

Boundary Without Judgment

How the Catastrophic Health Coverage Act Segments Risk Without Moral Policing

Core Framework Paper - Working Draft

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Executive Summary

The Catastrophic Health Coverage Act (CHCA) introduces a bounded federal program covering catastrophic medical costs arising from circumstances substantially beyond individual control. Central to the Act is the *agency principle*: a distinction between conditions caused by individual behavioral choices and conditions caused by factors outside individual agency.

This distinction has been mischaracterized by critics as a moral judgment about deservingness. That framing is incorrect. CHCA does not adjudicate virtue, responsibility, or worthiness. It routes categories of catastrophic risk using existing clinical taxonomies and constrained administrative processes, in order to allocate risk efficiently, preserve incentives, and maintain fiscal sustainability.

Every modern insurance system already segments risk. The failure of current U.S. healthcare financing is not that it segments risk - but that it does so implicitly, opaquely, and regressively, with boundaries enforced by wealth, employment status, and legal leverage rather than transparent rules. CHCA makes risk segmentation explicit, reviewable, procedurally constrained, and narrow in scope. It replaces hidden moral judgments with administrative clarity, medical humility, and due process.

This paper explains how CHCA achieves this distinction, why agency is a causal concept rather than a moral one, how the program handles mixed and ambiguous causation, what the program explicitly refuses to do, and why boundary discipline is essential to program durability. The framework established here provides the foundation for derivative communications including legislative briefings, media materials, and stakeholder education.

I. The Category Error: Why 'Deservingness' Is the Wrong Lens

Public debates about healthcare policy often collapse into moral language: deserving versus undeserving, personal responsibility versus compassion. These frames are emotionally powerful but analytically misleading. Healthcare systems do not function by rewarding virtue or punishing vice. They function by allocating risk, cost, and uncertainty across populations.

1.1 What Every System Must Decide

Every healthcare financing system - public or private - must decide three fundamental questions: which risks are pooled collectively, which risks are priced individually, and which risks are excluded or mitigated through other mechanisms. No system pools every risk. No system prices every risk individually. Every system draws boundaries, whether explicitly or implicitly.

In the current U.S. system, these decisions are made indirectly through multiple overlapping mechanisms. Employers choose which plans to offer and which risks to

self-insure. Insurers price premiums based on actuarial experience and regulatory constraints. Coverage limits and exclusions create implicit boundaries that individuals may not understand until they face a claim. Patients' ability to absorb financial shocks determines whether a technically covered event produces financial catastrophe or manageable expense.

These mechanisms already encode judgments about which risks society will absorb collectively and which individuals must bear alone. The concentration of healthcare spending is dramatic: according to the Agency for Healthcare Research and Quality, the top five percent of patients account for approximately fifty percent of total healthcare expenditures, while the bottom fifty percent account for less than three percent.ⁱ This concentration is not evenly distributed across the population - it reflects catastrophic events, chronic conditions, and serious illnesses that strike individuals without regard to their personal responsibility or behavioral choices.

1.2 The Hidden Boundaries of the Current System

The current system's boundaries are enforced through mechanisms that appear neutral but operate regressively. A family with substantial savings may absorb a \$10,000 deductible without disruption; a family living paycheck-to-paycheck may face bankruptcy from the same event. Both families had coverage. The boundary between manageable expense and financial catastrophe was determined by wealth, not by medical circumstance or behavioral choice.

Employment status creates another hidden boundary. Workers who remain in unwanted employment solely to maintain health insurance - a phenomenon documented extensively in the economics literature as 'job lock' - face a boundary that constrains their economic freedom without explicit acknowledgment.ⁱⁱ The boundary between labor mobility and employment lock is enforced by insurance attachment, not by any articulated principle about risk allocation.

Legal leverage creates a third hidden boundary. Individuals who suffer catastrophic injuries with clear third-party responsibility - motor vehicle accidents, product defects, medical malpractice - may recover costs through litigation. Those whose catastrophic conditions lack an identifiable tortfeasor face the same medical costs without the same recovery mechanism. The boundary between recoverable and unrecoverable catastrophic expense is determined by legal circumstance, not by the moral character of the patient.

