payment rate changes that take effect on a calendar year basis take effect on January 1 of the Implementation Year.

Spending rate reductions will be established at: 0.5 percent in 2015; 1.0 percent in 2016; 1.25 percent in 2017; and 1.5 percent in 2018 and beyond.

The board will be composed of 15 members appointed by the President, with the advice and consent of the Senate. As such, the members are officers of the United States under the appointments clause of the U.S. Constitution. The Secretary, the Administrator of CMS, and the Administrator of the Health Resources and Services Administration are ex-officio non-voting members. The Chairperson is appointed by the President from among the members of the Board. Each appointed member may serve two consecutive six-year terms. Appointed members of the board will be compensated at a rate equal to Level III of the Executive Schedule (\$165,300 for 2011), and the Chairperson will be compensated at a rate equal to Level II (\$179,700 for 2011).

At present, the Administration has not made known any attempt to nominate any members of the board. If the board does not make a recommendation or if the membership of the board is not filled, the Secretary is tasked with developing recommendations. If Congress is unable to pass legislation overturning the Secretary's recommendations, the Secretary must implement them.

The effect of the procedures in the legislation is to favor the continuation of the board and its recommendations, even in the face of significant opposition in both chambers of Congress. Section 3403 establishes a second "fast track" parliamentary mechanism for consideration of legislation discontinuing the automatic implementation process for the recommendations of the board. However, in order to qualify for consideration under "fast track" procedures, the House and Senate must adopt a joint resolution discontinuing the process. The joint resolution to discontinue the board must be introduced by February 1, 2017. If the joint resolution is adopted by both houses of Congress, but vetoed by the President, overriding the veto would require a super-majority vote of two-thirds in both chambers for the measure to become law, shifting the balance of power to the President and away from Congress.

The budget for the board for FY 2012 was to be \$15 million, with annual adjustments based on increases in the CPI. This is slightly more than the MedPAC budget. The FY 2012 Consolidated Appropriations Bill cut \$10 million of the \$15 million that PPACA appropriated for IPAB for FY 2012. The disposition of the remaining \$5 million, which was to be appropriated for FY 2012, remains unclear. The board is to be funded out of the Medicare trust funds—specifically, 60 percent of the board's funds will come from the Federal Hospital Insurance Trust Fund and 40 percent from the Federal Supplementary Medical Insurance Trust Fund.

Some have raised concerns that, in spite of the language in the legislation, IPAB will result in "de facto" rationing of care. Accord-

ing to MedPAC, some Medicare beneficiaries, especially those looking for a new primary care physician, are already having difficulty finding physicians to see them.³ The data is clear; faced with substantial fee cuts, such as those that are still pending under the Sustainable Growth Rate (SGR), most physicians will reduce the number of Medicare patients they treat, or stop seeing Medicare patients altogether. According to an American Medical Association survey, current reimbursement rates have already led 17 percent of doctors, including 31 percent of primary care physicians, to restrict the number of Medicare patients in their practices.⁴ Under the current SGR payment formula, cuts to physician fees of over 30 percent are pending for January 2013. Further arbitrary cuts under IPAB will only make access problems worse.

The CMS actuary has expressed concerns about the power given to the board's unelected officials and about the detrimental effect that ratcheting down payments could have on innovation and in limiting patient access to physicians, medicines, and other treatments, stating that the target growth rates create a situation in Medicare that is analogous to the SGR.⁵

Since hospitals, skilled nursing facilities, long-term care hospitals, and other providers are exempt from IPAB cuts through 2019, and laboratory services through 2015, physicians will be disproportionately affected. Again, there is a valid concern that the additional IPAB cuts will cause access problems for Medicare beneficiaries.

In March 2010, the Congressional Budget Office (CBO) estimated the cost savings from IPAB at \$15.5 billion during the 2015 to 2019 period.⁶ In March 2011, CBO changed their estimate and projected that, under current law, the IPAB mechanism would not affect Medicare spending during the 2011 to 2021 period.⁷ This meant that repeal of IPAB would not require an offset and, in fact, would be a likely cost saver by the amount appropriated (\$15 million per year, adjusted for inflation). Two months later, based on a "one-sided bet" statistical justification, CBO again rescored the repeal of IPAB at the current cost estimate of \$2.4 billion. Under the "one-sided" bet theory, IPAB has no cost and can only save money. Thus, because H.R. 452 strikes IPAB, and the hypothetical savings IPAB promises, CBO determined the bill will cost \$3.1 billion from 2013 to 2022.

