

CATASTROPHIC HEALTH COVERAGE ACT

119TH CONGRESS

1ST SESSION

S. _____

To amend the Social Security Act to provide for the establishment of a Catastrophic Health Coverage Program to eliminate medical bankruptcy, improve labor mobility by ending insurance-driven job lock, establish systematic accountability through subrogation, and create a unified federal trust fund for agency-decorrelated medical risks, and for other purposes.

IN THE SENATE OF THE UNITED STATES

_____, 2025

Mr./Ms. _____

introduced the following bill;

which was read twice and referred to the Committee on

A BILL

To be cited as the "Catastrophic Health Coverage Act of 2025" or the "CHCA"

TITLE I—GENERAL PROVISIONS

SEC. 101. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Catastrophic Health Coverage Act of 2025" or the "CHCA".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as set forth in the preliminary matter of this Act.

SEC. 102. FINDINGS.

Congress finds the following:

(a) *Burden on Interstate Commerce.*

(1) Interstate commerce is substantially burdened by "job lock," whereby workers remain in suboptimal employment solely to maintain health insurance against catastrophic risks beyond their control.

(2) Approximately 16 percent of the United States workforce remains

in unwanted employment primarily to maintain employer-provided health insurance, with rates reaching 28 percent among lower-income workers.

(3) The fear of catastrophic health costs—not routine care expenses—constitutes the primary driver of employment lock, as demonstrated by the Medicare age-65 natural experiment showing a 13.8 percent relative increase in business ownership precisely when catastrophic hospital coverage becomes available through Medicare Part A.

(4) This constraint on labor mobility impedes optimal allocation of human capital across industries, reduces entrepreneurship and business formation, and diminishes national economic productivity.

(b) *Market Distortion.*

(5) The inclusion of rare, genetic, and accidental catastrophic risks in employer-sponsored insurance pools creates extreme premium volatility that small and medium-sized businesses cannot actuarially manage, forcing such businesses to act as accidental healthcare administrators while lacking economies of scale.

(6) A single catastrophic claim can transform a small employer's renewal economics, forcing difficult choices between absorbing costs, reducing coverage, or disrupting employee care relationships.

(7) The concentration of healthcare costs—with the top 5 percent of patients accounting for nearly 50 percent of spending—represents precisely the catastrophic tail risk that neither individuals nor small employers can efficiently self-insure against, and which violates actuarial principles because such risks cannot be diversified away or predicted at the individual level.

(c) *The Agency Principle.*

(8) Medical science recognizes a fundamental distinction between conditions arising from individual lifestyle choices and conditions arising from circumstances substantially beyond individual control.

(9) The International Classification of Diseases, Tenth Revision (ICD-10), used worldwide for medical coding and insurance reimbursement, categorizes conditions by etiology and causation, providing an established framework for distinguishing agency-decorrelated conditions from lifestyle-derived conditions.

(10) Agency-decorrelated conditions—including genetic disorders, congenital conditions, accidents involving innocent victims, occupational injuries and illnesses, environmental exposures, and infectious diseases contracted despite reasonable precautions—constitute a collective social risk appropriately managed through unified federal coverage.

(11) Conditions substantially influenced by individual lifestyle choices appropriately remain individual responsibilities, preserving market incentives for health-promoting behavior and eliminating moral hazard concerns that accompany universal coverage proposals.

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(d) *Existing Spending Consolidation.*

(12) Federal, state, and private payers currently expend approximately \$575,000,000,000 to \$645,000,000,000 annually on agency-decorrelated catastrophic medical conditions through fragmented, duplicative administrative structures, including approximately \$280,000,000,000 through private insurance, \$200,000,000,000 through Medicare, \$60,000,000,000 through Medicaid, and \$50,000,000,000 through workers' compensation.

(13) This existing spending is distributed across multiple payer systems without systematic coordination, resulting in administrative inefficiency, coverage gaps, and inadequate cost recovery from responsible third parties.

(14) Consolidation of existing agency-decorrelated catastrophic spending into a unified federal program, combined with systematic subrogation recovery, could achieve administrative savings of approximately \$41,000,000,000 to \$46,000,000,000 annually through elimination of duplicative administrative functions.

(e) *Accountability Gap.*

(15) The current tort system recovers only a fraction of medical costs from parties responsible for injuries, with studies indicating that only 53 cents of each tort dollar reaches victims, while the remainder is consumed by attorney fees and administrative costs.

(16) Systematic government subrogation—as demonstrated by the Medicare Secondary Payer program, which achieved savings of \$9,040,000,000 in fiscal year 2024 and has recovered over \$63,000,000,000 cumulatively since fiscal year 2015—provides a proven mechanism for ensuring costs are borne by responsible parties.

(17) Government-initiated subrogation ensures immediate victim care without requiring victims to bear litigation risk, improves cost allocation to responsible parties, creates systematic deterrence incentives, and could recover \$80,000,000,000 to \$100,000,000,000 annually based on identified potentially recoverable claims.

SEC. 103. CONSTITUTIONAL AUTHORITY.

This Act is enacted pursuant to the power of Congress under the following provisions of the Constitution of the United States:

(a) *Spending Power.*

(1) Article I, Section 8, Clause 1 of the Constitution grants Congress authority to "provide for the common Defence and general Welfare of the United States."

(2) The establishment of a social insurance program for catastrophic health risks arising from circumstances beyond individual control serves the general welfare by—

(A) eliminating medical bankruptcy arising from agency-decorrelated conditions;

(B) removing barriers to labor mobility and entrepreneurship;

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(C) stabilizing private insurance markets by removing catastrophic tail risks that cannot be diversified away; and

(D) ensuring appropriate cost allocation through systematic subrogation.

(3) The subrogation provisions of this Act satisfy the requirements of *South Dakota v. Dole*, 483 U.S. 203 (1987), because—

(A) catastrophic healthcare coverage serves general welfare purposes;

(B) subrogation conditions are stated clearly in this Act;

(C) subrogation directly relates to program fiscal sustainability, a core federal interest; and

(D) no independent constitutional provision bars recovery from tortfeasors.

(4) The subrogation and preemption provisions of this Act are supported by *Coventry Health Care of Missouri v. Nevils*, 581 U.S. ____ (2017), in which the Supreme Court unanimously held that federal law may preempt state anti-subrogation statutes where the federal statute expressly provides for subrogation and reimbursement.

(5) Federal healthcare subrogation authority is well-established through four decades of Medicare Secondary Payer program operation under 42 U.S.C. 1395y(b), sustained through extensive litigation including—

(A) *United States v. Baxter International, Inc.*, 345 F.3d 866 (11th Cir. 2003), affirming government standing to pursue direct claims against settling defendants;

(B) *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995), affirming the Medicare Secondary Payer provisions as a valid exercise of spending power; and

(C) *In re Avandia Marketing, Sales Practices & Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012), affirming that Medicare Advantage Organizations may exercise the same subrogation and reimbursement recovery rights as traditional Medicare under the MSP provisions.

(6) The Medicare Secondary Payer program achieved cumulative savings exceeding \$63,000,000,000 from fiscal year 2015 through fiscal year 2021, with annual savings of approximately \$9,000,000,000 in subsequent years, demonstrating the fiscal viability and constitutional soundness of systematic federal healthcare subrogation.

(b) *Commerce Power.*

(1) Article I, Section 8, Clause 3 of the Constitution grants Congress authority to regulate commerce among the several States.

(2) Healthcare financing is quintessentially interstate activity,

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with insurance markets crossing state boundaries, providers serving patients from multiple states, and healthcare spending representing approximately 18 percent of gross domestic product.

(3) The removal of insurance-driven job lock and the stabilization of interstate insurance markets constitute regulation of commerce having substantial effects on interstate economic activity.

(4) This Act operates primarily through spending authority consistent with *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

(c) *Necessary and Proper Clause.*

(1) Article I, Section 8, Clause 18 of the Constitution grants Congress authority to make all laws necessary and proper for carrying into execution the foregoing powers.

(2) Consistent with *McCulloch v. Maryland*, 17 U.S. 316 (1819), and *United States v. Comstock*, 560 U.S. 126 (2010), the subrogation, preemption, and administrative provisions of this Act are means reasonably adapted to achieving the legitimate legislative objectives of comprehensive catastrophic coverage with appropriate cost allocation.

(3) Subrogation is a well-established legal device serving legitimate programmatic purposes, not prohibited by any constitutional provision, and reasonably adapted to achieve this Act's objectives.

(d) *Anti-Coercion Compliance.*

(1) This Act does not condition existing federal healthcare funding on state participation in CHCA, thereby avoiding the coercion concerns identified in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

(2) CHCA operates as a new federal program with independent funding through dedicated contributions under title II, not as a modification of existing programs that would threaten withdrawal of pre-existing funds.

(3) State participation in CHCA coordination under title V is incentivized through 100 percent federal reimbursement for qualifying claims, not compelled through loss of unrelated federal funds.

(4) The distinction between CHCA and the Medicaid expansion provision held unconstitutionally coercive in *NFIB v. Sebelius* is as follows:

(A) CHCA does not threaten existing Medicaid, Medicare, or other federal healthcare funds—state programs continue unchanged, with CHCA providing supplemental reimbursement for qualifying conditions;

(B) CHCA creates a new, independent funding stream through dedicated contributions rather than conditioning existing entitlements on new requirements;

(C) State coordination requirements under title V relate

directly to the federal interest in program fiscal sustainability, satisfying the relatedness requirement of *South Dakota v. Dole*, 483 U.S. 203 (1987); and

(D) States retain genuine choice regarding coordination, with non-coordinating states forgoing the benefits of CHCA reimbursement rather than losing existing federal funds—a constitutionally significant distinction.

(5) The state coordination provisions of this Act are analogous to cooperative federalism arrangements upheld under the spending power, including the Clean Air Act state implementation plan framework and the Medicaid program as originally enacted.

(e) Anti-Commandeering Compliance.

(1) This Act does not commandeer state legislative or executive officials to enact, enforce, or administer federal regulatory programs, consistent with *New York v. United States*, 505 U.S. 144 (1992), *Printz v. United States*, 521 U.S. 898 (1997), and *Murphy v. NCAA*, 584 U.S. ___ (2018).

(2) CHCA operates as a federal program administered by federal officials and federal contractors under title III and title IV. State officials are not required to administer CHCA provisions or enforce federal requirements.

(3) State coordination provisions under title V constitute cooperative federalism arrangements that allow, but do not require, state participation—

(A) States choosing to coordinate with CHCA receive 100 percent federal reimbursement for qualifying claims;

(B) States choosing not to coordinate continue processing claims through existing state systems without federal reimbursement; and

(C) The full regulatory and administrative burden of CHCA is borne by the Federal Government—consistent with the cooperative federalism standard articulated in *Hodel v. Virginia Surface Mining*, 452 U.S. 264 (1981), and reaffirmed in *Murphy v. NCAA*, under which states may choose to participate but are not compelled to do so.

(4) The preemption provisions of title V regulate private conduct—specifically, tortfeasor liability, insurance coordination, and the allocation of recovery proceeds between beneficiaries and the CHCA Trust Fund. Preemption of state common law doctrines (such as made-whole rules or anti-subrogation statutes) that would otherwise benefit private defendants falls within established federal authority under the Supremacy Clause, as affirmed in *Coventry Health Care v. Nevils*, and does not constitute commandeering of state officials.

(5) CHCA's subrogation framework operates through federal courts applying federal law and federal contractors operating under federal contracts, not through conscripted state officials or mandated state regulatory action.

(f) Due Process Preservation.

(1) Defendants in subrogation actions under this Act retain

full due process protections guaranteed by the Fifth and Fourteenth Amendments to the Constitution, including—

- (A) adequate notice of claims asserted;
- (B) opportunity to contest liability and damages;
- (C) access to federal and state courts of competent jurisdiction;
- (D) right to counsel of their choosing;
- (E) right to jury trial where constitutionally or statutorily guaranteed;
- (F) right to present evidence and cross-examine witnesses;
- (G) right to appeal adverse judgments through established appellate procedures; and
- (H) protection against double recovery by victims.

