What The "Affordable Health Care For America Act," HR3962, Actually Says

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What does the bill recently passed by the U.S. House of Representatives, HR3962, short-titled the Affordable Health Care for America Act, actually say about major health-care issues? I here pose a few commonsense questions, cite some relevant passages, and offer a few brief comments. (The bill is available here.)

This bill is 1,990 pages of mind-numbing legalese. It will reach deeply into federal and state regulations and laws, on a scale that will require years for experts to interpret. It will establish institutions that will be effectively irreversible. It will grant arbitrary powers to bureaucrats, who will have to interpret and enforce its dictates. A full analysis of its impact would require a commentary at least as long as the bill itself. American citizens cannot be expected to read and understand such legislation. But they should be aware that this is the nature of the laws being written by their (alleged) representatives in Washington.

I have only touched on pieces of the bill here. I have not considered the establishment of (1) the Health Choices Commissioner and the associated bureaucracy; (2) the Health Insurance Exchange, (a government-mandated insurance scheme to control all insurance activity); (3) the so-called Public Health Insurance Option, or similar provisions. I have not analyzed the *more than one hundred* new committees, boards, commissions, and bureaucratic institutions that it establishes (but I have listed them below under the section titled Special Note).

This legislation empowers the executive branch, namely the Secretary of Health and Human Services and a Health Choices Commissioner, to write thousands of pages of regulations, and to force Americans to comply with them. For every line in this bill, many pages of regulations will be written. As a result, the bureaucracy will expand, the final cost will be many times more than the original estimatesand the impact on American medicine will be devastating.

The overall result of this bill, if enacted, will be a complete government takeover of the health-care industry. This cannot be prevented by tweaking the language in the bill. The bill must be rejected in full before we can consider proper reforms to American medicine.

In many ways the bill is a convoluted, uncoordinated list of compromises between thousand of legislators, legislative aides, and lobbyists. Yet the bill has two main thrusts, with one central meaning. The first thrust is a *massive increase in government power*. The second is the *total rejection of the free market*. The central meaning of both is *the repudiation of individual rights*. No longer will Americans have the liberty to preserve their own lives in the way they judge bestfrom now on, they will have to conform to government controls on the most intimate details of their lives.

We may answer one question up front: How will the government pay for all this? By increasing taxes, cutting payments to doctors and other medical professionals, or rationing servicesthere are no other options. We will all pay for this, whether or not we are enrolled in the government optionbecause none of us may opt out of the taxes levied to finance it, or escape the controls it will breed.

1. Will the plan punish Americans who do not carry the required insurance, or employers who do not provide it?

What the Bill Says:

SEC. 501. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE (pp. 29697).

(a) In General.Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

PART VIIIHEALTH CARE RELATED TAXES

Subpart ATax on Individuals Without Acceptable Health Care Coverage

SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) Tax Imposed In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax equal to 2.5 percent of the excess of

(1) the taxpayers modified adjusted gross income for the taxable year, over

(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

SEC. 307. HEALTH INSURANCE EXCHANGE TRUST FUND (pp. 19596) . . .

(c) Transfers to Trust Fund

(1) DEDICATED PAYMENTS There are hereby appropriated to the Trust Fund amounts equivalent to the following:

(A) TAXES ON INDIVIDUALS NOT OBTAINING ACCEPTABLE COVERAGE The amounts received in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirement of health insurance coverage for individuals).

(B) EMPLOYMENT TAXES ON EMPLOYERS NOT PROVIDING ACCEPTABLE COVERAGE The amounts received in the Treasury under sections 3111(c) and 3221(c) of the Internal Revenue Code of 1986 (relating to employers electing to not provide health benefits).

(C) EXCISE TAX ON FAILURES TO MEET CERTAIN HEALTH COVERAGE REQUIREMENTS The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements).

Evaluation of the Passages:

1. This section amends the Internal Revenue Code. It adds a new category of taxes, to be levied against Americans who do not have acceptable health insurance.