HEARINGS

On July 13, 2011, the Subcommittee on Health held a hearing entitled "IPAB: The Controversial Consequences for Medicare and Seniors." At the hearing, the Subcommittee discussed the fundamental differences between the Republican and Democratic plans

³MedPAC Report to the Congress, Medicare Payment Policy, March, 2011; CH. 4, pg. 69, available at: http://www.medpac.gov/chapters/Mar11_Ch04.pdf

⁴AMA ONLINE SURVEY OF PHYSICIANS The Impact of Medicare Physician Payment on Seniors' Access To Care May 2010, available at: <http://www.ama-assn.org/resources/doc/washington/medicare-survey-results-0510.pdf>.

⁵Foster RS. Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended. Washington, DC.: Centers for Medicare and Medicaid Services, April 22, 2010.

⁶Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Honorable Nancy Pelosi, Speaker, House of Representatives, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁷CBO March, 2011 Medicare Baseline, Available at www.cbo.gov/budget/factsheets/2011b/medicare.pdf.

for Medicare reform and how IPAB will affect current reform efforts, ration health care goods and services, and may be unconstitutional.

The Subcommittee received testimony from: John Cornyn, Senator (TX); Allyson Schwartz (PA-13); David P. Roe (TN-01); George Miller (CA-07); Kathleen Sebelius, Secretary; Department of Health and Human Services; Chris Davis, Legislative Analyst, Congressional Research Service; David Newman, Financial Analyst, Congressional Research Service; Diane Cohen, Senior Attorney, Goldwater Institute; Judy Feder, Senior Fellow, Center for American Progress; Avik Roy, Healthcare Analyst, Monness, Crespi, Hardt & Co.; Stuart Guterman, Senior Program Director, the Commonwealth Fund; Scott Gottlieb, Resident Fellow, American Enterprise Institute; Alex Valadka, Chief Executive Officer, Seton Brain and Spine Institute; Mary Grealey, President, Healthcare Leadership Council.

COMMITTEE CONSIDERATION

On February 29, 2012, the Subcommittee on Health met in open markup session and forwarded H.R. 452, without amendment, to the full Committee by a vote of 17 yeas and 5 nays, a quorum being present.

On March 6, 2012, the full Committee met in open markup session to consider H.R. 452, the "Medicare Decisions Accountability Act of 2011." A motion by Mr. Upton to order H.R. 452 reported to the House, as amended, was agreed to by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 452 reported.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of H.R. 452 is to protect the future of the Medicare program by preserving the right of patients and their doctors to make decisions regarding the value of health care goods and services and preventing major health reform legislation from being implemented without being subjected to the usual legislative process.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 452, the "Medicare Decisions Accountability Act of 2011," would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI, the committee finds that H.R. 452, the “Medicare Decisions Accountability Act of 2011” contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 7, 2012.

Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

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

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

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

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

Summary: H.R. 452 would repeal the provisions of the Affordable Care Act (ACA) that established the Independent Payment Advisory Board (IPAB) and created a process by which that Board (or the Secretary of the Department of Health and Human Services) would be required under certain circumstances to modify the Medicare program to achieve certain specified savings.

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

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

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

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

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

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

Administrative costs

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

CBO estimates that net funding for IPAB administrative costs will total \$149 million over the 2013–2022 period, and that outlays will total \$137 million through 2022. Those amounts take into account that about 10 percent of the funds provided for the IPAB will be offset by changes in receipts from Medicare Part 13 premiums. For example, the estimated gross funding for 2013 under current law is \$15 million, and about \$1 million in additional Part B premiums will be collected, resulting in an estimated net change in budget authority of \$14 million for next year.

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

Net spending for Medicare benefits

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

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

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

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

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

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

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

In fact, the difference between the spending measure and the economic measure in each year that the Chief Actuary makes an IPAB determination will probably not be equal to the difference that CBO currently projects. If the Chief Actuary ends up projecting some combination of a higher spending measure or a lower economic measure than CBO currently projects, the savings target for the IPAB mechanism could exceed zero.