1.3 Why Implicit Boundaries Fail

Implicit boundaries fail for three reasons. First, they are invisible to those affected until the moment of crisis. A family cannot plan around a boundary they do not know exists. Second, they are unaccountable - no public process determines where boundaries fall, no appeal mechanism exists when boundaries produce unjust results, and no systematic review adjusts boundaries based on evidence. Third, they are regressive - the same nominal coverage produces vastly different outcomes depending on individual wealth, employment status, and legal circumstance.

CHCA does not introduce moral judgment into healthcare financing. The current system already makes moral judgments - it simply makes them invisibly, through mechanisms that appear neutral while producing systematically unequal results. CHCA proposes to replace these implicit, unaccountable judgments with explicit, bounded classification subject to public review and procedural safeguards.

II. Agency as a Causal Concept, Not a Moral One

The agency principle underlying CHCA is causal, not moral. Understanding this distinction is essential to understanding what CHCA does and what it refuses to do.

2.1 The Definition of Agency-Decorrelation

A condition is *agency-decorrelated* when two criteria are satisfied: its etiology is substantially independent of individual behavioral choice, and reasonable preventive action by the individual would not reliably avoid the outcome. This is a descriptive statement about causation - not a statement about character, blame, or worth.

Consider the distinction through concrete examples. A child born with cystic fibrosis exercised no behavioral choice that caused the condition. The genetic mutation was present at conception, determined by factors no individual could control. The condition is agency-decorrelated because no behavior by the child - or, indeed, by the parents - could have prevented it.

A driver struck by a drunk driver while lawfully proceeding through an intersection exercised no behavioral choice that caused the collision. The injury resulted from another party's action, not from the victim's behavior. The condition is agency-decorrelated because the victim's choices did not produce the outcome.

A factory worker who develops mesothelioma after decades of occupational asbestos exposure exercised no behavioral choice that caused the exposure. The worker accepted employment; the employer controlled workplace conditions. In most cases, the worker lacked knowledge of the exposure and could not have prevented it through personal behavior. The condition is agency-decorrelated because the relevant causal factor - asbestos exposure - was not within the worker's behavioral control.

2.2 What 'Agency' Does Not Mean

The agency principle does not ask whether a person 'deserves' care. Every person deserves care regardless of how their condition arose. The agency principle asks a different question: is this category of catastrophic risk suitable for collective, first-dollar federal coverage without creating perverse incentives or fiscal instability?

The agency principle does not require moral purity. A person who smokes and is later struck by a drunk driver while walking across the street has an agency-decorrelated injury. The smoking is irrelevant to the causation of the pedestrian injury. CHCA does

not ask whether the patient is a good person or has made good life choices. It asks whether the specific catastrophic condition in question arose from behavioral choice.

The agency principle does not punish patients for factors they cannot control. A person with genetic predisposition to certain conditions is not denied coverage because of that predisposition - rather, conditions arising from genetic factors are *more* clearly agency-decorrelated, not less. The framework identifies conditions where collective coverage is most clearly justified, not conditions where punishment is warranted.

2.3 What the Agency Principle Does Acknowledge

Critics may fairly observe that any framework distinguishing conditions for differential treatment contains some moral content. This is correct—and CHCA does not deny it. The distinction between agency-decorrelated and agency-correlated conditions is not morally empty. It reflects a judgment about the appropriate scope of collective risk-bearing.

That moral content, however, is narrow. It addresses a single question: which categories of catastrophic risk are appropriate for collective federal coverage without creating perverse incentives or fiscal instability? The agency principle does not judge character. It does not assess virtue. It does not rank human worth. It asks only whether a category of conditions arose from circumstances that individuals could not have controlled through their choices.

This narrow moral content is qualitatively different from the broad moral judgments critics fear. Broad moral judgment would ask: Is this person deserving? Has this person lived well? Did this person make good choices in life? CHCA asks none of these questions. It asks only: Did individual choice cause this category of condition? That question has moral implications for collective risk allocation, but it does not constitute moral evaluation of individuals.

The distinction matters because all insurance systems contain implicit moral content. The question is not whether to embed values in healthcare financing—that is unavoidable—but whether the embedded values are narrow, transparent, and defensible. CHCA's narrow moral content can be stated plainly: conditions arising from circumstances beyond individual control are appropriate for collective coverage; conditions substantially caused by individual choices are appropriate for individual responsibility. This principle resonates across political frameworks precisely because it is narrow enough to command broad assent while specific enough to create meaningful boundaries.