2. All Americans will be required to purchase health insurance that is acceptable to the government. Anyone caught without acceptable coverage and not in the government plan will pay a special tax of 2.5 percent on top of his existing taxes.

3. The IRS will be a major enforcement mechanism for the plan.

2. Will the plan make private insurance illegal?

What the Bill Says:

SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED (pp. 1047).

(a) In General. In this division, the term essential benefits package means health benefits coverage, consistent with standards adopted under section 224, to ensure the provision of quality health care and financial security, that [here follows a list of insurance services required]. . . .

(A) IN GENERAL. The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

Evaluation of the Passage:

1. The bill does not explicitly make private insurance illegal. But it does establish federal insurance requirements, enforced by the government, which will make many private plans illegal and will force many out of business.

2. The minimum actuarial value required by this bill means that catastrophic insurance policies, insurance plans that cover hospitalization alone, or other such coverage as Americans may elect to purchase for themselves, will not provide a level of coverage acceptable to the government. Americans must purchase more insurance, enroll in the government planor face tax penalties.

3. Many other passages in the bill place private insurance under government rules and will prevent Americans from negotiating private health-care coverage as they wish. For instance, section 223 establishes federal categories of insurance, under a new Health Benefits Advisory Committee, which will be used to control public and private plans.

3. Will the plan ration medical care through budgets?

What the Bill Says:

SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS (pp. 44148) . . .

(1) IN GENERAL.With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2011, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital. . . .

(ii) EXCLUSION OF CERTAIN READMISSIONS.For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

Evaluation of the Passage:

1. This section applies to Medicare Parts A and B. It is important to understand that the so-called Public Option is, in essence, an extended version of Medicare, and that millions of Americans will be enrolled in this plan. The Medicare guidelines written here will apply to the expanded government planand ultimately to millions of Americans.

2. The plan uses statistics to judge whether someone may be readmitted to the hospital. A patient will be allowed readmission only if a certain number of people with the same applicable condition have been discharged from that hospital. This is rationing, pure and simple.

3. The plan empowers bureaucrats to exercise this power over doctors and hospitals. Item (7) on page 450, for instance, allows bureaucrats to impose sanctions on hospitals whose statistics are determined to be out of line. Item (C), page 462, empowers the bureaucrats to apply a payment reduction for physicians who treat the patient during the initial admission that results in a readmission.

4. The bill allows the bureaucrats to define terms such as excess, readmission, and applicable condition. For instance, in the same section:

5) DEFINITIONS.For purposes of this subsection: . . .

(A) APPLICABLE CONDITION. The term applicable condition means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which

(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary) . . .

Evaluation of the Passage:

1. Applicable conditions are determined by the Secretary, meaning, as always, the bureaucrats. Such passages empower bureaucrats to determine the very meaning of the law. The bill is permeated with such arbitrary, open-ended language.

2. Should doctors treat, say, many people with cancer, this would indicate high volume and high expenditures. Bureaucrats will then be empowered to prevent other cancer patients from being readmitted, in order to prevent excess readmissions and improve the statistics.

3. The plan specifically calls for expansion of the Secretarys authority to determine what constitutes an applicable condition. From the same section:

(B) EXPANSION OF APPLICABLE CONDITIONS. Beginning with fiscal year 2013, the Secretary shall expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been so identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures which may include an all-condition measure of readmissions, as determined appropriate by the Secretary. In expanding such applicable conditions, the

Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement.

Evaluation of the Passage:

1. Such language is typical in this bill. In the end, the power to determine its meaning is left with the secretary, meaning the bureaucrats. This is arbitrary government powerpower without definition or limits.

2. It is important to stress that such arbitrary power is open ended bureaucrats will determine its meaning as they write their regulations.

4. Will this plan ration care through waiting lists?

What the Bill Says:

SEC. 101. NATIONAL HIGH-RISK POOL PROGRAM (pp. 1617) . . .