Because of the one-sided nature of the budgetary impact of variations in the spending and economic measures that determine IPAB's savings target, it is important to consider the probabilities associated with such variations when assessing the effects of possible changes in law. To assess the probability of the IPAB mechanism being triggered, CBO analyzed the technical component of changes in its recent baseline projections of Medicare spending.³ We concluded that there is a roughly two-thirds chance that the

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

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

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

amount of spending in five years will differ from the agency's current projection by less than 2 percent as a result of technical factors.⁴ (Thus, there is a one-third chance that the amount of spending in five years would differ by more than 2 percent as a result of such factors.) The uncertainty regarding the five-year moving average of the rate of growth in net Medicare spending per beneficiary is approximately one-fifth of the uncertainty concerning the amount of Medicare spending in the fifth year.

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

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

Following the above logic, repeal of the IPAB mechanism would have a budgetary cost. After application of the *de minimis* rule (for estimated effects that round to 0.0 percent), the expected value of the IPAB's savings target would be zero in 2015, 2016, 2017, 2020, and 2021 (but not in 2018, 2019, and 2022, when the expected value of the savings target would be between 0.1 percent and 0.2 percent of projected net Medicare spending). In addition, CBO anticipates that, if the IPAB mechanism was triggered, some of the savings in the target year would compound and produce savings in subsequent years. As a result, CBO estimates that repealing the IPAB mechanism would increase expected Medicare spending each year from 2018 through 2022, with the expected value of the net increase in Medicare spending for benefits totaling about \$3.3 billion over that five-year period.

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

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

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 452, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON MARCH 6, 2012

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

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

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

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

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this H.R. 452, the “Medicare Decisions Accountability Act of 2011.”

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 452, the “Medicare Decisions Accountability Act of 2011” does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short Title: the “Medicare Decisions and Accountability Act of 2011.”

Section 2. This section repeals section 3403 and section 10320 of the Patient Protection and Affordable Care Act (Public Law 111–148), effective as of the enactment of the same and any provision of law amended by such sections is restored as if such sections had not been enacted into law.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

* * * * *

Subtitle E—Ensuring Medicare Sustainability

* * * * *

[SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

[(a) BOARD.—

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

["INDEPENDENT MEDICARE ADVISORY BOARD

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

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

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

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

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

["(c) BOARD PROPOSALS.—

[(1) DEVELOPMENT.—

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

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

be subject to the rules for congressional consideration under subsection (d).

[(2) PROPOSALS.—

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

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

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

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

[(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4),

and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D-13(a).

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

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

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

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

[(ii) include recommendations that—

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

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

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

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

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

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

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

[(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The

Board shall submit such draft copy by not later than September 1 of the determination year.

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

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

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

【“(A) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(A) such proposal to the President; and

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

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

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

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

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

[(B) MEDICARE PER CAPITA GROWTH RATE.—

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

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

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

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

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

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

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

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

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

[(7) SAVINGS REQUIREMENT.—

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

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

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

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

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

[(i) in the case of—

[(I) implementation year 2015, 0.5 percent;

[(II) implementation year 2016, 1.0 percent;

[(III) implementation year 2017, 1.25 percent;

and

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

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

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

projected 5-year average (ending with such year) percentage increase in national health care expenditures.】

* * * * *

【“(e) IMPLEMENTATION OF PROPOSAL.—

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

【“(2) APPLICATION.—

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

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

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

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

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

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

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

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

【“(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this sec-

tion to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

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

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

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

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

[(B) which does not have a preamble;

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

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

[(2) PROCEDURE.—

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

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

[(C) CONSIDERATION.—

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

If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(1) MEMBERSHIP.—

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

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

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

[(B) QUALIFICATIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

【“(3) CHAIRPERSON.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

["(i) POWERS OF THE BOARD.—

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

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

["(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States 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 FACa.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

【“(1) DEFINITIONS.—In this section:

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

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

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

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

【“(m) FUNDING.—

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

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

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

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

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

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

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

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

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

【(1) INITIAL STUDY AND REPORT.—

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

1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

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

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

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

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

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

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

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

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

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

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

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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 “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”;