(2) Nothing in this Act creates presumptions of liability, shifts burdens of proof, or otherwise advantages the government in subrogation proceedings beyond advantages available to private litigants in comparable civil actions.

SEC. 104. PURPOSES.

The purposes of this Act are as follows:

(18) To establish a national program providing coverage for catastrophic medical expenses arising from agency-decorrelated conditions for all legal residents of the United States.

(19) To eliminate medical bankruptcy arising from health conditions beyond individual control.

(20) To end insurance-driven job lock by providing portable catastrophic coverage independent of employment.

(21) To promote entrepreneurship by eliminating catastrophic health cost fear as a barrier to business formation.

(22) To stabilize private insurance markets by removing agency-decorrelated catastrophic tail risks from employer-sponsored and individual insurance pools.

(23) To establish systematic accountability through federal subrogation, ensuring costs are borne by parties responsible for causing injuries through the Accountability-Through-Recovery Principle.

(24) To consolidate existing fragmented catastrophic spending into a unified, efficiently administered federal program without creating new spending or shifting costs to the federal government.

(25) To preserve individual responsibility for health conditions

substantially influenced by lifestyle choices, maintaining market incentives for health-promoting behavior.

SEC. 105. DEFINITIONS.

In this Act:

(1) AGENCY-DECORRELATED CONDITION.—

(A) IN GENERAL.—The term "agency-decorrelated condition" means a medical diagnosis, injury, or illness categorized under the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), or any successor classification system, as arising substantially from circumstances beyond the individual's control, where the condition's etiology is substantially independent of individual behavioral choices.

(B) INCLUDED CONDITIONS.—Such term includes—

(i) genetic and hereditary disorders, including rare diseases as defined under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb), which affect fewer than 200,000 persons in the United States;

(ii) congenital conditions and birth defects present at or arising from circumstances before birth;

(iii) traumatic injuries resulting from accidents in which the individual was not at fault, as determined under section 313;

(iv) occupational injuries and illnesses arising from workplace exposures, as determined under section 314;

(v) conditions arising from environmental or toxic exposures, identified through ICD-10-CM Z77 series codes or successor codes, as determined under section 315;

(vi) infectious diseases contracted despite reasonable precautions, as determined under section 316; and

(vii) such other conditions as the Secretary determines meet the criteria established under subparagraph (C) through the Code List maintained under section 303.

(C) CRITERIA FOR DETERMINATION.—A condition qualifies as agency-decorrelated if—

(i) the condition's etiology is substantially independent of individual behavioral choices;

(ii) the condition could not reasonably have been prevented through individual action; and

(iii) the individual exercised reasonable care with respect to factors within their control.

(D) EXCLUDED CONDITIONS.—Such term does not include conditions substantially attributable to individual lifestyle choices, including—

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- (i) diet-related conditions, except where such conditions arise from circumstances described in subparagraph (B);
- (ii) tobacco-related conditions, except where exposure was occupational or environmental;
- (iii) alcohol-related conditions resulting from voluntary consumption; and
- (iv) substance abuse-related conditions resulting from voluntary use.

(2) BOARD.—The term "Board" means the Board of Trustees of the CHCA Trust Fund established under section 212.

(3) CHCA TRUST FUND.—The term "CHCA Trust Fund" or "Trust Fund" means the trust fund established under section 211.

(4) CLEARINGHOUSE.—The term "Clearinghouse" means the National Claims Clearinghouse established under section 301.

(5) CODE LIST.—The term "Code List" means the authoritative list of CHCA-qualifying ICD-10-CM, CPT, and HCPCS codes maintained by the Secretary under section 303.

(6) CONTRIBUTION RATE.—The term "contribution rate" means the rate determined under section 225 and certified by the Board.

(7) LEGAL RESIDENT.—The term "legal resident" means any individual lawfully present in the United States, including citizens of the United States, lawful permanent residents, and any individual holding valid immigration status, consistent with eligibility standards for qualified health plans under section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)).

(8) LIABLE THIRD PARTY.—The term "liable third party" means any individual, entity, insurer, or other party legally responsible for causing an injury or condition giving rise to a claim under this Act, including tortfeasors, product manufacturers, premises owners, and employers whose negligence contributed to the condition.

(9) PROGRAM.—The term "Program" means the Catastrophic Health Coverage Program established under section 201.

(10) QUALIFIED CATASTROPHIC EXPENSE.—The term "qualified catastrophic expense" means any medically necessary item or service related to an agency-decorrelated condition, as determined under the standards applicable to covered services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(11) RECOVERY CONTRACTOR.—The term "recovery contractor" means

a contractor engaged under section 412 to pursue subrogation recovery on behalf of the CHCA Trust Fund, operating under Federal Acquisition Regulation-compliant, Defense Contract Audit Agency-auditable contracts.

(12) SECRETARY.—Except as otherwise provided, the term "Secretary" means the Secretary of Health and Human Services.

(13) SUBROGATION.—The term "subrogation" means the substitution of the United States in place of a beneficiary with respect to a legal claim against a liable third party, to the extent of payments made under this Act, consistent with the principles of section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)).

TITLE II—ESTABLISHMENT OF CHCA PROGRAM

Subtitle A—Program Establishment

SEC. 201. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—There is established a national program, to be known as the "Catastrophic Health Coverage Program," to provide coverage for qualified catastrophic expenses for all legal residents of the United States.

(b) ADMINISTRATION.—The Program shall be administered by the Secretary through the Centers for Medicare & Medicaid Services, utilizing existing claims processing infrastructure to the maximum extent practicable.

(c) PROGRAM DESIGN PRINCIPLES.—The Program shall be administered in accordance with the following principles:

(1) MINIMAL INFRASTRUCTURE.—The Secretary shall leverage existing CMS claims processing systems, IRS collection mechanisms, and state systems, avoiding creation of parallel bureaucracies. The Program shall not create new claims volume but shall redirect existing claims through existing infrastructure.

(2) CODE-BASED ROUTING.—Claims shall be routed based on ICD-10-CM diagnosis codes, with CHCA-qualifying codes routing automatically to the CHCA Trust Fund for payment. The diagnosis code shall determine the payer.

(3) FLOW-THROUGH.—Where practicable, existing state administrative structures for Medicaid and workers' compensation shall continue operations with federal reimbursement, with no provider-facing changes required.

(4) RATE NEUTRALITY AT LAUNCH.—Existing Medicare and Medicaid reimbursement rates shall continue initially for CHCA claims to ensure provider revenue neutrality. Cost savings shall accrue from administrative efficiency over time.

(5) NO COORDINATION OF BENEFITS.—For any claim with a

CHCA-qualifying diagnosis code, CHCA shall be the sole payer. There shall be no primary/secondary logic, no coordination of benefits determination, and no split payments.

SEC. 202. ELIGIBILITY.

(a) IN GENERAL.—All legal residents of the United States shall be eligible for coverage under this Act.

(b) NO ENROLLMENT REQUIRED.—Coverage under this Act shall be automatic and shall not require enrollment, application, or registration. Eligibility shall be determined at the point of service based on the presence of a CHCA-qualifying diagnosis code.

(c) NO PRIOR AUTHORIZATION.—Coverage under this Act shall not be subject to prior authorization requirements for emergency services or for services rendered by providers enrolled in the Medicare or Medicaid programs.

(d) CONTRIBUTION REQUIREMENT.—Nothing in this section shall be construed to exempt any individual from contribution obligations under sections 221, 222, or 223.

SEC. 203. COVERED SERVICES.

(a) IN GENERAL.—The Program shall provide coverage for all medically necessary items and services related to agency-decorrelated conditions, including—

- (1) hospital services (inpatient and outpatient);
- (2) physician and other professional services;
- (3) diagnostic testing and imaging;
- (4) prescription drugs and biologics;
- (5) medical devices and durable medical equipment;
- (6) rehabilitation services;
- (7) mental health services related to covered conditions;
- (8) home health services;
- (9) skilled nursing facility services; and
- (10) such other services as the Secretary determines medically

necessary.

(b) MEDICAL NECESSITY STANDARD.—The standard for medical necessity under this Act shall be the standard applicable under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(c) NO COST-SHARING FOR ADC CLAIMS.—Claims for agency-decorrelated conditions shall not be subject to deductibles, copayments, or cost-sharing.

SEC. 204. EXCLUSIONS.

- (a) **LIFESTYLE-DERIVED CONDITIONS.**—Coverage under this Act does not extend to conditions substantially attributable to individual lifestyle choices as determined under criteria established by the Secretary pursuant to section 105(1)(D).
- (b) **COSMETIC SERVICES.**—Coverage under this Act does not extend to cosmetic services unrelated to agency-decorrelated conditions.
- (c) **EXPERIMENTAL TREATMENTS.**—Coverage under this Act does not extend to experimental treatments not approved by the Food and Drug Administration, except as provided under applicable expanded access provisions under section 561 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb).
- (d) **NON-MEDICAL SERVICES.**—Coverage under this Act does not extend to custodial care, personal comfort items, or services not primarily medical in nature.

Subtitle B—CHCA Trust Fund

SEC. 211. ESTABLISHMENT OF TRUST FUND.

- (a) **CREATION.**—There is created on the books of the Treasury of the United States a trust fund to be known as the "CHCA Trust Fund," modeled on the Medicare Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).
- (b) **TRANSFERS TO TRUST FUND.**—There are hereby appropriated to the Trust Fund—
 - (1) amounts received under section 221 (relating to payroll contributions);
 - (2) amounts received under section 222 (relating to self-employment contributions);
 - (3) amounts received under section 223 (relating to investment income contributions);
 - (4) amounts received under section 224 (relating to state workers' compensation pool contributions);
 - (5) amounts recovered through subrogation under title IV, deposited in accordance with section 424;
 - (6) such gifts and bequests as may be made; and
 - (7) such amounts as may be appropriated under section 1004.
- (c) **DEDICATED REVENUE.**—Amounts in the Trust Fund shall be

available only for purposes of carrying out this Act and may not be diverted to the general fund of the Treasury or used for any purpose other than the payment of benefits and administrative expenses under this Act.

(d) INVESTMENT.—

(1) IN GENERAL.—The Managing Trustee shall invest such portion of the Trust Fund as is not, in the judgment of the Managing Trustee, required to meet current withdrawals, in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

(2) OBLIGATIONS.—Such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(3) SALE.—Any obligation acquired by the Trust Fund may be sold by the Managing Trustee at the market price.

(e) RESERVE REQUIREMENT.—The Trust Fund shall maintain a reserve of not less than 5 percent and not more than 10 percent of projected annual expenditures to provide a cushion for adverse experience.

SEC. 212. BOARD OF TRUSTEES.

(a) COMPOSITION.—There is hereby established a Board of Trustees of the Trust Fund, composed of—

(1) the Secretary of the Treasury, who shall serve as Managing Trustee;

(2) the Secretary of Health and Human Services;

(3) the Secretary of Labor;

(4) the Secretary of Commerce; and

(5) two members of the public (in this section referred to as 'public trustees'), appointed by the President, by and with the advice and consent of the Senate, of whom—

(A) not more than one shall be of the same political party;

(B) each shall have demonstrated expertise in healthcare economics, public finance, or actuarial science; and

(C) each shall serve for a term of 4 years, with terms staggered so that not more than one term expires in any 2-year period.

(b) DUTIES.—The Board of Trustees shall—

(1) hold the Trust Fund;

(2) report to Congress annually on the actuarial status of the Trust Fund pursuant to section 214;

- (3) review and certify the contribution rate under section 225;
- (4) report immediately to Congress if the Trust Fund is projected to become insolvent within 10 years;
- (5) recommend legislative or administrative actions to ensure long-term solvency; and
- (6) monitor subrogation recovery performance under title IV.