2.4 Medical Science Already Uses Causal Classification

Medicine already relies on causal classification for diagnosis, treatment, and epidemiology. The distinction between genetic and acquired conditions is clinically relevant - different conditions require different treatments and carry different prognoses. The distinction between occupational and non-occupational injury is legally relevant - it determines workers' compensation eligibility. The distinction between environmental

exposure and idiopathic disease is epidemiologically relevant - it determines public health interventions.

The International Classification of Diseases, Tenth Revision (ICD-10-CM), used worldwide for medical coding and insurance reimbursement, already categorizes conditions by etiology.ⁱⁱⁱ The system includes over 70,000 diagnostic codes organized into chapters that distinguish between conditions by causal category. Chapter Q covers congenital malformations and chromosomal abnormalities - conditions present from birth and arising from genetic or developmental factors. Chapters S and T cover injuries, poisoning, and certain other consequences of external causes. Chapter V covers external causes of morbidity. Chapter Z covers factors influencing health status and contact with health services, including codes for lifestyle factors and behavioral risks.

CHCA does not invent a new classification system. It uses the existing classification system that medical professionals already use for every diagnosis, every insurance claim, and every epidemiological study. The question is not whether causal classification is possible - it is already universal in medical practice. The question is whether that classification can be used for risk-routing in a publicly accountable way.

2.5 The Analogy to Other Accountability Systems

Other accountability systems routinely distinguish causal contribution from moral blame. Product liability law holds manufacturers responsible for defects without inquiring into the manufacturer's moral character. The question is whether the product was defective and whether the defect caused harm - not whether the manufacturer intended harm or acted virtuously in other contexts.

Aviation safety systems distinguish pilot error from mechanical failure from weather without assigning moral blame. The National Transportation Safety Board determines probable cause for accidents through technical investigation, not moral inquiry. The purpose is to prevent future accidents, not to pronounce judgment on the virtue of those involved.

Insurance underwriting distinguishes insurable from uninsurable risks based on actuarial analysis, not moral assessment. Flood insurance is difficult to provide through private markets because flood risk is concentrated geographically and correlated across policyholders - not because flood victims are morally suspect. The National Flood Insurance Program exists because certain risks require collective management regardless of individual virtue.

CHCA applies the same logic to catastrophic health risk. Certain categories of catastrophic health conditions are poorly suited to individual risk management - they cannot be predicted, prevented through individual action, or absorbed without financial catastrophe. Collective management of these specific risks does not require moral judgment about those who experience them.

III. How CHCA Determines Coverage: Process Over Judgment

CHCA does not empower administrators to make ad hoc moral determinations. Coverage is determined through pre-specified, auditable processes designed to minimize discretion and maximize consistency.

3.1 ICD-10 Anchoring

CHCA relies on the International Classification of Diseases (ICD-10-CM) as its taxonomic foundation. This is the same classification system already used for diagnosis, epidemiology, and reimbursement throughout the U.S. healthcare system. The system is maintained by the National Center for Health Statistics in cooperation with the Centers for Medicare and Medicaid Services, under authorization from the World Health Organization.

CHCA does not invent new moral categories. It designates subsets of existing diagnostic codes as qualifying for catastrophic coverage based on etiology, not behavior. The designation process begins with clinical classification - what category of condition is this? - rather than behavioral assessment - what did this patient do?

This anchoring serves multiple purposes. It ensures that coverage determinations are made using a standardized, professionally maintained classification system rather than ad hoc administrative judgment. It provides transparency - the qualifying codes are public and can be reviewed by any interested party. It creates consistency - the same condition receives the same classification regardless of where or by whom it is treated. It enables accountability - decisions can be audited against the published code list.

3.2 Code List Governance

The Secretary of Health and Human Services maintains a public list of CHCA-qualifying diagnostic codes. This list is reviewed annually through a formal process that includes clinical evidence review, stakeholder input, and public notice-and-comment rulemaking.