(2) INSUFFICIENT FUNDS If the Secretary estimates for any fiscal year that the aggregate amounts available for payment of expenses of the high-risk pool will be less than the amount of the expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit, including reducing benefits, increasing premiums, or establishing waiting lists.

Evaluation of the Passage:

1. This section establishes a temporary High-Risk Pool program, which is to operate until the Health Exchanges are established. Meanwhile the Secretary of Health and Human Services will decide who gets care and who goes on a waiting list.

2. This determination will be made on the basis of aggregate budget. The bill recognizes that there are only three ways to control the budget: reducing benefits, increasing premiums, or establishing waiting lists. The Secretarys bureaucrats will control all three.

3. Proponents of the bill will claim that this particular program will be temporary. But this next passage shows that under this plan, waiting lists will become the norm:

SEC. 1734. PREVENTING THE APPLICATION UNDER CHIP OF COVERAGE WAITING PERIODS FOR CERTAIN CHILDREN (p. 1079) . . .

(a) In General. Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397bb(b)(1)) is amended. . . . [in part by adding this new paragraph]

(C) DESCRIPTION OF CHILDREN NOT SUBJECT TO WAITING PERIOD For purposes of this paragraph, a child described in this subparagraph is a child who [here follows a list of requirements for children exempt from waiting lists]

Evaluation of the Passage:

1. This section amends the Social Security Act.

2. The bill specifically excludes certain children from government waiting lists.

3. This exclusion makes clear that proponents of the bill know that there will be government-controlled waiting lists. This is consistent with states and countries (such as Canada and the UK) that have waiting lists reaching into months for diagnostic tests and treatments.

4. This next passage again shows that waiting lists are already planned for the United States:

SEC. 3101. INDIAN HEALTH CARE IMPROVEMENT AMENDED (p. 1636) . . .

SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND (pp. 172429) . . .

(f) Report. By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service Unit, including newly recognized or acknowledged Indian Tribes. Such report shall set out . . . [among other requirements]:

(4) an estimate of . . .

(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

Evaluation of the Passage:
1. This section amends the Indian Health Care Improvement Act.

2. This passage specifically references waiting listsand excludes certain people from them.

3. The need for government-controlled waiting lists is understood by those who have promoted this plan. Government enforced waiting lists are rationing. Rationing is needed to control the governments budget.

5. Will the plan impose special, higher taxes on Americans who earn more than others?
What the Bill Says:
SEC. 551. SURCHARGE ON HIGH INCOME INDIVIDUALS (p. 33639).

Evaluation of this Section:
1. This section amends the Internal Revenue Code.

2. The title of this section is accurate. This section lays out the surcharges to be levied against Americans who earn more than an arbitrary levela level determined by the government and adjustable at its whim. This is simple, coercive wealth redistributiona tax on successful people because they are successful.

3. The section adds this surcharge on top of the existing federal tax rates, and states, The amendment made by subsection (a) shall not be treated as a change in a rate of tax.

4. This surcharge will be enforced by the IRS.

6. Will the plan levy special taxes and surcharges on medical devices (such as wheelchairs, walkers, canes, etc.)?

What the Bill Says:

SEC. 552. EXCISE TAX ON MEDICAL DEVICES (p. 339) . . .

(a) In General Chapter 31 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

Subchapter DMedical Devices . . .

SEC. 4061. MEDICAL DEVICES.

(a) In General There is hereby imposed on the first taxable sale of any medical device a tax equal to 2.5 percent of the price for which so sold.

Evaluation of this Passage:

1. This section amends the Internal Revenue Code.

2. This section puts a special federal tax on the first taxable sale of medical devices such as wheelchairs. This specifically targets medical device manufacturers and applies to sales made directly by those manufacturers. (It is worth noting that this clause was inserted because medical device companies opposed this bill.)

3. The bill will raise the price of such devices by the amount of the tax.

7. How will the plan affect health insurance provided by employers?

What the Bill Says:

SEC. 413. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE . . .

14 (a) IN GENERAL.A contribution is made in accordance with this section with respect to an employee if such contribution is equal to an amount equal to 8 percent of the average wages paid by the employer during the period of enrollment (determined by taking into account all employees of the employer and in such manner as the Commissioner provides, including rules providing for the appropriate aggregation of related employers) but not to exceed the minimum employer contribution described in section 412(b)(1)(A) (pp. 27577). . . .

SEC. 806. REGULATIONS.

The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part (p. 283). . . .

(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS

(A) CIVIL PENALTIESIn the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

Evaluation of the Passages:

1. The bill does not explicitly prohibit an employer from providing private insurance. But the bill will make it increasingly difficult, if not impossible, to do so. Bureaucrats will determine whether any particular insurance plan provides acceptable coverage. (Section 806 amends the Employee Retirement Income Security Act.)

2. Businesses will either have to provide insurance to federal standards, or pay a payroll tax. The tax is calculated on a sliding scale, starting at 8 percent for businesses with the largest payrolls and decreasing to zero for those with the smallest (i.e., payrolls under $500,000 annually).

3. Business costs for health care are generally higher than 8 percent. Any competitive business with a private plan will face a payroll disadvantage against competitors who go with the government option. The pressure on business owners to terminate their private plans and to pay the tax instead will be enormous. Very small employers (payrolls under $500,000 per year) will be pressured into saving all of the costs by canceling their employee health plans. This will force employees into the government plan.

4. With employers ending plans, and millions of Americans losing their private coverage, fewer companies will offer private coverage. This will cause prices to rise further.

5. As the subscriber bases of private insurance companies shrink, they will be financially starved and many will be unable to manage their risks. Many of them will go out of business. With fewer private options available to individual Americans, many people will have no place to go except the government plan.

8. Does the plan allow the government to set fees?

What the Bill Says:

SEC. 304. CONTRACTS FOR THE OFFERING OF EXCHANGE PARTICIPATING HEALTH BENEFITS PLANS (pp. 17273) . . .

(B) BID REVIEW AND NEGOTIATION.The Commissioner shall, based upon a review of such bids including the premiums and their affordability, negotiate with such entities for the offering of such plans.

(C) DENIAL OF EXCESSIVE PREMIUMS.The Commissioner shall deny excessive premiums and premium increases.

Evaluation of the Passages:

1. Federal bureaucrats, with control over the national insurance market, will have enormous powers in setting insurance and health-care payment rates, and in pressuring those who try to remain outside the government plan to follow those rates.

2. As more people are forced into the government plan, price controlsalong with costs, cuts in payments, and waiting listswill increase.

9. Can the government officials audit taxpayers, employers, and insurance plans to enforce compliance?

What the Bill Says:

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER (pp. 13234) . . .

(2) COMPLIANCE EXAMINATION AND AUDITS.

A) IN GENERAL.The Commissioner shall, in coordination with States, conduct audits of qualified health benefits plan compliance with Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected noncompliance.

(B) RECOUPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.The Commissioner is authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations. . . .

SEC. 321. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN (pp. 21113) . . .

(e) DATA COLLECTION. The Secretary shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care.

SEC. 412. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARD EMPLOYEE AND DEPENDENT COVERAGE (pp. 26971).

(a) IN GENERAL. An employer meets the requirements of this section with respect to an employee if the following requirements are met: . . .

(3) PROVISION OF INFORMATION. The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section, including the following:

A) The name, date, and employer identification number of the employer . . .

D) The name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such plans.

SEC. 541. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES (pp. 32728) . . .

(A) IN GENERAL. The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 308 of the, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit . . . Such return information shall be limited to . . .

(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof). . . .

Evaluation of the Passages:

1. Federal and state bureaucrats will have the power to enforce federal standards by launching audits against individuals and businesses. Section 541 amends the Internal Revenue Act, and extends this power to taxpayer audits.

2. The bureaucrats power to gather the data will expand as the number of people enrolled in the government program increases. Item (v) allows federal and state officials to decide what information they needthere will be no effective limit to their power to demand information.