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

[(iii) in subparagraph (A)(ii)—

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

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

[(III) by striking subclause (III);

[(E) in paragraph (4)—

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

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

[(F) in paragraph (5)—

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

- [(ii) by inserting “Congress and” after “submit a proposal to”; and
- [(G) in paragraph (6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A, B, and D)”;
- [(2) in subsection (d)—
 - [(A) in paragraph (1)(A)—
 - [(i) by inserting “the Board or” after “a proposal is submitted by”; and
 - [(ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”; and
 - [(B) in paragraph (2)(A), by inserting “the Board or” after “a proposal is submitted by”;
- [(3) in subsection (e)—
 - [(A) in paragraph (1), by inserting “the Board or” after “a proposal submitted by”; and
 - [(B) in paragraph (3)—
 - [(i) by striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting “EXCEPTIONS.—
 - [(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or”;
 - [(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and
 - [(iii) by adding at the end the following new subparagraph:
- [(B) LIMITED ADDITIONAL EXCEPTION.—
 - [(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—
 - [(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and
 - [(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).
 - [(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.
 - [(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—
 - [(I) the requirement of the Board or the President to submit a proposal to Congress in a pro-

positional year in accordance with the provisions of this section; or

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

(4) in subsection (f)(3)(B)—

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

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

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

(n) ANNUAL PUBLIC REPORT.—

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

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

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

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

(C) Epidemiological shifts and demographic changes.

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

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

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

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

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

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

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

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

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

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

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

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

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

* * * * *

SOCIAL SECURITY ACT

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) * * *

(b) DUTIES.—

(1) * * *

* * * * *

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

【(5)】 (4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission’s agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating

to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

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

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

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

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

* * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * *

[INDEPENDENT MEDICARE ADVISORY BOARD

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

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

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

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

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

[(c) BOARD PROPOSALS.—

[(1) DEVELOPMENT.—

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

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

[(2) PROPOSALS.—

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

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

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

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

suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

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

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

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

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

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

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

[(ii) include recommendations that—

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

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

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

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

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

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

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

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

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

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

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

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

[(A) IN GENERAL.—

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

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

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

growth rate described in clause (ii) of such paragraph; or

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

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

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

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

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

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

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

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

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

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

[(A) such proposal to the President; and

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

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

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

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

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

[(B) MEDICARE PER CAPITA GROWTH RATE.—

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

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

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

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

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

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

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

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

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

[(7) SAVINGS REQUIREMENT.—

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

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

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

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

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

[(i) in the case of—

[(I) implementation year 2015, 0.5 percent;

[(II) implementation year 2016, 1.0 percent;

[(III) implementation year 2017, 1.25 percent;

and

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

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

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

* * * * *

[(e) IMPLEMENTATION OF PROPOSAL.—

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

tion 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 subsist-

ence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

[(3) STAFF.—

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

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

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

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

[(k) CONSUMER ADVISORY COUNCIL.—

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

[(2) MEMBERSHIP.—

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

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

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

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

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

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

[(l) DEFINITIONS.—In this section:

[(1) BOARD; CHAIRPERSON; MEMBER.—The terms “Board”, “Chairperson”, and “Member” mean the Independent Medicare

Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

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

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

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

[(m) FUNDING.—

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

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

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

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

[(n) ANNUAL PUBLIC REPORT.—

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

* * * * *

SECTION 207 OF TITLE 18, UNITED STATES CODE

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

(a) * * *

* * * * *

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

(1) * * *

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

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

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

* * * * *

DISSENTING VIEWS

H.R. 452, the “Medicare Decisions Accountability Act of 2011,” introduced by Congressman Phil Roe, would repeal, effective as of the enactment of the Patient Protection and Affordable Care Act (ACA), sections 3403 and 10320. These repealed sections pertain to the Independent Payment Advisory Board (IPAB) and subsequent amendments to the IPAB. This legislation should be rejected because it furthers the anti-Medicare agenda of the Republican majority in the House.