Changes to the qualifying code list require documented clinical justification. The justification must address etiology - does the condition arise from circumstances substantially beyond individual control? - and must be supported by peer-reviewed clinical literature or established medical consensus. Stakeholders may submit evidence and objections during the review process. All changes are subject to judicial review under standard administrative law procedures.

This governance structure prevents both expansion creep and political manipulation. The code list cannot expand without clinical justification. It cannot be manipulated for political purposes without public process. It cannot be frozen against new medical evidence. The system learns and adapts while remaining constrained by its core principle.

3.3 No Bedside Adjudication

Coverage routing occurs at the claims-processing level, not at the point of care. This separation is essential to the program's integrity and to the preservation of the physician-patient relationship.

Providers deliver care as medically indicated. The diagnostic code assigned to a patient's condition is determined by clinical judgment about what condition the patient has - the same judgment physicians already make for every patient they treat. No additional inquiry is required. No behavioral assessment is performed. No interrogation of the patient's lifestyle occurs.

Claims processing then determines payer routing based on the diagnostic code. If the code appears on the CHCA qualifying list, the claim is routed to the CHCA Trust Fund. If not, the claim follows existing payer arrangements - private insurance, Medicare, Medicaid, or other applicable coverage. The routing decision is automatic, based on pre-specified rules, with no discretionary judgment about the individual patient's behavior or moral character.

This architecture eliminates discretionary judgment where it would be most dangerous and least defensible. No clinician is asked to assess moral responsibility. No administrator decides whether a particular patient 'deserves' coverage. The system operates through rules, not judgments - through taxonomy, not morality.

IV. Mixed and Ambiguous Causation: Designed for Reality

Medicine does not offer clean binaries. CHCA is designed for the messy reality of actual medical causation, not for a simplified world that does not exist.

4.1 Mixed Etiology Is the Norm

Many catastrophic conditions involve multiple causal factors. A patient may have genetic predisposition plus environmental trigger. A worker may have occupational exposure plus background risk from other sources. An accident victim may have pre-existing conditions that are exacerbated by trauma. CHCA does not pretend that causation is always simple.

Consider a worked example: A coal miner develops lung cancer after thirty years of underground work. The miner also smoked cigarettes for most of his adult life. Both coal dust exposure and tobacco use are known risk factors for lung cancer. What is the 'cause' of this patient's condition?

CHCA does not require answering this question with certainty at the individual level. The question is whether the category of condition - occupational lung disease in coal miners - is appropriately classified as agency-decorrelated. The clinical and epidemiological evidence is clear: coal miners develop lung cancer at elevated rates due to occupational exposure, regardless of smoking status.^{iv} The occupational

exposure is a sufficient cause for many cases, independent of lifestyle factors. The category qualifies; the individual case is covered.

4.2 Clear Qualification Standards

A condition qualifies as agency-decorrelated only when behavioral choice is not the dominant causal driver. Where lifestyle factors are the primary or sufficient cause of a condition category, that category does not qualify—not because those patients are undeserving of care, but because including such conditions would undermine the program’s fiscal sustainability and create incentive distortion.

The standard is applied at the category level, not the individual case level. This protects patients from two distinct harms. First, it prevents the program from becoming an inquisition into individual behavior—no patient faces interrogation about their lifestyle choices. Second, it prevents arbitrary bureaucratic discretion—administrators cannot selectively apply behavioral standards to disfavored patients while waiving them for others. Category-level determination means the rules are known in advance, applied uniformly, and subject to public review.

When substantial uncertainty exists about the role of behavioral factors in a category of conditions, the program errs toward clarity rather than expansion. This is not because CHCA is stingy or suspicious of claimants. It is because ambiguous boundaries invite both bureaucratic overreach and political manipulation. Clear boundaries protect patients by ensuring that coverage decisions are predictable, that denials are reviewable, and that the rules cannot be quietly expanded or contracted based on political convenience.

The clarity standard serves patients’ long-term interests even when it excludes some marginally qualifying categories in the short term. Programs with ambiguous boundaries are politically vulnerable—critics can always find cases at the margins to attack. Programs with clear boundaries can be defended on principle. CHCA’s boundaries are designed to be defensible across political cycles, which is the only way to ensure they will still exist when patients need them.