3. Employers will be required to report whatever information government bureaucrats say they need to enforce the plan. Employers will have to provide personal information about employees to the government. Fear of an audit will be made worse by the threat of having to reimburse the government for the costs of such examinations.

4. Such powers to gather information and to conduct audits are reinforced throughout the bill. For instance, Sec. 1174 is specifically titled Strengthening audit authority.

10. What limits are set to the powers of government officials?

What the Bill Says:

SEC. 102. ENSURING VALUE AND LOWER PREMIUMS (pp. 26-28).

(a) GROUP HEALTH INSURANCE COVERAGE.Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

SEC. 2714. ENSURING VALUE AND LOWER PREMIUMS.

(a) IN GENERAL. Each health insurance issuer that offers health insurance coverage in the small or large group market shall provide that for any plan year in which the coverage has a medical loss ratio ***below a level specified by the Secretary*** *(but not less than 85 percent), the issuer shall provide* ***in a manner specified by the Secretary*** *for rebates to enrollees of the amount by which the issuers medical loss ratio is less than the level so specified.*
*(b) IMPLEMENTATION.****The Secretary shall establish*** *a uniform definition of medical loss ratio and methodology for determining how to calculate it based on the average medical loss ratio in a health insurance issuers book of business for the small and large group market. Such methodology shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.* ***In determining the medical loss ratio, the Secretary shall exclude*** *State taxes and licensing or regulatory fees. Such methodology shall be designed and exceptions shall be established to ensure adequate participation by health insurance issuers, competition in the health insurance market, and value for consumers so that their premiums are used for services. . . .*
(b) INDIVIDUAL HEALTH INSURANCE COVERAGE. Such title is further amended by inserting after section 2753 the following new section:

SEC. 2754. ENSURING VALUE AND LOWER PREMIUMS.

*The provisions of section 2714 shall apply to health insurance coverage offered in the individual market in the same manner as such provisions apply to health insurance coverage offered in the small or large group market****except to the extent the Secretary determines*** *that the application of such section may destabilize the existing individual market.*
Evaluation of the Passages:
1. The bill amends the Public Health Service Act by granting new powers to the Secretary of Health and Human Services. [Bold emphasis in the passages added.]

2. Federal bureaucrats will determine how insurance companies keep their books, how they calculate their revenues and claims, what constitutes acceptable competition in insurance markets, and what makes such markets stable.

3. The bill empowers bureaucrats to wield power over companies and individuals in terms decided by the bureaucrats.

4. This is arbitrary power, granted by Congress to the Secretary, meaning to thousands of bureaucrats. Every American will be subject to their decisions, on local, state and national levels.

5. A text search of the bill reveals more than one hundred instances of language such as the Secretary shall determine.

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Special Note: a list of new boards, committees, programs, and other bureaucratic encumbrances established by HR3962.
(Source: House Republican Conference, http://www.gop.gov/bill/111/1/hr3962)
1. Retiree Reserve Trust Fund (Section 111(d), p. 61)
2. Grant program for wellness programs to small employers (Section 112, p. 62)