The Affordable Care Act created the IPAB to provide a backup cost control option in case the other delivery system reforms in the legislation did not adequately slow the growth in health care spending. The ACA was the largest deficit reducing bill passed in the last decade, saving taxpayers \$210 billion over the next decade and \$1.2 trillion in the second decade.¹ In addition to contributing to deficit reduction, the bill was also the most significant improvement to Medicare passed in years, and it reduced Medicare cost growth per beneficiary from an average of 7.8% to just less than 3%.²

Repealing the IPAB would add more than \$3 billion to the cost of Medicare over the next decade. Rather than addressing the need to manage Medicare responsibly, this legislation would simply add more costs on to the program. IPAB is intended to be a moderate, evidence-based, consumer oriented panel that would protect Medicare benefits and beneficiary costs. The Republican alternative to IPAB is to eliminate Medicare’s benefit guarantee and shift more costs on to patients.

House Republicans have made every effort to dismantle the health reform law by any means possible. Fortunately, their efforts to enact wholesale repeal have been rejected.³ As a result, they are now attempting to repeal the law piece by piece.⁴ The IPAB repeal

¹ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Speaker John Boehner, U.S. House of Representatives (Jan. 6, 2011) (online at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12040/01-06-ppaca_repeal.pdf).

² Center on Budget and Policy Priorities, Statement: *Robert Greenstein, President, on the 2011 Medicare Trustees’ Report* (May 13, 2011) (online at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3494>).

³ Although the House of Representatives has passed a bill to repeal the ACA (H.R. 2), that legislation will not become law since the Senate has defeated the proposal. (H.R. 2 passed the House on January 22, 2011 (Congressional Record, H322–323). The Senate defeated a similar proposal the following month on February 2, 2011 (Congressional Record S475)). In any case, President Obama has made clear that he will veto any such legislation. (Executive Office of the President, Office of Management and Budget, *Statement of Administration Policy: H.R. 2—Repealing the Affordable Care Act* (Jan. 6, 2011) (online at http://www.whitehouse.gov/sites/default/files/omb/legislative/sap/112/saphr2r_20110106.pdf)).

⁴ Efforts in the House of Representatives to repeal or otherwise destroy individual parts of the ACA include: H.R. 1173, *Fiscal Responsibility and Retirement Security Act of 2011* (passed the House on Feb. 1, 2012 (Congressional Record, H322–354)); H.R. 358, *Protect Life Act* (passed the House on Oct. 13, 2011 (Congressional Record, H6885–6903)); H.R. 1214, *To Repeal Mandatory Funding for School-Based Health Center Construction* (passed the House on May 4, 2011 (Congressional Record H2969–2977)); H.R. 1216, *To Convert Funding for Graduate Medical Education in Qualified Teaching Centers from Direct Appropriations to an Authorization of Ap-*

bill is nothing more than yet another assault on the health reform law, which has to date provided benefits to tens of millions of Americans.

IPAB in Context

It is important to consider the IPAB in the context of the entire Affordable Care Act. The law included a variety of innovative programs that protected Medicare's guarantee for seniors and people with disabilities while at the same time driving the program toward better value and quality for patients. These include linking hospital payments to rates of readmission; value-based purchasing for fee-for-service (FFS) providers and Medicare Advantage plans; attention to patient safety; disclosure of financial relationships between manufacturers and physicians; and research on the comparative effectiveness of different clinical interventions.⁵ In addition, the new Center for Medicare & Medicaid Innovation, along with the new office of Medicare-Medicaid Coordination Office, is tasked with researching new ways of paying for and delivering care that will reduce costs and increase quality. Together, these initiatives encourage providers to focus on the outcomes that are important to patients and to taxpayers.

In addition to delivery system reforms that will drive down costs, the ACA made significant strides in rooting out waste and overpayments in the traditional Medicare program. For example, overpayments to Medicare Advantage plans were reduced, and payments to providers were aligned to encourage improvements in health care productivity. The Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services Inspector General, and the Justice Department were given more tools and more resources to find and prevent fraud in Medicare and Medicaid. In February 2012, the Justice Department and the Department of Health and Human Services announced record-breaking health care fraud recoveries for the preceding year of \$4.1 billion—the highest annual amount ever recovered from individuals and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.⁶

The net effect of all of these system improvements—which will benefit patients directly through lower out of pocket costs and improved care—is a dramatic slowdown in projected Medicare spending. Over the 25 years from 1985 to 2009, Medicare per capita spending growth averaged 6.7%; over the next 10 years, the Medicare Trustees project that Medicare per capita spending will grow by just 3% on average.⁷ The long-run actuarial deficit in Part A,

appropriations (passed the House on May 25, 2011 (Congressional Record H3361–3388; H3396–3401; H3430–3434)); and H.R. 1217, *To Repeal the Prevention and Public Health Fund* (passed the House on Apr. 13, 2011 (Congressional Record H2633–2647)). To date, none of these bills has been considered by the Senate.