4.3 A Non-Qualifying Example: Tobacco-Related Lung Cancer

Understanding how CHCA handles non-qualifying conditions is as important as understanding qualifying ones. Consider a fifty-year-old patient diagnosed with lung cancer after thirty years of voluntary tobacco use, with no occupational or environmental exposure history.

This condition does not qualify for CHCA coverage—not because the patient is undeserving of care, and not because CHCA judges the patient’s character. The patient receives care through exactly the same mechanisms available before CHCA existed: private insurance, Medicare or Medicaid if eligible, charity care, or personal resources. Non-qualification is not punishment; it is a determination that this category of condition—where lifestyle choice is the dominant causal factor—is not appropriate for this specific federal program.

The rationale is both principled and practical. First, tobacco-related conditions arise substantially from behavioral choice. The causal relationship between smoking and lung cancer is among the most thoroughly documented in medical science. While addiction complicates simple notions of “free choice,” the initial decision to smoke and the ongoing decision to continue represent behavioral factors that the agency framework reserves for individual responsibility.

Second, including lifestyle-related conditions would undermine the program’s fiscal sustainability and create incentive distortion. If CHCA covered conditions regardless of behavioral causation, the program’s costs would expand unpredictably, and individuals would have reduced incentive to make health-promoting choices. This is not because CHCA wants to punish unhealthy behavior—it simply recognizes that collective coverage of behaviorally-influenced conditions creates dynamics that threaten program durability.

Third, and crucially, the patient’s existing coverage is not diminished. CHCA adds coverage for agency-decorrelated conditions; it subtracts nothing from anyone. The tobacco user’s private insurance, Medicare eligibility, and other coverage mechanisms continue exactly as before. The patient is not worse off because CHCA exists—but the patient does not gain CHCA’s specific catastrophic protection for a condition substantially caused by behavioral choice.

Compare this case to the coal miner in Section 4.1. Both patients have lung cancer. The difference is causal: the coal miner’s occupational exposure was beyond individual control, while the tobacco user’s exposure resulted from behavioral choice. The distinction is not about the patients’ worth as human beings. Both deserve care. Both receive care. The distinction is about which mechanism appropriately provides that care—and whether collective first-dollar federal coverage is the right mechanism for conditions with substantial behavioral causation.

4.4 Appeals and Learning Loops

Individual coverage determinations can be appealed through a formal administrative process. The appeals process serves two purposes: it provides due process for individuals who believe their specific case was incorrectly classified, and it generates data that informs future code list updates.

When appeals reveal systematic patterns - categories of conditions that are frequently misclassified, or individual cases within excluded categories that consistently demonstrate agency-decorrelated causation - that evidence feeds into the annual code list review. The system improves through evidence, not ideology. Errors are corrected through process, not politics.

This creates a feedback mechanism that narrows error over time rather than freezing mistakes into statute. Unlike programs whose boundaries are set once and never revisited, CHCA's boundaries are subject to continuous improvement based on actual experience. The program learns from its operation rather than defending its initial assumptions against accumulating evidence.

4.5 The 'Reasonable Preventive Action' Criterion

The second criterion for agency-decorrelation - that reasonable preventive action by the individual would not reliably avoid the outcome - requires careful interpretation. 'Reasonable' is assessed against population-level feasibility, not individual hindsight.

A resident of a community with contaminated groundwater cannot reasonably be expected to have known about contamination that was not publicly disclosed, to have tested their water supply for industrial pollutants, or to have relocated their family to avoid exposure they did not know existed. The burden lies with the program to demonstrate individual preventability, not with the patient to prove they could not have avoided harm.

This interpretation prevents the 'reasonable preventive action' criterion from becoming a backdoor for victim-blaming. It would be unreasonable to deny coverage because, in hindsight, a patient 'could have' moved away from a pollution source they did not know about, or 'could have' declined employment at a workplace whose hazards were concealed. Preventability is assessed based on what a reasonable person could have known and done, not on what an omniscient observer might have predicted.

V. What CHCA Explicitly Refuses to Do

To prevent mission creep and moral overreach, CHCA includes explicit prohibitions on activities that might transform a risk-routing system into a moral tribunal. These prohibitions are not merely policy preferences - they are structural constraints embedded in the legislation.