(c) **COMPENSATION.**—Public trustees shall receive compensation at a rate equal to the daily equivalent of the annual rate of basic pay for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which they are engaged in the actual performance of duties as trustees.

SEC. 213. ACTUARIAL CERTIFICATION.

(a) **ANNUAL CERTIFICATION.**—The Board shall annually certify that the contribution rate under section 225 is sufficient to maintain Trust Fund solvency over a 10-year projection period with the reserve margin specified in section 211(e).

(b) **ACTUARIAL ASSUMPTIONS.**—The Board shall use actuarial assumptions consistent with those used by the Congressional Budget Office and the CMS Office of the Actuary, including—

- (1) economic growth projections;
- (2) healthcare cost inflation projections;
- (3) demographic projections; and
- (4) subrogation recovery rate projections.

(c) **INDEPENDENT REVIEW.**—The Government Accountability Office shall conduct an independent review of actuarial assumptions and projections at least every 3 years and shall report its findings to Congress. (d) **80TH PERCENTILE METHODOLOGY.**—Rate-setting shall use 80th percentile expenditure projections (conservative/pessimistic scenario) to ensure adequate funding.

SEC. 214. ANNUAL REPORTS.

(a) **REQUIREMENT.**—The Board shall submit to Congress, not later than April 1 of each year, an annual report on the financial and actuarial status of the Trust Fund.

(b) **CONTENTS.**—Each report shall include—

- (1) a statement of assets and liabilities as of the end of the preceding fiscal year;
- (2) short-range (10-year) and long-range (75-year) actuarial projections;

- (3) an assessment of contribution rate adequacy;
 - (4) subrogation recovery performance data, including—
 - (A) total amounts recovered;
 - (B) recovery rates by ADC category;
 - (C) contractor performance metrics; and
 - (D) comparison to projected recovery amounts;
 - (5) administrative cost ratios compared to Medicare and private insurance benchmarks;
 - (6) claims volume and expenditure data by ADC category;
 - (7) recommendations on rate adjustments if a projected shortfall is identified; and
 - (8) such other information as the Board determines appropriate.
- (c) PUBLIC AVAILABILITY.—Each report under this section shall be made available to the public on the websites of the Department of the Treasury and the Department of Health and Human Services.

Subtitle C—Contribution Structure

SEC. 221. PAYROLL CONTRIBUTIONS.

(a) EMPLOYEE CONTRIBUTION.—Section 3101 of the Internal Revenue Code of 1986 is amended by adding at the end the following: "(c) CHCA CONTRIBUTION.—"(1) IN GENERAL.—In addition to other taxes imposed by this section, there is hereby imposed on the income of every individual a tax equal to the applicable percentage of the wages (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b)). "(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means the rate certified by the Board of Trustees of the CHCA Trust Fund under section 225 of the Catastrophic Health Coverage Act of 2025. "(3) INITIAL RATE.—For the period beginning on the effective date of the Catastrophic Health Coverage Act of 2025 and ending on the date on which the first rate certification under section 225 of such Act takes effect, the applicable percentage shall be 1.2 percent."

(b) EMPLOYER CONTRIBUTION.—Section 3111 of the Internal Revenue Code of 1986 is amended by adding at the end the following: "(c) CHCA CONTRIBUTION.—In addition to other taxes imposed by this section, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the applicable percentage (as defined in section 3101(c)(2)) of the wages (as defined in section 3121(a)) paid by the employer with respect to employment (as defined in section 3121(b))."

(c) EQUAL BURDEN.—The employee and employer contributions under this section shall be equal, with the total CHCA contribution rate split 50 percent employee and 50 percent employer.

SEC. 222. SELF-EMPLOYMENT CONTRIBUTIONS.

(a) IN GENERAL.—Section 1401 of the Internal Revenue Code of 1986 is amended by adding at the end the following: "(c) CHCA CONTRIBUTION.—In addition to other taxes imposed by this section, there is hereby imposed on the self-employment income of every individual a tax equal to the combined employee and employer CHCA contribution rate under sections 3101(c) and 3111(c) (that is, twice the rate applicable to employees)."

(b) DEDUCTION.—Section 164(f) of the Internal Revenue Code of 1986 is amended to provide that 50 percent of the tax imposed by section 1401(c) shall be deductible in computing net earnings from self-employment.

SEC. 223. INVESTMENT INCOME CONTRIBUTIONS.

(a) IN GENERAL.—Section 1411 of the Internal Revenue Code of 1986 (relating to unearned income Medicare contribution) is amended by adding at the end the following: "(f) CHCA CONTRIBUTION.—"(1) IN GENERAL.—In addition to any tax imposed by this section, there is hereby imposed for each taxable year a tax equal to the applicable percentage of the lesser of—"(A) net investment income for such taxable year, or "(B) the excess (if any) of the modified adjusted gross income for such taxable year over the threshold amount. "(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means the rate certified by the Board of Trustees of the CHCA Trust Fund under section 225 of the Catastrophic Health Coverage Act of 2025. "(3) THRESHOLD AMOUNT.—For purposes of paragraph (1)(B), the threshold amount shall be \$400, indexed annually to the Consumer Price Index for All Urban Consumers (CPI-U), matching the self-employment income threshold under section 1402(b)(2)."

(b) NET INVESTMENT INCOME.—For purposes of this section, net investment income includes interest, dividends, capital gains, rental income, and royalties, as defined in section 1411(c).

SEC. 224. STATE WORKERS' COMPENSATION POOL CONTRIBUTIONS.

(a) ACTUARIAL CONTRIBUTION.—Each State operating a workers' compensation program shall contribute to the CHCA Trust Fund at an actuarially determined rate reflecting predicted CHCA claims arising from occupational injuries and illnesses within such State.

(b) REIMBURSEMENT.—States shall receive 100 percent reimbursement from the Trust Fund for qualifying CHCA claims processed through state workers' compensation systems, not limited to the Federal Medical Assistance Percentage.

(c) RATE DETERMINATION.—The Secretary, in consultation with state insurance commissioners and workers' compensation administrators, shall establish the actuarial methodology for determining state contribution rates, considering—

- (1) historical claims data by State;

- (2) industry composition within each State;
- (3) State safety enforcement records; and
- (4) projected demographic changes.

(d) FLOW-THROUGH MECHANICS.—States may continue their current workers' compensation operations with no provider-facing changes required. States shall—

- (1) receive claims and pay providers without delay;
- (2) tag claims with CHCA-qualifying ICD-10-CM codes;
- (3) submit periodic annotated ledgers to the CHCA portal established by the Secretary; and
- (4) receive 100 percent federal reimbursement for qualifying expenditures.

SEC. 225. RATE DETERMINATION FORMULA.

(a) FORMULA-DERIVED RATE.—The contribution rate shall be formula-derived based on actuarial projections, not legislatively fixed. The Board shall certify the rate annually.

(b) METHODOLOGY.—The Board shall determine the contribution rate using the following methodology:

(1) PROJECTED EXPENDITURES.—Project CHCA Trust Fund expenditures over a 10-year period using 80th percentile (conservative) scenarios and CMS Office of the Actuary methodology.

(2) PROJECTED SUBROGATION RECOVERY.—Subtract projected subrogation recovery amounts under title IV.

(3) PROJECTED STATE WC CONTRIBUTIONS.—Subtract projected state workers' compensation pool contributions under section 224.

(4) RESERVE ADJUSTMENT.—Add or subtract amounts necessary to maintain the reserve target under section 211(e).

(5) NET CONTRIBUTION REQUIRED.—Calculate the net contribution required.

(6) TAXABLE BASE.—Divide by the projected taxable base (wages, self-employment income, and investment income above the threshold).

(7) CERTIFIED RATE.—The quotient shall be the certified CHCA contribution rate.

(c) INITIAL BASELINE.—For purposes of initial rate determination,

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the Board shall use a baseline of \$575,000,000,000 to \$645,000,000,000 in annual agency-decorrelated catastrophic costs, as documented in the legislative findings under section 102(d).

(d) ANNUAL REVIEW.—The Board shall review and recertify the contribution rate annually in conjunction with the annual report required under section 214.

SEC. 226. RATE ADJUSTMENT PROCEDURES.

(a) MINISTERIAL ADJUSTMENTS.—Rate adjustments that do not exceed the prior rate by more than 0.25 percentage points shall be treated as ministerial calculations implementing the formula under section 225 and shall not be subject to the Congressional Review Act (5 U.S.C. 801 et seq.), consistent with the treatment of Social Security cost-of-living adjustments under section 215(i) of the Social Security Act (42 U.S.C. 415(i)).

(b) STANDARD ADJUSTMENTS.—Rate adjustments exceeding 0.25 percentage points but not exceeding 0.50 percentage points shall be subject to standard notice-and-comment rulemaking under section 553 of title 5, United States Code, and the Congressional Review Act.

(c) MAJOR ADJUSTMENTS.—Rate adjustments exceeding 0.50 percentage points, or any adjustment that the Board determines would affect Trust Fund solvency by more than 5 percent over 10 years, shall be—

(1) published in the Federal Register with not less than 90 days for public comment;

(2) submitted to Congress with a detailed explanation; and

(3) subject to enhanced Congressional notification procedures.

(d) EFFECTIVE DATE.—Rate adjustments under this section shall take effect on January 1 of the calendar year following certification, unless Congress enacts a joint resolution of disapproval within 60 days of submission.

TITLE III—CLAIMS PROCESSING AND ADMINISTRATION

Subtitle A—Claims Processing Infrastructure

SEC. 301. NATIONAL CLAIMS CLEARINGHOUSE.

(a) ESTABLISHMENT.—There is established within the Centers for Medicare & Medicaid Services a National Claims Clearinghouse for the purpose of routing and processing claims under this Act.

(b) FUNCTIONS.—The Clearinghouse shall—

(1) receive claims from healthcare providers through existing CMS claims submission systems;

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(2) identify claims that include CHCA-qualifying diagnosis codes through the Code List maintained under section 303;

(3) route qualifying claims to the CHCA Trust Fund for payment;

(4) coordinate with existing Medicare and Medicaid claims processing systems and contractors;

(5) maintain records necessary for subrogation recovery under title IV, including external cause codes (ICD-10-CM V, W, X, Y series) that indicate third-party causation; and

(6) provide real-time claims status information to providers and beneficiaries.

(c) EXISTING INFRASTRUCTURE.—To the maximum extent practicable, the Clearinghouse shall utilize existing CMS claims processing infrastructure, contractor relationships, and provider enrollment systems. The Clearinghouse shall not create parallel systems or require providers to submit separate claims for CHCA-qualifying conditions.

(d) SYSTEM DEVELOPMENT.—The Secretary shall develop or modify claims processing systems to implement the routing rules required by this section within the timeframe specified in section 803.

SEC. 302. CODE-BASED ROUTING.

(a) ROUTING PRINCIPLE.—Claims shall be routed based on the primary diagnosis code. A CHCA-qualifying diagnosis code routes the claim to the CHCA Trust Fund. There are no 'private insurance claims' for CHCA-qualifying codes.

(b) CHCA AS SOLE PAYER.—For any claim with a CHCA-qualifying diagnosis code on the Code List, the CHCA Trust Fund shall be the sole payer for covered services. Private insurers shall not receive claims for, and shall not be responsible for payment of, CHCA-qualifying conditions.

(c) NO COORDINATION OF BENEFITS.—There shall be no coordination of benefits logic, primary/secondary determination, or split payments for CHCA-qualifying claims. This eliminates the administrative overhead that exists in the current system where Medicare, Medicaid, and private insurance must determine payment order.

(d) SECONDARY CONDITIONS.—Where a CHCA-qualifying condition coexists with a non-qualifying condition, the Secretary shall establish regulations for appropriate allocation of costs between CHCA and other payers.