3. Grant program for State health access programs (Section 114, p. 72)
4. Program of administrative simplification (Section 115, p. 76)
5. Health Benefits Advisory Committee (Section 223, p. 111)
6. Health Choices Administration (Section 241, p. 131)
7. Qualified Health Benefits Plan Ombudsman (Section 244, p. 138)
8. Health Insurance Exchange (Section 201, p. 155)
9. Technical assistance to employees of small businesses buying Exchange coverage (Section 305(h), p. 191)
10. Insurance risk pooling to be established by Health Choices Commissioner (Section 306(b), p. 194)
11. Health Insurance Exchange Trust Fund (Section 307, p. 195)
12. State-based Health Insurance Exchanges (Section 308, p. 197)
13. Grant program for health insurance cooperatives (Section 310, p. 206)
14. Public Health Insurance Option (Section 321, p. 211)
15. Ombudsman for Public Health Insurance Option (Section 321(d), p. 213)
16. Account for receipts and disbursements for Public Health Insurance Option (Section 322(b), p. 215)
17. Tele health Advisory Committee (Section 1191 (b), p. 589)
18. Demonstration program providing for culturally and linguistically appropriate services (Sec 1222, p. 617)
19. Demonstration program for shared decision making using patient decision aids (Section 1236, p. 648)
20. Accountable Care Organization pilot program under Medicare (Section 1301, p. 653)
21. Independent patient-centered medical home pilot program under Medicare (Section 1302, p. 672)
22. Community-based medical home pilot program under Medicare (Section 1302(d), p. 681)
23. Independence at home demonstration program (Section 1312, p. 718)
24. Center for Comparative Effectiveness Research (Section 1401(a), p. 734)
25. Comparative Effectiveness Research Commission (Section 1401(a), p. 738)
26. Patient ombudsman for comparative effectiveness research (Section 1401(a), p. 753)
27. Q/A and performance improvement program for skilled nursing facilities (Section 1412 (b)(1), p. 784)
28. Q/A and performance improvement program for nursing facilities (Section 1412 (b)(2), p. 786)
29. Special focus facility program for skilled nursing facilities (Section 1413(a)(3), p. 796)
30. Special focus facility program for nursing facilities (Section 1413(b)(3), p. 804)
31. Independent monitor pilot program for skilled nursing facilities and nursing facilities (Section 1422, p. 859)
32. Demonstration program for approved teaching health centers for Medicare GME (Section 1502(d), p. 933)
33. Pilot program to develop anti-fraud compliance systems for Medicare providers (Section 1635, p. 978)
34. Special Inspector General for the Health Insurance Exchange (Section 1647, p. 1000)
35. Medical home pilot program under Medicaid (Section 1722, p. 1058)
36. Accountable Care Organization pilot program under Medicaid (Section 1730A, p. 1073)
37. Nursing facility supplemental payment program (Section 1745, p. 1106)
38. Demonstration program for Medicaid medical conditions for mental diseases (Sec 1787, p. 1149)
39. Comparative Effectiveness Research Trust Fund (Section 1802, p. 1162)
40. Identifiable office or program for coordination between Medicare and Medicaid (Section 1905, p. 1191)
41. Center for Medicare and Medicaid Innovation (Section 1907, p. 1198)
42. Public Health Investment Fund (Section 2002, p. 1214)
43. Scholarships for service in health professional needs areas (Section 2211, p. 1224)
44. Program for training medical residents in community-based settings (Section 2214, p. 1236)
45. Grant program for training in dentistry programs (Section 2215, p. 1240)
46. Public Health Workforce Corps (Section 2231, p. 1253)
47. Public health workforce scholarship program (Section 2231, p. 1254)
48. Public health workforce loan forgiveness program (Section 2231, p. 1258)
49. Grant program for innovations in interdisciplinary care (Section 2252, p. 1272)
50. Advisory Committee on Health Workforce Evaluation and Assessment (Section 2261, p. 1275)
51. Prevention and Wellness Trust (Section 2301, p. 1286)
52. Clinical Prevention Stakeholders Board (Section 2301, p. 1295)
53. Community Prevention Stakeholders Board (Section 2301, p. 1301)
54. Grant program for community prevention and wellness research (Section 2301, p. 1305)
55. Grant program for research and demonstration projects for wellness incentives (Section 2301, p. 1305)
56. Grant program for community prevention and wellness services (Section 2301, p. 1308)
57. Grant program for public health infrastructure (Section 2301, p. 1313)
58. Center for Quality Improvement (Section 2401, p. 1322)
59. Assistant Secretary for Health Information (Section 2402, p. 1330)