5.1 No Behavioral Monitoring

CHCA does not monitor patient behavior. There is no surveillance of lifestyle choices, no tracking of health-related behaviors, no data collection about individual decisions regarding diet, exercise, substance use, or other personal conduct. The program operates through diagnostic codes, not behavioral profiles.

This prohibition is absolute. Even if behavioral data might theoretically improve coverage accuracy, collecting such data would transform the program into something fundamentally different - a system that watches citizens rather than a system that routes risk. The administrative efficiency gains from behavioral data would not justify the civil liberties costs or the political vulnerability such data collection would create.

5.2 No Retroactive Denial

CHCA does not deny care retroactively based on subsequently discovered behavioral factors. If a condition is diagnosed and initially covered, later discovery that the patient engaged in behaviors that might have contributed to the condition does not result in coverage revocation or repayment demands.

This protection ensures that patients do not face incentives to conceal medical history or avoid seeking care for fear of retroactive denial. It also prevents administrative resources from being consumed by retrospective behavioral investigations. Coverage decisions are made prospectively based on diagnosis; they are not revisited based on behavioral archaeology.

5.3 No Means Testing

CHCA does not means-test coverage eligibility. Wealthy individuals with agency-decorrelated conditions receive the same coverage as low-income individuals with identical conditions. The program routes based on medical causation, not financial circumstance.

This design choice reflects both administrative efficiency and political durability. Means testing would require income verification, asset assessment, and ongoing eligibility monitoring - administrative burdens that would increase program costs while reducing uptake among those who need coverage. Universal programs also tend to maintain broader political support than targeted programs, because every citizen perceives potential benefit.

5.4 No Punitive Treatment

CHCA does not punish illness. Conditions that do not qualify for CHCA coverage are not thereby stigmatized or penalized. They simply remain under existing coverage arrangements - private insurance, Medicare, Medicaid, or other applicable programs. Non-qualification for CHCA is not a verdict of moral failure; it is a determination that a particular category of risk is not appropriate for this specific federal program.

A patient with a lifestyle-related condition receives care through the same mechanisms available before CHCA existed. The program adds coverage for categories that qualify; it does not subtract coverage from categories that do not. CHCA improves the situation for those with agency-decorrelated conditions without worsening the situation for anyone else.

5.5 No Bedside Fault Determination

No clinician is asked to assess patient fault as a condition of treatment. Physicians diagnose conditions and provide care; they do not adjudicate moral responsibility. The coverage determination is made by claims processing systems using diagnostic codes, not by clinicians making judgments about patient behavior.

This separation protects the physician-patient relationship. Patients can disclose relevant medical history without fear that their physician will use that information to deny coverage. Physicians can focus on treatment without being drafted into a gatekeeping role that would distort clinical judgment and erode patient trust.

VI. Why Boundary Discipline Is a Feature, Not a Flaw

Critics sometimes argue that any boundary is inherently unjust - that a compassionate society would simply cover everyone for everything without distinctions. History suggests the opposite conclusion.

6.1 Programs Without Boundaries Fail

Programs without clear boundaries expand unpredictably, accumulate unfunded obligations, collapse politically, and ultimately fail the populations they were meant to protect. The history of social insurance is littered with programs that promised everything to everyone and delivered disappointment when fiscal or political reality reasserted itself.

Medicare's current trajectory illustrates the challenge. The program's trust funds face projected depletion within the coming decade, requiring either benefit cuts or revenue increases that may prove politically impossible.^v The program's unbounded benefit structure - covering essentially all medical care for the elderly regardless of causation - creates fiscal pressures that threaten the program's long-term viability. A program that covers everything risks covering nothing when fiscal constraints bind.

CHCA's bounded structure is designed to avoid this trajectory. By covering a defined category of risk - agency-decorrelated catastrophic conditions - the program maintains predictable costs, sustainable financing, and durable political support. The boundary is not a flaw to be apologized for; it is the feature that makes the program workable.

6.2 Boundaries Enable Fiscal Sustainability

CHCA's boundaries enable fiscal sustainability through three mechanisms. First, the defined category of covered conditions creates predictable actuarial costs. Unlike open-ended benefit structures that depend on utilization patterns, CHCA's costs are tied to the incidence of specified conditions - a quantity that can be estimated with reasonable accuracy based on epidemiological data.