SEC. 303. ICD-10 CODE LIST AUTHORITY.

(a) CODE LIST MAINTENANCE.—The Secretary shall maintain an

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authoritative list of CHCA-qualifying ICD-10-CM diagnosis codes, CPT procedure codes, and HCPCS codes (the 'Code List').

(b) INITIAL CODE LIST.—Not later than 12 months after the date of enactment of this Act, the Secretary shall publish an initial Code List through notice-and-comment rulemaking, which shall include codes for—

(1) rare diseases included in the National Institutes of Health Genetic and Rare Diseases Information Center database;

(2) genetic and hereditary disorders identified through codes in the ICD-10-CM Q chapter (Congenital malformations, deformations and chromosomal abnormalities);

(3) injuries with external cause codes (V, W, X, Y series) indicating third-party causation;

(4) occupational injuries and illnesses as coded through workers' compensation systems;

(5) environmental exposure conditions identified through Z77 series codes; and

(6) such other codes meeting the agency-decorrelation criteria under section 105(1)(C).

(c) ANNUAL REVIEW.—The Secretary shall review and update the Code List annually, incorporating—

(1) new ICD-10-CM codes adopted by the World Health Organization or CMS;

(2) clinical evidence regarding agency-decorrelation criteria;

(3) feedback from appeals and litigation outcomes from the prior year; and

(4) recommendations from the CHCA Medical Advisory Committee established under subsection (e).

(d) CRITERIA.—In determining whether a diagnosis code qualifies for inclusion on the Code List, the Secretary shall apply the agency-decorrelation criteria established under section 105(1)(C).

(e) MEDICAL ADVISORY COMMITTEE.—The Secretary shall establish a CHCA Medical Advisory Committee, composed of physicians, genetic counselors, occupational health specialists, environmental health experts, and patient advocates, to advise on Code List maintenance and agency-decorrelation determinations.

SEC. 304. REIMBURSEMENT RATES.

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(a) INITIAL RATES.—For the 3-year period beginning on the effective date of this Act—

(1) claims previously paid through Medicare shall be reimbursed at Medicare rates;

(2) claims previously paid through Medicaid shall be reimbursed at Medicaid rates;

(3) claims previously paid through workers' compensation shall be reimbursed at applicable workers' compensation rates; and

(4) claims previously paid through private insurance shall be reimbursed at commercial rates established under subsection (b).

(b) COMMERCIAL RATE BASELINE.—Claims previously paid by private insurance shall initially be paid at commercial rates established as follows:

(1) BASELINE.—Per-state, per-prior-approved-policy rates from state insurance commission filings.

(2) TRANSITION.—Rates maintained at launch to ensure provider revenue neutrality.

(c) SUBSEQUENT RATES.—After the initial 3-year period, the Secretary may establish CHCA-specific reimbursement rates through notice-and-comment rulemaking. The Secretary shall target 5 to 7 percent reduction in rates as administrative efficiencies are realized, moving toward Medicare rate uniformity over time.

(d) PROVIDER ACCEPTANCE.—Any provider accepting Medicare patients shall accept CHCA patients at the applicable reimbursement rate. Any provider accepting Medicaid patients shall accept CHCA patients at not less than the applicable Medicaid rate.

Subtitle B—Eligibility Determination

SEC. 311. CATEGORY-SPECIFIC DETERMINATION PROCEDURES.

(a) IN GENERAL.—The Secretary shall establish category-specific procedures for determining whether a condition qualifies as an agency-decorrelated condition, recognizing that different categories of conditions require different determination methods.

(b) STANDARDS BY CATEGORY.—

(1) GENETIC AND RARE DISEASE.—Code presence on the Code List shall be determinative. ICD-10-CM diagnosis codes from rare disease registries automatically qualify.

(2) MOTOR VEHICLE ACCIDENTS.—Not-at-fault determination per

property damage adjudication, as specified in section 313.

(3) OCCUPATIONAL INJURIES AND ILLNESSES.—Workers' compensation determination shall be determinative, as specified in section 314.

(4) ENVIRONMENTAL EXPOSURES.—Civil standard (preponderance of the evidence) with Z77 codes plus causation investigation, as specified in section 315.

(5) INFECTIOUS DISEASES.—Reasonable precautions standard, as specified in section 316.

SEC. 312. GENETIC AND RARE DISEASE DETERMINATIONS.

(a) CODE-BASED DETERMINATION.—For genetic and rare diseases listed on the Code List, the presence of the qualifying diagnosis code shall be determinative. No additional eligibility determination shall be required.

(b) RARE DISEASE REGISTRY.—The Secretary shall maintain coordination with the National Institutes of Health genetic and rare disease registries, the Orphan Products Grants Program, and international rare disease databases for Code List maintenance.

(c) GENETIC TESTING.—Where genetic testing is necessary to establish diagnosis, such testing shall be covered as a diagnostic service under section 203.

(d) SUBROGATION EXCEPTION.—Subrogation shall generally not apply to genetic conditions, except in cases involving teratogenic pharmaceutical exposure, environmental mutagenic exposure, or similar third-party liability.

SEC. 313. MOTOR VEHICLE ACCIDENT DETERMINATIONS.

(a) FAULT DETERMINATION.—Eligibility for motor vehicle accident claims shall be based on fault determination from property damage insurance adjudication. The goals of assigning fault are agnostic to injury versus property loss—the same factual inquiry applies.

(b) NOT-AT-FAULT REQUIREMENT.—A claimant shall be eligible if determined to be not at fault under applicable property damage determination.

(c) COMPARATIVE NEGLIGENCE.—In comparative negligence jurisdictions, eligibility and cost allocation shall be determined through standard litigation or arbitration procedures until the Secretary establishes a more efficient administrative scheme.

(d) APPEALS.—The Secretary shall establish an appeals process for disputed fault determinations. Normal litigation shall remain available for parties disputing fault allocation.

(e) ADVANTAGES.—This approach uses established insurance industry

processes with decades of precedent and avoids creating a parallel fault-finding bureaucracy.

SEC. 314. OCCUPATIONAL INJURY AND ILLNESS DETERMINATIONS.

(a) **WORKERS' COMPENSATION DETERMINATION.**—For occupational injuries and illnesses, the determination of the applicable state workers' compensation system shall be determinative for CHCA eligibility.

(b) **IMMEDIATE COVERAGE.**—Upon application of an agency-decorrelated diagnosis code to an occupational injury or illness, CHCA shall provide immediate coverage. The injured worker shall receive treatment without delay.

(c) **SUBROGATION STANDING.**—Upon payment, CHCA immediately acquires subrogation standing and shall seek reimbursement in place of the worker through whatever context would otherwise cover the worker, whether workers' compensation carrier, employer, or liable third party.

(d) **ACCEPTED WC CLAIMS.**—A claimant whose workers' compensation claim is accepted shall automatically be eligible for CHCA coverage, with CHCA pursuing reimbursement from the workers' compensation system.

(e) **DENIED WC CLAIMS.**—A claimant whose workers' compensation claim is denied may file directly with CHCA, with eligibility determined under criteria established by the Secretary consistent with the agency-decorrelation principles of this Act.

(f) **STATE ADJUSTMENT.**—States and employers may adjust their workers' compensation arrangements on their own timetable. CHCA claims shall be processed independently, with states and employers free to make adjustments and arrangements as they see fit.

SEC. 315. ENVIRONMENTAL EXPOSURE DETERMINATIONS.

(a) **CIVIL STANDARD.**—Environmental exposure determinations shall be made using the civil standard (preponderance of the evidence).

(b) **GOVERNMENT ADVOCACY.**—For environmental exposure cases, the Secretary may provide legal representation for claimants through the subrogation provisions of title IV. Victims of environmental injury generally have no fault for slow-onset environmental harm and shall have access to government-funded advocacy.

(c) **Z77 CODES.**—Environmental exposure claims shall be identified through ICD-10-CM Z77 series codes (contact with and exposure to environmental pollution and hazards) or successor codes.

(d) **EXTENDED LIMITATIONS.**—Environmental exposure subrogation claims shall be subject to the extended limitations period under section 415(a)(4).

SEC. 316. INFECTIOUS DISEASE DETERMINATIONS.

(a) REASONABLE PRECAUTIONS.—Eligibility for infectious disease claims shall be based on a determination that the claimant exercised reasonable precautions.

(b) CRITERIA.—The Secretary shall establish criteria for determining reasonable precautions, considering—

- (1) availability of vaccines and whether the claimant received available vaccines;
- (2) public health guidance in effect at the time of exposure;
- (3) individual circumstances including occupation and underlying health conditions;
- (4) community transmission levels at the time of exposure; and
- (5) whether the disease was acquired through healthcare settings, travel, or community transmission.

(c) PRESUMPTIVE ELIGIBILITY.—The Secretary may establish categories of infectious diseases for which eligibility shall be presumed, particularly for diseases with high transmissibility or for which effective vaccines were not available.

Subtitle C—Administrative Procedures

SEC. 321. APPEALS PROCESS.

(a) ADMINISTRATIVE APPEALS.—The Secretary shall establish an administrative appeals process, modeled on the Medicare Appeals Council under section 1869 of the Social Security Act (42 U.S.C. 1395ff), for claimants disputing—

- (1) denial of coverage based on Code List determination;
- (2) fault determination in motor vehicle cases under section 313;
- (3) agency-decorrelation determination under section 311; or
- (4) any other eligibility or coverage determination under this

Act.

(b) CHCA APPEALS COUNCIL.—There is established a CHCA Appeals Council within the Department of Health and Human Services to hear administrative appeals under this section.

(c) LEVELS OF APPEAL.—The appeals process shall include—

- (1) redetermination by the Clearinghouse;
- (2) reconsideration by a qualified independent contractor;
- (3) hearing before an administrative law judge; and

(4) review by the CHCA Appeals Council.

(d) EXHAUSTION.—Claimants shall exhaust administrative remedies before seeking judicial review, except in cases involving constitutional claims or extraordinary circumstances.

(e) EXPEDITED APPEALS.—The Secretary shall establish expedited appeals procedures for claims involving urgent medical conditions.

SEC. 322. JUDICIAL REVIEW.

(a) JURISDICTION.—The district courts of the United States shall have jurisdiction to review final decisions of the CHCA Appeals Council.

(b) STANDARD OF REVIEW.—Judicial review of factual determinations shall be conducted under the substantial evidence standard. Questions of law shall be reviewed de novo.

(c) VENUE.—Actions for judicial review may be brought in—

(1) the district in which the claimant resides;

(2) the district in which the principal place of business of any defendant is located; or

(3) the United States District Court for the District of Columbia.

(d) ATTORNEY FEES.—The court may award reasonable attorney fees to a prevailing claimant in accordance with the Equal Access to Justice Act (28 U.S.C. 2412).

SEC. 323. CONTRACTOR AUTHORIZATION.

(a) CLAIMS PROCESSING.—The Secretary may contract with fiscal intermediaries and carriers, including Medicare Administrative Contractors, to process claims under this Act.

(b) EXISTING CONTRACTORS.—To the maximum extent practicable, the Secretary shall utilize existing Medicare and Medicaid contractor relationships.

(c) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for contractors, including—

(1) claims processing accuracy rates of not less than 95 percent;

(2) clean claims processing times of not more than 14 days;

(3) appeals processing times consistent with Medicare standards;
and

(4) administrative cost efficiency metrics.

(d) DCAA AUDIT.—All contractor costs shall be subject to audit by the Defense Contract Audit Agency or equivalent audit procedures.

TITLE IV—SUBROGATION AND ACCOUNTABILITY

Subtitle A—Subrogation Authority

SEC. 401. FEDERAL SUBROGATION RIGHTS.

(A) IN GENERAL.—Consistent with the principles of section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) (relating to Medicare Secondary Payer), upon payment of any claim under this Act, the United States shall be subrogated to all rights of the beneficiary against any liable third party to the extent of such payment.