60. Grant program to support the operation of school-based health clinics (Section 2511, p. 1352)
61. Grant program for nurse-managed health centers (Section 2512, p. 1361)
62. Grants for labor-management programs for nursing training (Section 2521, p. 1372)
63. Grant program for interdisciplinary mental and behavioral health training (Section 2522, p. 1382)
64. No Child Left Unimmunized Against Influenza demonstration grant program (Section 2524, p. 1391)
65. Healthy Teen Initiative grant program regarding teen pregnancy (Section 2526, p. 1398)
66. Grant program for interdisciplinary training, education, and services for autism (Section 2527(a), p. 1402)
67. University centers for excellence in developmental disabilities education (Section 2527(b), p. 1410)
68. Grant program to implement medication therapy management services (Section 2528, p. 1412)
69. Grant program to promote positive health behaviors in underserved communities (Section 2530, p. 1422)
70. Grant program for State alternative medical liability laws (Section 2531, p. 1431)
71. Grant program to develop infant mortality programs (Section 2532, p. 1433)
72. Grant program to prepare secondary school students for health care training (Section 2533, p. 1437)
73. Grant program for community-based collaborative care (Section 2534, p. 1440)
74. Grant program for community-based overweight and obesity prevention (Section 2535, p. 1457)
75. Grant program for reducing the student-to-school nurse ratio (Section 2536, p. 1462)
76. Demonstration project of grants to medical-legal partnerships (Section 2537, p. 1464)
77. Center for Emergency Care (Section 2552, p. 1478)
78. Council for Emergency Care (Section 2552, p 1479)
79. Grant program to support demonstration programs for regionalized emergency care (Section 2553, p. 1480)
80. Grant program to assist veterans who wish to become EMTs (Section 2554, p. 1487)
81. Interagency Pain Research Coordinating Committee (Section 2562, p. 1494)
82. National Medical Device Registry (Section 2571, p. 1501)
83. CLASS Independence Fund (Section 2581, p. 1597)
84. CLASS Independence Fund Board of Trustees (Section 2581, p. 1598)
85. CLASS Independence Advisory Council (Section 2581, p. 1602)
86. Health and Human Services Coordinating Committee on Womens Health (Section 2588, p. 1610)
87. National Womens Health Information Center (Section 2588, p. 1611)
88. Centers for Disease Control Office of Womens Health (Section 2588, p. 1614)
89. Agency for Healthcare Research and Quality Office of Womens Health Research (Section 2588, p. 1617)
90. Health Resources and Services Administration Office of Womens Health (Section 2588, p. 1618)
91. Food and Drug Administration Office of Womens Health (Section 2588, p. 1621)
92. Personal Care Attendant Workforce Advisory Panel (Section 2589(a)(2), p. 1624)
93. Grant program for national health workforce online training (Section 2591, p. 1629)
94. Grant program to disseminate best practices on implementing health workforce (Section 2591, p. 1632)
95. Demonstration program for chronic shortages of health professionals (Section 3101, p. 1717)
96. Demonstration program for substance abuse counselor educational curricula (Section 3101, p. 1719)
97. Program of Indian community education on mental illness (Section 3101, p. 1722)
98. Intergovernmental Task Force on Indian environmental and nuclear hazards (Section 3101, p. 1754)
99. Office of Indian Mens Health (Section 3101, p. 1765)
100. Indian Health facilities appropriation advisory board (Section 3101, p. 1774)
101. Indian Health facilities needs assessment workgroup (Section 3101, p. 1775)
102. Indian Health Service tribal facilities joint venture demonstration projects (Section 3101, p. 1809)
103. Urban youth treatment center demonstration project (Section 3101, p. 1873)
104. Grants to Urban Indian Organizations for diabetes prevention (Section 3101, p. 1874)
105. Grants to Urban Indian Organizations for health IT adoption (Section 3101, p. 1877)
106. Mental health technician training program (Section 3101, p. 1898)
107. Indian youth telemental health demonstration project (Section 3101, p. 1909)
108. Program for treatment of child sexual abuse victims and perpetrators (Section 3101, p. 1925)
109. Program for treatment of domestic violence and sexual abuse (Section 3101, p. 1927)
110. Native American Health and Wellness Foundation (Section 3103, p. 1966)
111. Committee for the Native American Health and Wellness Foundation (Section 3103, p. 1968)

About John David Lewis

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