Second, the agency-decorrelation criterion eliminates the incentive distortion concerns that accompany many social insurance programs. Incentive distortion occurs when coverage changes behavior in ways that increase costs—when the availability of insurance leads people to take risks they would otherwise avoid. But individuals cannot choose to develop genetic conditions, choose to be struck by drunk drivers, or choose to be exposed to workplace carcinogens. The behaviors that would generate agency-decorrelated conditions are not behaviors at all; they are circumstances. Coverage cannot distort incentives for behaviors that do not exist.

This is not a semantic distinction. The standard critique of social insurance programs is that coverage encourages the covered behavior. Unemployment insurance may extend unemployment duration. Disability insurance may discourage return to work. These concerns have empirical foundation and must be addressed in program design. But CHCA covers conditions that cannot be chosen. No amount of coverage will cause anyone to develop cystic fibrosis, to be hit by a drunk driver, or to contract

mesothelioma from occupational asbestos exposure. The incentive distortion critique simply does not apply to circumstances where no incentive-responsive behavior exists.

Third, the subrogation provisions ensure that costs are recovered from responsible third parties where such parties exist. Motor vehicle accidents involving at-fault drivers, workplace injuries involving employer negligence, product defects involving manufacturer liability, and environmental contamination involving polluter responsibility all create recovery opportunities. Systematic government subrogation - modeled on the Medicare Secondary Payer program that has recovered billions annually - ensures that CHCA does not subsidize tortfeasors.^{vi}

6.3 Boundaries Preserve Private Markets

CHCA explicitly preserves market-based coverage for routine care and lifestyle-related conditions. By removing catastrophic agency-decorrelated risk from employer insurance pools, the program actually strengthens private markets by eliminating the catastrophic tail risk that creates premium volatility and administrative burden for employers.

Small and medium-sized businesses currently struggle with health insurance because a single catastrophic claim can transform their renewal economics. CHCA removes precisely those claims from employer risk pools - the rare, unpredictable, extremely expensive conditions that employers cannot diversify away. What remains is more manageable routine care risk that private insurance markets can efficiently price and administer.

This design reflects a principle of appropriate risk allocation: risks that cannot be predicted or prevented at the individual level are appropriate for collective management; risks that respond to individual incentives are appropriate for market-based coverage. CHCA does not displace private insurance - it unbundles risks so that each mechanism handles the risks it is suited to manage.

6.4 Boundaries Build Political Durability

Programs with clear boundaries maintain political support across ideological divides more effectively than programs that attempt to satisfy everyone. CHCA's boundaries reflect principles that resonate across the political spectrum: individual responsibility for controllable choices, collective support for uncontrollable circumstances, accountability for those who cause harm, and fiscal discipline to ensure program sustainability.

The boundary structure also makes the program defensible against attack. Critics cannot accurately characterize CHCA as 'government takeover of healthcare' because it explicitly preserves private insurance for most care. Critics cannot accurately characterize it as 'moral policing' because it explicitly prohibits behavioral monitoring and bedside fault determination. Critics cannot accurately characterize it as 'fiscally irresponsible' because it includes built-in sustainability mechanisms. The boundaries define what the program is - and equally important, what it is not.

6.5 The Messaging Challenge

CHCA's framework is defensible on its merits, but political discourse does not always operate on merits. Headlines will simplify. Critics will distort. The framework that distinguishes "conditions beyond individual control" from "conditions influenced by lifestyle choices" will be characterized as "the government deciding who deserves healthcare."

This paper provides the substantive foundation for responding to such characterizations, but the response requires discipline. Defenders of CHCA must consistently emphasize what the program refuses to do: no behavioral monitoring, no retroactive denial, no bedside fault determination, no punishment of non-qualifying patients. These prohibitions are not afterthoughts—they are structural constraints that distinguish CHCA from the caricature its critics will construct.

The messaging challenge is manageable precisely because the framework's moral content is narrow. CHCA does not ask whether patients are good people. It does not assess virtue. It does not rank human worth. It asks only whether a category of conditions arose from circumstances beyond individual control. That question can be explained. That principle can be defended. The task of derivative communications—op-eds, briefing materials, media responses—is to ensure that explanation reaches audiences before the caricature solidifies.