(B) MANDATORY RIGHT.—The right of subrogation established under this section is mandatory and may not be waived by the beneficiary, any settlement agreement, or any private contract.

(C) STATUTORY STANDING.—The United States shall have standing to bring any action that the beneficiary could have brought against a liable third party, to the extent of payments made under this Act. This standing is created by this Act and is analogous to the statutory standing created for Medicare under 42 U.S.C. 1395y(b) and for Medicaid under 42 U.S.C. 1396a(a)(25).

(d) ACCOUNTABILITY-THROUGH-RECOVERY PRINCIPLE.—The subrogation framework established by this title embodies the Accountability-Through-Recovery Principle: systematic government subrogation ensures immediate victim care, proper cost allocation to responsible parties, and systematic deterrence, while delivering better outcomes than the current tort system which provides only 53 cents per dollar to victims.

(E) EQUITABLE AND CONVENTIONAL SUBROGATION.—CHCA's subrogation operates through both conventional (statutory) subrogation arising from this Act and equitable (legal) subrogation arising by operation of law when the government pays an obligation properly borne by a tortfeasor. Both forms are well-established in American jurisprudence.

SEC. 402. SCOPE OF SUBROGATION.

(A) CATEGORIES SUBJECT TO SUBROGATION.—Subrogation shall apply to claims arising from—

- (1) motor vehicle accidents involving liable third parties;
- (2) environmental and toxic exposures caused by negligent parties;
- (3) occupational injuries and illnesses involving employer negligence or third-party liability;
- (4) medical malpractice;
- (5) product liability, including pharmaceutical and medical device

liability;

(6) premises liability; and

(7) such other categories as the Secretary determines involve identifiable liable third parties.

(B) GENETIC CONDITIONS.—Subrogation shall generally not apply to genetic conditions, except in cases involving—

(1) teratogenic pharmaceutical exposure;

(2) environmental mutagenic exposure; or

(3) similar third-party liability where the genetic condition was caused or exacerbated by external agents.

(C) RECOVERY POTENTIAL BY CATEGORY.—The Secretary shall prioritize subrogation efforts based on recovery potential, recognizing that motor vehicle accidents and environmental exposures typically present higher subrogation potential than genetic conditions due to the presence of identifiable liable third parties.

SEC. 403. PRIORITY OF CLAIMS.

(A) CHCA PRIORITY.—The subrogation rights of the United States under this Act shall take precedence over—

(1) any subrogation rights of private insurers;

(2) any subrogation rights of state programs, including Medicaid and workers' compensation; and

(3) any subrogation rights of ERISA plans.

(B) MEDICAL COST RECOVERY FIRST.—In any recovery from a liable third party, CHCA shall recover compensatory medical costs first. Amounts above compensatory recovery (punitive damages, pain and suffering) flow to the victim.

(C) COORDINATION.—The Secretary shall establish procedures for coordinating with other subrogation claimants to avoid duplicative recovery efforts while preserving CHCA priority.

SEC. 404. ASSIGNMENT OF CLAIMS AND CASE PATHWAYS.

(A) CONSTRUCTIVE ASSIGNMENT.—Upon payment by the CHCA Trust Fund, the beneficiary's right of action against a liable third party shall be deemed assigned to the United States to the extent of such payment. This partial assignment structure is common in insurance subrogation.

(B) RETAINED RIGHTS.—The beneficiary shall retain the right to pursue claims against the liable third party for—

(1) non-medical compensatory damages, including economic losses not covered by this Act;

- (2) pain and suffering;
- (3) punitive damages; and
- (4) such other non-medical damages as may be available under applicable law.

(C) CASE PATHWAY OPTIONS.—Victims with potential non-medical claims against CHCA defendants shall have two structured options:

(1) COORDINATED PROSECUTION (PREFERRED PATH).—A single attorney represents both CHCA's medical cost recovery interest and the victim's personal damage claims in a unified proceeding. The attorney operates under CHCA contract for the medical recovery component and under separate victim engagement for personal damage claims. Coordinated prosecution provides unified discovery, single trial presentation, coordinated legal strategy, reduced total litigation costs, and victim benefit from CHCA pre-screening (asset verification, liability assessment).

(2) SEQUENTIAL PROSECUTION.—CHCA pursues medical cost recovery first through contracted counsel. Following CHCA case resolution, victims may pursue personal damage claims through private counsel of their choosing, benefiting from collateral estoppel effect of any CHCA liability determination under section 432.

(D) COORDINATED PROSECUTION FEE STRUCTURE.—Under coordinated prosecution, fees shall be structured as follows:

- (1) Medical costs: CPFF plus 10 percent incentive (government as client);
- (2) Non-medical compensatory: 25 percent of net after government premium (moderate complexity, victim-side representation);
- (3) Punitive damages: 15 percent of net after government referral fee (liability already established, marginal effort lower).

(E) SEQUENTIAL PROSECUTION FEE STRUCTURE.—Under sequential prosecution, CHCA medical recovery operates under standard CPFF plus incentive; victim's subsequent private claims operate under traditional fee arrangements between victim and private counsel, subject to the benefit of collateral estoppel from the CHCA proceeding.

SEC. 405. JOINED CASE FRAMEWORK.

(A) FRAMEWORK OBJECTIVES.—The joined case framework established by sections 404 and 405 shall balance the following objectives:

(1) CHCA FISCAL INTEGRITY.—Medical cost recovery must flow to the Trust Fund to maintain program solvency. No arrangement between victims and attorneys may subordinate the government's subrogation interest to private recovery.

(2) VICTIM WELFARE MAXIMIZATION.—Victims should receive the

maximum feasible non-medical recovery. The framework shall improve victim outcomes compared to traditional contingency practice.

(3) ATTORNEY INCENTIVE ALIGNMENT.—Fee structures should encourage efficient case prosecution, appropriate case selection, and outcomes that serve both CHCA and victim interests.

(4) ANTI-GAMING PROVISIONS.—The framework must prevent arrangements where attorneys leverage government resources to capture private fees without corresponding value contribution.

(5) MORAL DEFENSIBILITY.—All fee allocations shall be justifiable on principled grounds representing fair dealing among government, victims, and their representatives.

(B) VICTIM OUTCOME IMPROVEMENT.—Under the joined case framework, victims shall retain approximately 65-80 percent of non-medical recovery, compared to approximately 55-67 percent under traditional 33-40 percent contingency arrangements, by virtue of the reduced fee percentages enabled by CHCA's assumption of litigation risk and cost.

(C) PROHIBITED ARRANGEMENTS.—The following arrangements are prohibited:

(1) Side agreements between defendants and victims that impair CHCA's medical cost recovery;

(2) Attorney fee arrangements that subordinate CHCA's interest to maximize private recovery;

(3) Settlements structured to minimize apparent recovery while providing non-transparent benefits to victims or their counsel; and

(4) Any arrangement that would circumvent the allocation structure under section 421.

Subtitle B—Recovery Procedures

SEC. 411. CASE SCREENING AND SELECTION.

(A) AUTOMATED SCREENING.—The Clearinghouse shall automatically screen claims for subrogation potential based on—

(1) diagnosis codes indicating third-party causation;

(2) external cause codes (ICD-10-CM V, W, X, Y series);

(3) claim amounts exceeding a threshold established by the Secretary; and

(4) such other criteria as the Secretary determines appropriate.

(B) ASSET VERIFICATION.—The Secretary may access tax records and

financial databases, consistent with applicable privacy laws, to identify defendants with recoverable assets. Cases shall be prioritized by recovery potential. This asset verification capability—unavailable to individual litigants—represents a significant advantage over traditional tort recovery.

(C) REFERRAL.—Claims meeting screening criteria shall be referred to recovery contractors for further evaluation and potential recovery action.

(D) TIERED THRESHOLDS.—Recovery efforts shall be tiered by claim value to optimize administrative efficiency:

(1) ADMINISTRATIVE TIER.—Claims below 50 percent of annual per-capita allocation shall be recovered through administrative mechanisms without litigation.

(2) SMALL CLAIMS TIER.—Claims between the 50th and 80th percentile shall be resolved through small claims court or binding arbitration.

(3) FULL ADVERSARIAL TIER.—Claims above the 80th to 90th percentile shall be subject to government-initiated litigation.

(e) PRE-SCREENING EFFECT.—Government pre-screening transfers case-selection risk from attorneys to the government. Attorneys receiving CHCA assignments receive pre-qualified cases with verified asset availability, eliminating the 15-20 percent of attorney time traditionally consumed evaluating matters that will be declined.

SEC. 412. RECOVERY CONTRACTOR PROGRAM.

(A) AUTHORIZATION.—The Secretary shall establish a Recovery Contractor Program to pursue subrogation recovery on behalf of the CHCA Trust Fund.

(B) QUALIFICATION.—Recovery contractors shall be law firms or recovery specialists meeting qualification standards established by the Secretary, including—

(1) bar membership in good standing in the jurisdiction(s) where they will practice;

(2) demonstrated experience in subrogation recovery, medical cost recovery litigation, or personal injury law;

(3) adequate professional liability insurance;

(4) no conflicts of interest with categories of liable third parties;

(5) DCAA-compliant accounting systems, or willingness to implement same; and

(6) capacity to handle assigned case volume.

(C) NO CAPITAL REQUIREMENTS.—No minimum capital requirements

shall apply to contractor qualification. The elimination of capital barriers enables the over 75 percent of personal injury practitioners operating as solo or small-firm attorneys to compete based on legal skill rather than financing capacity.

(D) CONTRACT TYPE.—Recovery contractors shall operate under Cost-Plus-Fixed-Fee (CPFF) plus incentive contracts compliant with Federal Acquisition Regulation (FAR) section 16.306 (48 C.F.R. 16.306). The CPFF structure separates cost recovery from profit generation:

(1) DIRECT COSTS.—All allowable litigation costs shall be reimbursed at audited actuals, with the government bearing cost risk. Allowable direct costs include expert witness fees, court filing fees, deposition costs, medical record retrieval, document production, and case-related travel per federal travel regulations.

(2) LABOR COSTS.—Attorney and staff time shall be reimbursed at approved billing rates. Billing rates shall include direct labor (salary and benefits), indirect costs (facilities, support staff, technology), general and administrative allocation, and embedded margin. Attorneys are paid for all hours worked regardless of case outcome.

(3) INCENTIVE FEE.—A percentage of net recovery, calibrated to achieve compensation parity with traditional practice per section 413.

(4) AUDIT COMPLIANCE.—All costs shall be subject to Defense Contract Audit Agency (DCAA) standards.

(E) REIMBURSEMENT CYCLE.—Costs shall be reimbursed within standard federal payment cycles (approximately 30 days), eliminating the cash flow burden that traditional contingency practice imposes. Attorneys need not finance litigation costs for months or years awaiting case resolution.

(F) COST ALLOWABILITY.—Costs charged to CHCA contracts must satisfy allowability (necessary and reasonable), allocability (benefits CHCA work), and reasonableness (reflects prudent business judgment) requirements. Documentation must be contemporaneous and sufficient to verify the expense.

(G) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure adequate geographic distribution of qualified recovery contractors.

(h) SMALL BUSINESS SET-ASIDES.—The Secretary shall establish small business set-asides for recovery contractor awards, targeting 40 percent of contract value reserved for small businesses, to ensure broad market participation and create a constituency invested in program continuation.

(I) DCAA AUDIT.—Recovery contractors shall comply with Defense Contract Audit Agency audit requirements, including contemporaneous timekeeping, incurred cost submission, and truthful cost representations subject to the False Claims Act (31 U.S.C. 3729 et seq.).

(J) PAST PERFORMANCE.—Contract awards shall incorporate past performance weighting based on recovery rate (percentage of pursued claims resulting in recovery), cycle time (average time from case assignment to resolution), audit findings (clean

audits weighted positively), and victim satisfaction (for cases with non-medical recovery components).

