

The Social Security Act, Section 1899A establishes the Independent Payment Review Board as mandated by the Patient Protection and Affordable Care Act (PPACA). This is a copy of that section with highlighted portions and comments to aid in reading it.

Comments are in [blue text](#). The entire text should be read, except perhaps the convoluted rules for passing any congressional resolutions regarding recommendations or proposals by the board.

Some areas are highlighted:

Yellow for the Board's role in Medicare for cutting costs,

Green for the areas outside of Medicare like the private sector,

Aqua for the same powers given to the Secretary of HHS, and

Red for the laws mandating the inability to have Congress do away with the board except for a 6 month period in 2017, and a provision that the board can accept gifts and other items so even if not funded the board could continue to operate or the Secretary of HHS could just do it all. However Congress may be able to just eliminate the law establishing IPAB or PPACA.

The original document, or section of the Social Security Act, establishing IPAB is 19 pages, and one page of footnotes is removed from this review. Note that about 1/3 of the section deals with complex rules for Congress to follow if they want to override proposals for Medicare or to repeal the board. Congress has no power to review recommendations outside of Medicare, and the Judiciary is mandated to have no review of the actions of the board or Secretary of HHS regarding carrying out any of this section of the Social Security Act.

INDEPENDENT MEDICARE ADVISORY BOARD [\[1032\]](#)

Sec. 1899A. [42 U.S.C. 1395kkk] (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—[\(This is the main purpose, and the one addressed by Medical Groups – note it says reduce, not keep the same or limit growth as SGR.\)](#)

(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. (This section in green is key as it says they can recommend changes in non-Medicare areas (private sector) and what they recommend is not subject to either Congressional or Judicial review).¹¹⁰³³¹

(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 costsharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria. (No patient incentives are allowed in controlling costs.)

(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. (Section 1861(u): The term “provider of services” means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund. 1861(d): The term

“supplier” means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.) Hospitals currently account for >30% of Medicare payments, so with this mandate they can continue to cause increasing costs but are exempt from cuts.)

(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)^[1034]. (Medicare Advantage programs will not be doing well.)

(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)^[1035] 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. (This is fairy tale economics.)

(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;^[1036]

(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX; and^[1037]

(vii)^[1038] 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. (This means Medicare spending will not increase more than would happen with SGR cuts – so the SGR is not going away. More importantly, physicians, payments for drugs and devices, and Advantage Medicare programs will all be faced with reductions to offset increasing hospital expenses and the dramatic increase in costs from rapidly increased numbers of people –baby boomers - joining Medicare.) (SGR – Sustainable Growth Rate is a flawed method of trying to control the costs of physician charges in Medicare by not allowing them to grow faster than the national economy. There are multiple problems with the way it calculates these cuts so it has never been implemented and has gotten a “temporary” delay each year by Congress for a decade. Currently if implemented, SGR would cut physician payments approximately 30%.)

(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^[1039].—

(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^[1040] 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^[1041]

(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.^[1042]

(III) [Stricken.^[1043]]

(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— (The secretary of HHS essentially has all the powers of the Board, and the Board is not really needed.)

(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.

(d) Congressional Consideration.—

(1) Introduction.—

(A) In general.—On the day on which a proposal is submitted by the Board or^[1044] the President to the House of Representatives and the Senate under subsection (c)(3)(A)(i) or^[1045] subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

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

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

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

(2) Committee consideration of proposal.—

(A) Reporting bill.—Not later than April 1 of any proposal year in which a proposal is submitted by the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

(B) Calculations.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

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

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

(3) Limitation on changes to the board recommendations.—

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

(B) Limitation on changes to the board recommendations in other legislation.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

(C) Limitation on changes to this subsection.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

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

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

(4) Expedited procedure.—

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

(B) Amendment.—

(i) Time limitation.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

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

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

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

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

(C) Consideration by the other house.—

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

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

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

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

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

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

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

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

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

(D) Senate limits on debate.—

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

(ii) Motion to further limit debate.—A motion to further limit debate on the bill is in order and is not debatable.

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

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

(E) Consideration in conference.—

(i) In general.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority

and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

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

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

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

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

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

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

(5) Rules of the senate and house of representatives.—This subsection and subsection (f)(2) are enacted by Congress—

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

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

(e) Implementation of Proposal.—

(1) In general.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the Board or ^[1046] 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) [\[1047\]](#) 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) [\[1048\]](#) 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) [\[1049\]](#) 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) [\[1050\]](#) Limited additional exception.—

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

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

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

(ii) Limited additional exception may not be applied in two consecutive years.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

(iii) No affect on requirement to submit proposals or for congressional consideration of proposals.—Clause (i) and (ii) shall not affect—

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

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

(4) No affect on authority to implement certain provisions.— Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

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

(f) Joint Resolution Required to Discontinue the Board.—

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

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

(B) which does not have a preamble;

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

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

(2) Procedure.—

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

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

(C) Consideration.—

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

(ii) Debate limitation.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided

equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

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

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

(D) Other house acts first.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

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

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

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

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

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

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

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

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

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

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

(B) the Board shall not submit any proposals, advisory reports, or advisory recommendations^[1051] under this section or produce the public report under subsection (n)^[1052] 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.—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.

(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.

(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. (This is better funding increases than the Medicare system they are regulating!)

(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) [\[1053\]](#) 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. (This is a far reaching provision that gives them power over all areas of the economy – kind of a summary of Obama Care in general. And recall that the Secretary of HHS has all the powers of the Board. Also recall above that the board is given power to secure information from any other agency of the federal government to carry out its activities. Perhaps any business or organization, may by its affect on the economy, education, food, social interactions, etc. may directly or indirectly affect how spending happens in health care – then this board has powers over it.)

(o) [\[1054\]](#) 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.

Summary comment on this Law:

The wide reaching and absolute power of the board and HHS Sec are clearly laid out. These powers include setting civil and criminal fines and penalties. Anticipating the eventual unpopularity of the IPAB, about 1/3 of the law is devoted to preventing debate on the proposals and repeal of this section of the Social Security Act.

A Consumer Advisory Council is created which can publicly publish individual physician performance data of it's own criteria. There are no physicians on this board so there is a very real possibility that results can be taken out of context. For instance they could publish the rates of patients dying for doctors who take care of severely affected cancer patients where the expected rates of death may be nearly 100%. Publishing results out of context will encourage physicians and hospitals to limit care for those with chronic conditions or severe problems of any type.

IPAB is funded from the hospital and SSA trust funds at or above \$15 million per year with guaranteed future budget increases tied to the Consumer Price Index. So, while per capita Medicare spending must decrease in absolute numbers, the advisory board enjoys a guaranteed annual percentage increase in funding from the very program that they are tasked with cutting. This is bureaucratic brilliance at it's best.

A goal of IPAB is to forcefully and irreversibly implement a "super SGR" a flawed method of tying physician reimbursements to the Gross Domestic Product. The SGR cuts are so flawed, that each year Congress passes temporary delays to implementing them. IPAB's mandate to cut costs will greatly increase the payment cut to Medicare physicians over and above the current SGR decreases of 30%. Cuts of this degree will make seeing Medicare patients a money-losing proposition for almost all doctors.

Since hospitals account for over 30% of Medicare costs but are exempted from funding cuts, it appears that the goal of IPAB is to drive non-hospital physicians into hospital organizations or out of business. This will lead to higher health care costs (hospital associated charges are higher than independent physician charges). It will also lead to restrictions on access to care, and potentially lead to a single payer system for all of health care.

The only reasonable way to repeal IBAB is full repeal of PPACA.