⁵D. Cutler, et al., *The Impact of Health Reform on Health System Spending*, The Commonwealth Fund (May 2010) (online at http://www.commonwealthfund.org//media/Files/Publications/Issue%20Brief/2010/May/1405_Cutler_impact_hlt_reform_on_hlt_sys_spending_ib_v4.pdf).

⁶U.S. Department of Justice, *Health Care Fraud Prevention and Enforcement Efforts Result in Record-Breaking Recoveries Totaling Nearly \$4.1 Billion*, (Feb. 14, 2012) (online at www.justice.gov/opa/pr/2012/February/12-ag-213.html).

⁷J. Ebeler et al., *The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending*, The Kaiser Family Foundation (Apr. 2011) (online at <http://www.kff.org/medicare/upload/8150.pdf>); see also Center on Budget and Policy Priorities, *Statement: Robert*

hospital insurance, was reduced by more than 80%, contributing to a significant extension in the solvency of the Trust Fund.

Savings estimated to arise from IPAB-directed payment changes were just 4% of the overall savings in the ACA. Nevertheless, the IPAB was included in the legislation as a back stop. While we have seen cost growth slow significantly, and anticipate the Affordable Care Act's reforms further contributing to moderating health care cost growth, in the event that the cost trends change, the IPAB remains as a patient-oriented, evidence-based approach to addressing spending challenges—without sacrificing coverage, quality, or access to care.

IPAB is not perfect; even IPAB supporters have advocated for changes in the IPAB statute. But it is far preferable to wholesale repeal, particularly in the face of the Republican alternative to the IPAB's patient-focused approach.

In contrast to the IPAB, which kicks in only if spending targets are exceeded and which explicitly cannot recommend changes that would affect a beneficiary's costs, benefits, or access, the Republican proposals for Medicare, as outlined in the Ryan budget, would increase beneficiary costs starting in 2013. These costs increases rise dramatically in 2022, when the Republican plan would end the Medicare program and replace it with a voucher.

Below are a few examples of how the Republican alternative would adversely affect seniors. In contrast, with the IPAB, these important areas would be harmed under the Republican plan:

Prevention and wellness. The Republican plan for Medicare would impose cost sharing of 20% or more on those services.

In contrast, under the ACA, the average Medicare beneficiary will save \$4,200 between 2011 and 2021 in out of pocket costs. Already, from January through November 2011, 24.2 million individuals enrolled in traditional Medicare (or 69.5% of those enrolled in the program) received one or more free preventive services. In addition, 1.9 million individuals enrolled in traditional Medicare took advantage of the new free Annual Wellness Visit.⁸

Savings on drug costs. The Republican plan for Medicare would put an end to the savings on prescription drug costs provided to people with Medicare under the ACA and would instead increase seniors' costs for these medicines.

In contrast, under the ACA, seniors benefit from a drug discount program for beneficiaries in the "donut hole." These discounts started in 2010, and they will phase out the donut hole by 2020. During 2011, 3.6 million people with Medicare saved \$2.1 billion on their prescription drugs due to the Affordable Care Act. These individuals who hit the donut hole saved an average of \$604 on the cost of their prescription drugs.⁹

Individuals who are dually eligible for Medicare and Medicaid. The Republican plan for Medicare would slash the Medicaid program beginning in 2013, leading states "to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive cov-

Greenstein, *President, on the 2011 Medicare Trustees' Report* (May 13, 2011) (online at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3494>).

⁸ Office of the Assistant Secretary for Planning and Evaluation, *ASPE Issue Brief: Medicare Beneficiary Savings And the Affordable Care Act* (Feb. 2, 2012) (online at <http://aspe.hhs.gov/health/reports/2012/MedicareBeneficiarySavings/ib.pdf>).