SEC. 413. FEE STRUCTURE AND COMPENSATION PARITY.

(A) FEE STRUCTURE.—Recovery contractors shall be compensated through a combination of cost reimbursement (labor and direct costs per section 412) and incentive fees tied to recovery performance.

(B) DIFFERENTIATED RATES.—The Secretary shall establish differentiated fee rates by recovery component:

(1) MEDICAL COST RECOVERY.—Attorney incentive fees on medical cost recovery shall not exceed 10 percent of net recovery, reflecting government as direct client and pre-screened cases with established liability.

(2) NON-MEDICAL COMPENSATORY.—Attorney incentive fees on non-medical compensatory recovery shall not exceed 25 percent of the victim's share (remainder after 10 percent government risk premium). The government risk premium reflects genuine value provided through case identification, asset screening via tax record access, and liability establishment benefiting victim recovery.

(3) PUNITIVE DAMAGES.—Attorney incentive fees on punitive damages shall not exceed 15 percent of the victim's share (remainder after 5 percent government referral fee). The lower rate reflects that liability is typically established through the compensatory phase and marginal effort for punitive recovery is lower.

(C) PARITY PRINCIPLE.—Fee structures shall be calibrated such that attorneys contributing equivalent skill and effort receive equivalent net profit, regardless of which economic functions (capital provision, risk bearing) are performed by the attorney versus the government.

(D) PARITY DERIVATION.—The incentive fee range of 6-8 percent on medical recovery achieves profit parity with traditional 33 percent contingency practice after adjusting for:

(1) Elimination of capital costs (approximately 10 percent of traditional firm revenue);

(2) Transfer of case-loss risk to government;

(3) Efficiency gains from government case screening and administrative support; and

(4) CPFF labor reimbursement covering what contingency fees cover through the 'attorney compensation' component.

(e) LOSER-PAYS.—In any proceeding where the Secretary prevails, the defendant shall be liable for litigation costs and reasonable attorney fees under section 431. The defendant pays the attorney fee, not the victim or CHCA.

(F) **RATE CALIBRATION AUTHORITY.**—The Secretary shall set incentive fee rates within the analytically-derived ranges based on observed market conditions, including demonstrated market compensation levels, contractor participation rates, recovery performance metrics, and public interest in maximizing victim recovery share. The statute establishes the framework and ranges; the Secretary sets specific values and adjusts them as experience accumulates.

SEC. 414. SETTLEMENT AUTHORITY.

(A) **CONTRACTOR AUTHORITY.**—Recovery contractors may negotiate and settle claims within parameters established by the Secretary.

(B) **APPROVAL THRESHOLDS.**—Settlements exceeding \$500,000 shall require approval by the Secretary or the Secretary's designee. The Secretary may by regulation adjust this threshold based on program experience, provided that any increase shall not exceed 25 percent in any 12-month period.

(C) **SETTLEMENT CRITERIA.**—The Secretary shall establish criteria for evaluating settlement offers, including—

- (1) likelihood of success at trial based on liability evidence;
- (2) defendant's ability to pay, including asset verification results;
- (3) projected litigation costs;
- (4) precedential value for future cases; and
- (5) settlement timing relative to victim needs.

(D) **DOCUMENTATION.**—All settlement negotiations shall be documented and available for government review. Side agreements between victims and defendants that affect CHCA's recovery shall be void.

SEC. 415. STATUTE OF LIMITATIONS.

(A) **FEDERAL LIMITATIONS.**—Notwithstanding any State law, the following limitations periods shall apply to subrogation claims under this Act:

(1) **MOTOR VEHICLE ACCIDENTS.**—4 years from the date of payment by the CHCA Trust Fund.

(2) **ACUTE OCCUPATIONAL INJURIES.**—4 years from the date of payment by the CHCA Trust Fund.

(3) **LATENT OCCUPATIONAL ILLNESSES.**—6 years from the date of payment by the CHCA Trust Fund.

(4) **ENVIRONMENTAL EXPOSURES.**—10 years from the date of payment by the CHCA Trust Fund, or 3 years from discovery of causal link, whichever is later.

(B) TOLLING.—Limitations periods under this section shall be tolled during the pendency of any related criminal or civil enforcement action against the same defendant.

(C) PREEMPTION.—This section preempts any State statute of limitations that would provide a shorter period for the claims described herein.

(D) RATIONALE.—The tiered limitations structure reflects the differing causal chains, latency periods, and timelines for establishing causation among different injury categories, with environmental exposures requiring the longest periods due to significant latency and complex causation chains.

Subtitle C—Allocation and Distribution

SEC. 421. RECOVERY ALLOCATION FORMULA.

(A) ALLOCATION ORDER.—Amounts recovered through subrogation shall be allocated in the following order:

- (1) Litigation costs and expenses (at audited actuals).
- (2) Attorney incentive fees (calculated per section 413).
- (3) Non-medical compensatory damages to the victim.
- (4) Punitive damages to the victim.
- (5) Reimbursement to the CHCA Trust Fund for medical costs paid.

(b) MADE-WHOLE PRINCIPLES.—The allocation structure incorporates made-whole principles by ensuring victims receive non-medical damages (pain and suffering, punitive damages) before CHCA asserts claims against those amounts. CHCA's claim is limited to the compensatory medical cost portion.

(C) DEFENDANT OBLIGATION.—When CHCA prevails, the defendant's total obligation includes medical costs, non-medical compensatory damages, punitive damages (where applicable), litigation costs, and attorney incentive fees. The defendant pays all costs when liable.

(D) ILLUSTRATIVE ALLOCATION.—For a weighted average case with \$182,500 medical, \$46,250 non-medical compensatory, and \$30,000 punitive recovery (net of 19 percent litigation costs), allocation yields approximately: CHCA Trust Fund 63 percent of net; government premiums/referrals 2 percent; attorney incentive 13 percent; victim 22 percent.

SEC. 422. VICTIM PRIORITY.

(a) NON-MEDICAL DAMAGES.—The victim shall have priority over the CHCA Trust Fund for recovery of non-medical damages, including pain and suffering, loss of consortium, and punitive damages.

(B) MEDICAL COSTS.—The CHCA Trust Fund shall have priority for recovery of amounts representing medical costs paid under this Act.

(C) VICTIM PROTECTION.—Victims cannot be required to accept settlements that impair their recovery of non-medical damages. CHCA cannot force victims to accept settlement of non-medical claims.

(D) IMPROVED VICTIM OUTCOMES.—A victim injured by a liable third party receives immediate medical care from CHCA, then receives punitive damages and pain-and-suffering compensation from the tortfeasor—without the 33 to 40 percent fee extraction that would apply under traditional contingency representation. Analysis indicates victims retain approximately 27 percent more under coordinated prosecution than under traditional contingency.

SEC. 423. ATTORNEY FEE ALLOCATION.

(A) MAXIMUM FEES.—Total attorney fees (including fees to both government recovery contractors and private victim attorneys) shall not exceed 25 percent of total recovery.

(B) SCOPE.—The limitation under subsection (A) applies only to recovery of amounts paid by the CHCA Trust Fund and to victim claims joined with such recovery under section 403. Nothing in this section shall be construed to limit attorney fee arrangements in actions not involving CHCA subrogation rights.

(C) ADJUSTMENT.—The Secretary may by regulation reduce, but not increase, the percentage specified in subsection (A) based on program experience and market conditions.

(D) ALLOCATION BETWEEN ATTORNEYS.—Where both government and private attorneys contribute to recovery, fees shall be allocated based on relative contribution to the recovery.

(E) FEE DISPUTES.—The Secretary shall establish procedures for resolving disputes regarding fee allocation between government contractors and private attorneys.

(F) AUDIT.—All attorney fees shall be subject to DCAA-standard audit. Attorneys cannot inflate expenses or obscure fee calculations.

SEC. 424. TRUST FUND DEPOSITS.

(A) DEPOSIT REQUIREMENT.—Amounts recovered under this title and allocated to the CHCA Trust Fund under section 421(a)(5) shall be deposited into the Trust Fund within 30 days of receipt.

(B) ACCOUNTING.—The Secretary shall maintain separate accounting for subrogation recoveries by—

- (1) ADC category (motor vehicle, occupational, environmental, etc.);
- (2) recovery contractor;
- (3) geographic region; and
- (4) recovery mechanism (settlement vs. judgment).

(C) REPORTING.—Subrogation recovery data shall be included in the annual report under section 214.

Subtitle D—Fee-Shifting and Deterrence

SEC. 431. LOSER-PAYS PROVISIONS.

(A) GOVERNMENT RECOVERY.—In any proceeding where the Secretary prevails against a liable third party, the defendant shall be liable for—

- (1) the government's reasonable attorney fees;
- (2) expert witness costs;
- (3) court costs and filing fees; and
- (4) such other litigation costs as the court determines reasonable.

(B) FRIVOLOUS DEFENSE.—Enhanced fee-shifting shall apply where the court determines the defendant's defense was frivolous, interposed for delay, or in bad faith.

(C) POLICY OBJECTIVES.—The loser-pays structure serves multiple objectives:

(1) FISCAL SUSTAINABILITY.—Successful subrogation actions fully recover CHCA expenditures plus litigation costs.

(2) DEFENDANT ACCOUNTABILITY.—Tortfeasors cannot escape full accountability by forcing CHCA to absorb litigation costs.

(3) SETTLEMENT INCENTIVES.—Defendants facing loser-pays exposure cannot use litigation cost pressure to force below-value settlements.

(4) CASE SELECTION DISCIPLINE.—CHCA has incentive to pursue only meritorious claims since unsuccessful cases mean unrecovered litigation costs.

(D) CONTRAST WITH AMERICAN RULE.—This loser-pays structure (sometimes called fee-shifting or the 'English Rule') contrasts with the 'American Rule' where each party typically bears its own costs regardless of outcome.

SEC. 432. COLLATERAL ESTOPPEL.

(A) EFFECT OF GOVERNMENT JUDGMENT.—A final judgment of liability in a suit brought by the Secretary shall have collateral estoppel effect in any subsequent private suit by the victim for non-medical damages against the same defendant, consistent with *Parklane Hosiery Co. v. Shore*, 439 U.S. 322 (1979).

(B) REQUIREMENTS FOR PRECLUSIVE EFFECT.—For a CHCA liability determination to bind defendants in subsequent victim proceedings, all of the following conditions must be satisfied:

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(1) IDENTITY OF ISSUE.—The liability question in the victim's case must be identical to the issue determined in the CHCA proceeding.

(2) ACTUALLY LITIGATED.—The liability issue must have been contested and determined in the CHCA proceeding, not admitted or stipulated.

(3) NECESSARILY DETERMINED.—Liability must have been essential to the CHCA judgment, not merely incidental or advisory.

(4) FULL AND FAIR OPPORTUNITY.—The defendant must have had a full and fair opportunity to litigate liability in the CHCA proceeding.

(c) NON-MUTUAL OFFENSIVE USE.—Victims seeking to benefit from CHCA liability findings invoke 'non-mutual offensive collateral estoppel'—use of a prior judgment by a party who was not involved in the prior proceeding against a party who was. This application satisfies Parklane Hosiery requirements because defendants receive full procedural protections in government subrogation actions, individual victims cannot join government subrogation proceedings (standing belongs to CHCA), and defendants who lose to the government cannot claim unfairness.

(D) BENEFIT TO VICTIMS.—This section benefits victims by establishing liability through government prosecution, simplifying subsequent private recovery of non-medical damages to a damages-only proceeding.

(E) DEFENDANT INCENTIVE.—Defendants facing the prospect of collateral estoppel have incentive to litigate the liability issue fully in the government action, ensuring due process protections are observed.

SEC. 433. REPORTING REQUIREMENTS FOR INSURERS.