VII. Conclusion: Legitimacy Through Constraint

CHCA's central insight is not that society should judge health outcomes. It is that society already allocates catastrophic risk - and does so badly. The current system draws boundaries invisibly, enforces them regressively, and provides no accountability when the results prove unjust. CHCA proposes to make those boundaries explicit, reviewable, and narrow.

By making boundaries explicit, CHCA enables citizens to understand how risk is allocated before catastrophe strikes. By making boundaries reviewable, CHCA ensures that classification errors can be corrected through evidence-based processes rather than preserved through bureaucratic inertia. By making boundaries narrow, CHCA maintains fiscal sustainability and political durability while providing comprehensive protection against the specific risks it addresses.

The agency principle is not a moral judgment. It is a causal classification that identifies conditions arising from circumstances beyond individual control. The ICD-10 anchoring is not administrative arbitrariness. It is adoption of a globally standardized, professionally maintained classification system already used throughout medical practice. The governance structure is not bureaucratic overreach. It is procedural constraint that prevents mission creep while enabling evidence-based improvement.

Boundary without judgment is not cruelty. It is how complex systems remain humane and functional over time. The alternative - boundless promises that collapse under fiscal or political pressure - is not compassion. It is cruelty deferred.

CHCA offers a durable solution to a defined problem: catastrophic financial destruction from medical conditions beyond individual control. It offers that solution without moral inquisition, without behavioral surveillance, without means testing, and without displacing the private insurance markets that serve other healthcare needs. It creates boundaries that are explicit, reviewable, narrow - and defensible across ideological perspectives because they reflect principles that Americans broadly share.

That is the promise of boundary without judgment: protection against catastrophe, preservation of responsibility, and sustainability across political cycles. It is not a perfect solution to every healthcare problem. It is a workable solution to one critical problem - achieved through constraint, not through promises that cannot be kept.

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ⁱ Agency for Healthcare Research and Quality, *Concentration of Healthcare Expenditures and Selected Characteristics of People with High Expenses, United States Civilian Noninstitutionalized Population, 2018-2022*, Statistical Brief #560 (December 2024). AHRQ analysis of Medical Expenditure Panel Survey data consistently shows that the top 5 percent of the population accounts for approximately 50 percent of total healthcare expenditures, while the bottom 50 percent accounts for less than 3 percent.

ⁱⁱ The job lock phenomenon is extensively documented in economics literature. Fairlie, Kapur, and Gates (2011) found that business ownership increases 13.8 percent in the single month workers gain Medicare eligibility at age 65, demonstrating that catastrophic cost fear—not routine care costs—drives employment lock. See Robert W. Fairlie, Kanika Kapur, and Susan Gates, “Is employer-based health insurance a barrier to entrepreneurship?” *Journal of Health Economics* 30, no. 1 (2011): 146-162.

ⁱⁱⁱ The ICD-10-CM is maintained by the National Center for Health Statistics (NCHS) in cooperation with the Centers for Medicare and Medicaid Services (CMS), under authorization from the World Health Organization. The system includes over 70,000 diagnostic codes and is used throughout the U.S. healthcare system for diagnosis, epidemiology, and reimbursement. See Centers for Disease Control and Prevention, “ICD-10-CM Official Guidelines for Coding and Reporting,” FY 2025, available at <https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf>.

^{iv} The relationship between occupational coal dust exposure and lung cancer is well-established in occupational health literature. The International Agency for Research on Cancer classifies coal dust as carcinogenic to humans (Group 1). Epidemiological studies demonstrate elevated lung cancer risk among coal miners that persists after controlling for smoking status. See IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Vol. 100C (2012).

^v The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds projects that the Medicare Hospital Insurance (Part A) trust fund will be depleted in 2036 under current law. See Centers for Medicare and Medicaid Services, *2024 Annual Report of the Boards of Trustees*, available at <https://www.cms.gov/oact/tr/2024>.

^{vi} The Medicare Secondary Payer program achieved savings of \$9.04 billion in fiscal year 2024 and has recovered over \$63 billion cumulatively since fiscal year 2015. See Centers for Medicare and Medicaid Services, “Medicare Secondary Payer,” MLN Fact Sheet MLN006903, July 2025; Congressional Research Service, “Medicare Secondary Payer: Coordination of Benefits,” RL33587 (August 2023).