⁹*Id.*

erage to beneficiaries, or pay more themselves than would be the case under current law,” according to the CBO.¹⁰

Medicaid is the largest payer for long-term care services, and helps 9 million Medicare beneficiaries fill in the cost sharing, premiums, and other benefits Medicare does not cover. The Affordable Care Act not only protected coverage for these individuals but also increased benefits and boosted provider payments to ensure access to care.

In all, the Republican plan would end the Medicare program in 2022 and replace it with a voucher. Most dramatically, the Republican plan would increase overall Medicare costs for new beneficiaries by more than \$6,000 per person per year, starting in 2022, and would compound those costs indefinitely. Total cuts to the Medicare program would reach \$20 trillion by 2050.

Far from promoting efficiency, as the IPAB would do, the Republican proposal is actually estimated to increase health care costs overall by requiring seniors to buy coverage from inefficient private plans. CBO said:

A typical beneficiary would spend more for health care under the proposal than under CBO’s long-term scenarios for several reasons. First, private plans would cost more than traditional Medicare because of the net effect of differences in payment rates for providers, administrative costs, and utilization of health care services Second, the government’s contribution would grow more slowly than health care costs, leaving more for beneficiaries to pay.¹¹

IPAB Operations

The Independent Payment Advisory Board is an expert panel composed of 15 Presidentially appointed and Senate-confirmed individuals.¹² The IPAB is designed to be a fallback option for cost control, not a primary option. Only if Medicare spending growth is not brought lower than the statutory targets are binding IPAB recommendations issued.

IPAB not likely to be triggered. The ACA reduced projected Medicare spending growth to historically low levels; accordingly, CBO has judged that IPAB is not likely to make binding recommendations at any point in the next decade. Only if CBO is incorrect, and Medicare spending growth exceeds projections, will IPAB be empowered to make binding recommendations to the Congress.

IPAB is statutorily prohibited from rationing, raising costs on seniors, or cutting benefits. The statute is explicit in stating that IPAB recommendations may not involve rationing care, increasing cost sharing, premiums, or taxes, or reducing benefits. The statute provides expressly that IPAB’s recommendations may not “include any recommendation to ration health care, raise revenues or Medi-

¹⁰ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Rep. Paul Ryan, U.S. House of Representatives (Apr. 5, 2011) (online at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf).

¹¹ *Id.*

¹² The Affordable Care Act, Section 3403. For a comprehensive summary of the IPAB’s statutory design, see David Newman and Christopher Davis, *The Independent Payment Advisory Board*, Congressional Research Service (online at <http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41511&Source=search>); see also J. Ebeler et al., *The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending*, The Kaiser Family Foundation (Apr. 2011) (online at <http://www.kff.org/medicare/upload/8150.pdf>).

care beneficiary premiums . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”¹³

IPAB does not usurp congressional authority. Once the IPAB recommendations are submitted to the Congress, they may be modified by committees of jurisdiction and 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).

IPAB savings are moderate, based on evidence, and intended as a backstop to advise the Congress. Spending reductions recommended by the IPAB may not exceed 0.5% of Medicare spending in 2015, phasing up to 1.5% in 2018 and beyond. If the spending growth targets are not exceeded, the IPAB may still make recommendations to reduce spending in Medicare, but those recommendations are not automatically implemented and are not given fast track procedures in Congress.

If the IPAB is not able to produce recommendations that meet the requirements in statute, the Secretary of HHS is required to submit recommendations to Congress that meet those requirements. The Secretary’s recommendations would then be referred to committees for the same consideration received by IPAB recommendations.

In conclusion, H.R. 452 is simply another attempt on the part of the Republicans to repeal the Affordable Care Act by any means possible, with no alternative to address America’s health care needs other than a draconian plan to destroy Medicare, shifting more costs on to individuals who need health care in their time of need. That is why this bill should be rejected on the House floor.

HENRY A. WAXMAN.

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¹³Section 1899A(c)(2)(ii) of the Social Security Act (P.L. 74–271) added by Section 3403 of the ACA. The board is required to consider giving priority to recommendations that increase Medicare’s solvency, protect and improve access to care, and consider targeting recommendations on sources of excess growth in Medicare.