(A) REPORTING REQUIREMENT.—Consistent with section 1862(b)(8) of the Social Security Act (42 U.S.C. 1395y(b)(8)), liability insurers, no-fault insurers, and workers' compensation carriers shall report settlements and judgments to the Secretary.

(B) CONTENT.—Reports shall include information necessary for the Secretary to pursue subrogation recovery, including—

- (1) claimant identifying information;
- (2) date of incident;
- (3) nature of claim;
- (4) settlement or judgment amount; and
- (5) attorney information.

(C) TIMING.—Reports shall be submitted within 60 days of settlement or judgment.

(D) PENALTIES.—The Secretary may impose civil monetary penalties

for failure to report as required under this section, consistent with penalties under section 1862(b)(8) of the Social Security Act.

SEC. 434. ANTI-GAMING PROVISIONS.

(A) PROHIBITED CONDUCT.—The following conduct is prohibited and shall be grounds for contract termination, fee disgorgement, and referral for appropriate professional discipline:

- (1) Padding billable hours to compensate for lower incentive fee percentages;
- (2) Inflating cost markups beyond allowable rates;
- (3) Settling cases at below-value amounts to accelerate fee receipt;
- (4) Deliberately delaying case resolution to maximize billable hours;
- (5) Side agreements with victims or defendants that impair CHCA recovery; and
- (6) Any arrangement that circumvents the allocation structure under section 421.

(B) STRUCTURAL DISINCENTIVES.—The CPFF plus incentive structure incorporates self-enforcing mechanisms that discourage rent-seeking behavior:

- (1) Hour padding triggers audit flags and performance rating reductions;
- (2) Cost inflation triggers DCAA disallowance;
- (3) Quick cheap settlements reduce incentive fees;
- (4) Case delays consume contractor capacity without revenue benefit;
- (5) Cherry-picking cases is impossible under government assignment; and
- (6) Side deals with victims result in contract termination.

(C) AUDIT VERIFICATION.—Every rent-seeking behavior either triggers audit consequences or reduces firm profitability. The incentive structure is self-enforcing beyond standard DCAA audit procedures.

TITLE V—FEDERAL PREEMPTION AND STATE COORDINATION

Subtitle A—Federal Preemption

SEC. 501. PREEMPTION OF STATE ANTI-SUBROGATION LAWS.

(a) **PREEMPTION.**—State laws that would limit, prevent, or reduce subrogation recovery by the United States under this Act are preempted to the extent of any conflict with this Act.

(b) **COVENTRY PRECEDENT.**—This section is supported by *Coventry Health Care of Missouri v. Nevils*, 581 U.S. ___ (2017), in which the Supreme Court unanimously held that federal law may preempt state anti-subrogation statutes where the federal statute expressly provides for subrogation and reimbursement. The express subrogation provisions of title IV satisfy this requirement.

(c) **SCOPE OF PREEMPTION.**—The preemption under this section includes, but is not limited to—

(1) state common law and statutory made-whole doctrines that would subordinate federal recovery to victim recovery;

(2) state anti-subrogation statutes that would bar or limit federal recovery;

(3) state collateral source rules that would reduce tortfeasor liability based on federal payments; and

(4) state laws purporting to allocate settlement proceeds in a manner inconsistent with section 421.

(d) **PRESERVATION OF STATE REMEDIES.**—Nothing in this section preempts state law causes of action against tortfeasors. Victims retain all state law remedies, subject only to the allocation provisions of section 421 and the coordination requirements of this title.

(e) **FEDERAL SUPREMACY.**—This preemption is authorized under the Supremacy Clause of the Constitution, Article VI, Clause 2, which establishes federal law as the supreme law of the land.

SEC. 502. NATIONALIZED STATUTE OF LIMITATIONS.

(a) **FEDERAL RULE.**—The limitations periods established under section 415 preempt State statutes of limitations for subrogation claims under this Act.

(b) **RATIONALE.**—Uniform federal limitations serve administrative efficiency, defendant predictability, anti-forum-shopping, and program integrity purposes.

(c) **PRECEDENT.**—Federal preemption of state limitations periods is well-established, including—

(1) ERISA's uniform limitations period for plan enforcement actions, which preempts varying state limitations periods to ensure program uniformity;

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(2) the Federal Tort Claims Act's limitations period for claims against the United States under 28 U.S.C. 2401(b);

(3) the Medicare Secondary Payer program's recovery procedures, which operate under federal timelines regardless of state limitations law; and

(4) numerous federal regulatory programs that establish uniform federal limitations periods to ensure consistent nationwide administration.

(d) UNIFORMITY RATIONALE.—Uniform federal limitations periods serve essential purposes including—

(1) administrative efficiency through standardized case management timelines;

(2) defendant predictability regarding exposure periods;

(3) prevention of forum-shopping based on favorable limitations rules; and

(4) program integrity by ensuring federal recovery rights are not defeated by jurisdictional technicalities.

SEC. 503. PROCEDURAL UNIFORMITY.

(a) FEDERAL PROCEDURES.—The recovery procedures established under subtitle B of title IV preempt inconsistent State regulation of subrogation practice.

(b) STATE SUBSTANTIVE LAW.—State substantive tort law shall continue to govern liability determinations, including duty, breach, causation, and damages.

(c) STATE PROCEDURAL RULES.—State procedural rules shall apply in State court proceedings except to the extent of direct conflict with this Act.

SEC. 504. DEFENDANT DUE PROCESS PROTECTIONS.

(a) FULL PROCEDURAL RIGHTS.—Defendants in subrogation actions under this Act retain all procedural rights available in civil litigation, including—

(1) adequate notice of claims and opportunity to respond;

(2) right to discovery under the Federal Rules of Civil Procedure;

(3) right to assert affirmative defenses and counterclaims;

(4) opportunity to file dispositive motions;

(5) right to present evidence and witnesses at trial;

(6) right to cross-examine adverse witnesses;

(7) right to jury trial where guaranteed by the Seventh Amendment or applicable statute; and

(8) right to appeal adverse judgments.

(b) NO SPECIAL PROCEDURES.—This Act does not authorize—

(1) summary judgment standards more favorable to the government than those applicable in ordinary civil litigation;

(2) burden-shifting that would relieve the government of proving elements of its claims;

(3) limitations on defendant discovery rights beyond those applicable in ordinary civil litigation; or

(4) any other procedural mechanism that would disadvantage defendants relative to private-party civil litigation.

(c) FEE-SHIFTING.—The fee-shifting provisions of section 431 are constitutional and do not violate due process because—

(1) fee-shifting statutes are common in American law and have been consistently upheld, including under 42 U.S.C. 1988 (civil rights), the Clean Air Act, the Clean Water Act, and numerous consumer protection statutes;

(2) defendants retain full opportunity to contest liability before any fee-shifting applies;

(3) fee-shifting applies only when the government prevails, providing defendants with incentive to settle meritorious claims at fair value; and

(4) the fee-shifting structure serves legitimate governmental interests in program fiscal sustainability and appropriate cost allocation.

(d) SUBSTANTIVE DUE PROCESS.—The subrogation framework serves legitimate governmental interests and does not infringe any fundamental right. The interests served include—

(1) fiscal sustainability of the CHCA Trust Fund;

(2) appropriate allocation of costs to parties responsible for injuries;

(3) creation of deterrence incentives for negligent conduct;

(4) protection of victims from bearing litigation risk; and

(5) efficient administration of federal healthcare programs.

(e) EQUAL PROTECTION.—The subrogation framework treats similarly situated defendants similarly and applies uniform standards across all categories of agency-decorrelated conditions, consistent with equal protection requirements.

Subtitle B—ERISA Coordination

SEC. 511. PLAN COVERAGE COORDINATION.

(a) CHCA PRIMARY.—For agency-decorrelated conditions, CHCA shall be the primary payer, and ERISA plans shall be secondary for any non-ADC conditions the beneficiary may have.

(b) ERISA PLAN COVERAGE.—ERISA plans shall continue to provide coverage for conditions not qualifying as agency-decorrelated under this Act.

(c) PARALLEL TO MEDICARE.—This coordination structure parallels existing Medicare-ERISA coordination, where Medicare's secondary payer rules establish priority relationships without broader ERISA preemption.

(d) ERISA PREEMPTION INTERACTION.—

(1) IN GENERAL.—ERISA's broad preemption of state law under 29 U.S.C. 1144(a) does not preempt CHCA, which is federal law enacted by Congress.

(2) NO CONFLICT.—This coordination structure does not conflict with ERISA because CHCA—

(A) does not require ERISA plans to structure benefits in any particular way;

(B) does not require ERISA plans to provide or deny any specific benefit;

(C) does not reference ERISA plans in a manner that would trigger ERISA preemption analysis; and

(D) merely establishes coordination of benefits between federal programs, consistent with existing Medicare coordination that has operated since 1980.

(3) RUTLEDGE STANDARD.—Consistent with *Rutledge v. Pharmaceutical Care Management Ass'n*, 592 U.S. 80 (2020), CHCA does not trigger ERISA preemption because it does not force ERISA plans "to adopt a particular scheme of substantive coverage" but merely establishes payment priority for certain categories of claims.

(4) DECADES OF PRECEDENT.—Medicare's coordination with ERISA plans under the Medicare Secondary Payer program has operated successfully for over four decades without constitutional challenge to the coordination framework.

SEC. 512. SUBROGATION PRIORITY.

(a) CHCA PRIORITY.—The subrogation rights of the United States under this Act take precedence over any subrogation rights of ERISA plans.

(b) PLAN SUBROGATION.—ERISA plans may exercise subrogation rights

only after CHCA has recovered amounts due under title IV.

SEC. 513. PLAN AMENDMENT REQUIREMENTS.

(a) AMENDMENT REQUIRED.—Each ERISA plan shall amend its plan documents to reflect coordination with CHCA not later than 24 months after the effective date of this Act.

(b) DEPARTMENT OF LABOR GUIDANCE.—The Secretary of Labor shall issue guidance on plan amendment requirements within 12 months of enactment.

Subtitle C—State Program Coordination

SEC. 521. MEDICAID COORDINATION.

(a) FEDERAL REIMBURSEMENT.—States shall receive federal reimbursement from the CHCA Trust Fund for CHCA-qualifying claims processed through State Medicaid programs at 100 percent (not limited to the Federal Medical Assistance Percentage).

(b) FLOW-THROUGH.—States may continue processing Medicaid claims through existing infrastructure, with claims annotated for CHCA reimbursement through the state ledger portal.

SEC. 522. WORKERS' COMPENSATION COORDINATION.

(a) IMMEDIATE COVERAGE.—Upon application of an agency-decorrelated diagnosis code, CHCA shall provide immediate coverage and acquire subrogation rights.

(b) REIMBURSEMENT.—CHCA shall pursue reimbursement from workers' compensation carriers, employers, or liable third parties as appropriate.

(c) STATE ADJUSTMENT.—States and employers may adjust workers' compensation arrangements on their own timetable.

SEC. 523. STATE INSURANCE REGULATION.

(a) PREMIUM ADJUSTMENT GUIDANCE.—The Secretary, in coordination with State insurance commissioners, shall issue guidance regarding premium adjustments reflecting CHCA coverage of agency-decorrelated conditions not later than 18 months after enactment.

(b) MARKET EXPECTATIONS.—Such guidance shall provide the public and employers with clear expectations regarding premium reductions resulting from transfer of catastrophic risk to CHCA.

(c) OUTLIER REPORTING.—The Secretary shall publish annual reports

identifying insurers whose premium adjustments are inconsistent with CHCA coverage assumptions, allowing market forces to drive out gouging behaviors.

SEC. 524. TERRITORIAL APPLICATION.

(a) UNIFORM APPLICATION.—This Act shall apply uniformly to all territories of the United States, including Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(b) TERRITORIAL RESIDENTS.—Residents of United States territories shall be treated identically to State residents for coverage and contribution purposes.

TITLE VI—COORDINATION WITH FEDERAL PROGRAMS

SEC. 601. MEDICARE COORDINATION.

(a) CHCA PRIMARY.—For agency-decorrelated conditions, CHCA shall be the primary payer for Medicare beneficiaries.

(b) CLAIMS ROUTING.—Medicare claims with CHCA-qualifying diagnosis codes shall be automatically routed to the CHCA Trust Fund through the existing CMS claims processing infrastructure.

(c) SEAMLESS TRANSITION.—The transition shall be seamless for providers and beneficiaries, with no change to claims submission procedures.

SEC. 602. CHIP COORDINATION.

(a) CHCA PRIMARY.—For agency-decorrelated conditions, CHCA shall be the primary payer for CHIP beneficiaries.

(b) STATE REIMBURSEMENT.—States shall receive CHCA reimbursement for qualifying claims processed through CHIP programs.

SEC. 603. VETERANS AFFAIRS AND TRICARE COORDINATION.

(a) CHCA PRIMARY.—For agency-decorrelated conditions, CHCA shall be the primary payer for VA and TRICARE beneficiaries.

(b) COORDINATION AGREEMENTS.—The Secretary shall enter into coordination agreements with the Secretary of Veterans Affairs and the Secretary of Defense within 12 months of enactment.

(c) APPROPRIATION REDIRECT.—Appropriations for VA and TRICARE catastrophic care for agency-decorrelated conditions shall be redirected to the CHCA Trust Fund.

SEC. 604. FEDERAL EMPLOYEES HEALTH BENEFITS COORDINATION.

- (a) CHCA PRIMARY.—For agency-decorrelated conditions, CHCA shall be the primary payer for FEHB participants.
- (b) OPM GUIDANCE.—The Office of Personnel Management shall issue guidance regarding FEHB plan coordination with CHCA within 12 months of enactment.

SEC. 605. ACA MARKETPLACE COORDINATION.

- (a) MARKETPLACE COVERAGE.—ACA marketplace plans shall provide coverage for conditions not qualifying as agency-decorrelated.
- (b) ACTUARIAL ADJUSTMENT.—The Secretary shall issue guidance regarding actuarial adjustments to marketplace plans reflecting CHCA coverage.
- (c) ESSENTIAL HEALTH BENEFITS.—The Secretary shall issue guidance regarding the interaction between CHCA coverage and essential health benefits requirements for marketplace plan certification.

TITLE VII—REVENUE AMENDMENTS

SEC. 701. AMENDMENT TO INTERNAL REVENUE CODE—PAYROLL CONTRIBUTIONS.

- (a) IN GENERAL.—Section 3101 of the Internal Revenue Code of 1986 is amended as provided in section 221.
- (b) EMPLOYER CONTRIBUTION.—Section 3111 of such Code is amended as provided in section 221.

SEC. 702. AMENDMENT TO INTERNAL REVENUE CODE—SELF-EMPLOYMENT.

Section 1401 of the Internal Revenue Code of 1986 is amended as provided in section 222.

SEC. 703. AMENDMENT TO INTERNAL REVENUE CODE—INVESTMENT INCOME.

Section 1411 of the Internal Revenue Code of 1986 is amended as provided in section 223.

SEC. 704. TAX TREATMENT OF CONTRIBUTIONS.

- (a) FICA TREATMENT.—CHCA contributions shall receive the same tax treatment as contributions under sections 3101 and 3111 of the Internal Revenue Code of 1986, including—

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- (1) exclusion from federal income tax withholding calculations;
- (2) inclusion in W-2 wage reporting;
- (3) deductibility as a business expense for employers under section 162 of such Code; and
- (4) application of the same withholding, deposit, and reporting rules applicable to FICA taxes.

(b) SELF-EMPLOYMENT.—Self-employment CHCA contributions shall receive the same treatment as self-employment taxes under section 1401 of such Code.

SEC. 705. COLLECTION AND DEPOSIT PROCEDURES.

(a) COLLECTION.—CHCA contributions shall be collected through existing IRS infrastructure for FICA collection, including electronic fund transfer requirements.

(b) DEPOSIT.—The Secretary of the Treasury shall deposit CHCA contributions into the CHCA Trust Fund in accordance with procedures established for Medicare Hospital Insurance Trust Fund deposits under section 1817 of the Social Security Act (42 U.S.C. 1395i).

SEC. 706. REDUCTION IN ADDITIONAL MEDICARE TAX.

(a) IN GENERAL.—Section 3101(b)(2) of the Internal Revenue Code of 1986 is amended by striking "0.9 percent" and inserting "0.5 percent".

(b) SELF-EMPLOYMENT TAX.—Section 1401(b)(2) of such Code is amended by striking "0.9 percent" and inserting "0.5 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the effective date of this Act.

(d) COORDINATION WITH CHCA.—The reduction under this section reflects the transfer of catastrophic coverage responsibility from the Medicare program to the CHCA program for agency-decorrelated conditions, reducing the justification for the Additional Medicare Tax at its current rate.

(e) FISCAL NOTE.—The reduction from 0.9 percent to 0.5 percent is projected to reduce federal receipts by approximately \$40,000,000,000 annually, which is offset by CHCA contributions under section 221.

SEC. 707. REDUCTION IN NET INVESTMENT INCOME TAX.

(a) IN GENERAL.—Section 1411(a)(1) of the Internal Revenue Code of 1986 is amended by striking "3.8 percent" and inserting "2.1 percent".

(b) TRUSTS AND ESTATES.—Section 1411(a)(2) of such Code is amended by striking "3.8 percent" and inserting "2.1 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the effective date of this Act.

(d) COORDINATION WITH CHCA.—The reduction under this section reflects that CHCA contributions under section 223 apply to net investment income, creating partial overlap with the Net Investment Income Tax. The reduction eliminates double-taxation while maintaining appropriate contribution levels.

(e) FISCAL NOTE.—The reduction from 3.8 percent to 2.1 percent is projected to reduce federal receipts by approximately \$50,000,000,000 to \$60,000,000,000 annually. Combined with the Additional Medicare Tax reduction under section 706, total ACA tax reductions of approximately \$90,000,000,000 to \$100,000,000,000 annually are substantially offset by CHCA contributions projected at \$160,000,000,000 to \$180,000,000,000 annually, yielding net new federal receipts of approximately \$60,000,000,000 to \$80,000,000,000 annually.

TITLE VIII—TRANSITION AND IMPLEMENTATION

SEC. 801. TRANSITION PERIOD.

(a) 24-MONTH TRANSITION.—There shall be a 24-month transition period between the date of enactment of this Act and the effective date specified in section 1002.

(b) PHASED IMPLEMENTATION.—Implementation shall proceed in phases as specified in sections 802 through 804.

SEC. 802. PHASE 1: REGULATORY DEVELOPMENT.

(a) TIMELINE.—Phase 1 shall comprise months 1 through 12 following enactment.

(b) ACTIVITIES.—During Phase 1, the Secretary shall—

(1) conduct notice-and-comment rulemaking for all regulations required under this Act;

(2) publish the initial Code List under section 303;

(3) establish contractor qualification standards under section 323 and section 412;

(4) negotiate state coordination agreements for Medicaid and workers' compensation flow-through;

(5) issue guidance for ERISA plan amendments under section 513;

(6) establish the CHCA Medical Advisory Committee under section

303(e); and

(7) develop the state ledger portal for flow-through reimbursement.

SEC. 803. PHASE 2: SYSTEMS DEVELOPMENT.

(a) **TIMELINE.**—Phase 2 shall comprise months 13 through 18 following enactment.

(b) **ACTIVITIES.**—During Phase 2, the Secretary shall—

(1) develop and test claims processing system modifications for code-based routing;

(2) establish the National Claims Clearinghouse;

(3) procure recovery contractors through competitive processes;

(4) conduct provider enrollment and education;

(5) develop the subrogation case management portal; and

(6) conduct staff training for CMS and contractor personnel.

SEC. 804. PHASE 3: PHASED CLAIMS ACCEPTANCE.

(a) **TIMELINE.**—Phase 3 shall comprise months 19 through 24 following enactment.

(b) **PHASED ACCEPTANCE.**—During Phase 3, the Secretary shall begin accepting claims in the following order:

(1) **MONTH 19.**—Genetic and rare disease claims, which have the cleanest codes and most straightforward agency-decorrelation determination.

(2) **MONTH 21.**—Occupational injury and illness claims, building on workers' compensation integration.

(3) **MONTH 23.**—Motor vehicle accident claims, which require fault determination procedures.

(4) **MONTH 25 (EFFECTIVE DATE).**—Environmental exposure claims and full operation across all ADC categories.

(c) **RATIONALE.**—Beginning with high-clarity, high-recovery categories provides immediate demonstration of system benefits while generating revenue through systematic subrogation recovery.

SEC. 805. PUBLIC EDUCATION.

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- (a) PUBLIC EDUCATION CAMPAIGN.—The Secretary shall conduct a public education campaign regarding CHCA coverage, eligibility, and claims procedures.
- (b) PROVIDER EDUCATION.—The Secretary shall provide education and training for healthcare providers regarding CHCA claims submission.
- (c) EMPLOYER EDUCATION.—The Secretary, in coordination with the Secretary of Labor, shall provide education for employers regarding contribution obligations and premium adjustment expectations.

SEC. 806. PREMIUM ADJUSTMENT GUIDANCE.

- (a) GUIDANCE.—Not later than 18 months after the date of enactment, the Secretary shall issue guidance regarding expected premium adjustments for private insurance.
- (b) MARKET EXPECTATIONS.—The guidance shall provide the public and employers with clear expectations regarding premium reductions resulting from transfer of catastrophic risk to CHCA.
- (c) OUTLIER REPORTING.—Beginning in the third year following enactment, the Secretary shall publish annual reports identifying insurers whose premiums are inconsistent with CHCA coverage assumptions.
- (d) MARKET ENFORCEMENT.—The Secretary shall publicize outlier bad actors, allowing market forces to drive competitive responses and deter gouging behaviors.

TITLE IX—OVERSIGHT AND ACCOUNTABILITY

SEC. 901. GAO AUDIT REQUIREMENTS.

- (a) ANNUAL AUDIT.—The Comptroller General shall conduct an annual audit of CHCA Trust Fund operations.
- (b) REPORTS.—The Comptroller General shall report audit findings to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives.
- (c) SCOPE.—Audits shall include review of claims processing accuracy, subrogation recovery performance, contractor performance, and administrative cost efficiency.

SEC. 902. INSPECTOR GENERAL AUTHORITY.

- (a) JURISDICTION.—The Inspector General of the Department of

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Health and Human Services shall have jurisdiction over the CHCA program.

(b) FRAUD AND ABUSE.—The Inspector General shall investigate fraud and abuse in CHCA claims, with authority to impose civil monetary penalties and exclusions consistent with authorities under title XI of the Social Security Act (42 U.S.C. 1301 et seq.).

SEC. 903. CONGRESSIONAL REPORTING.

(a) ANNUAL REPORT.—In addition to the Board's annual report under section 214, the Secretary shall submit to Congress an annual report on CHCA program operations.

(b) CONTENTS.—Such report shall include claims volume and expenditures by ADC category, administrative costs, subrogation recovery performance, appeals and litigation outcomes, and recommendations for program improvements.

SEC. 904. CONGRESSIONAL REVIEW PROCEDURES.

(a) MAJOR RULES.—Regulations under this Act that constitute major rules under the Congressional Review Act (5 U.S.C. 801 et seq.) shall be submitted to Congress as required under that Act.

(b) MINISTERIAL DETERMINATIONS.—Rate adjustments and other determinations classified as ministerial under section 226(a) shall not be subject to Congressional Review Act requirements.

SEC. 905. GAO OCCUPATIONAL FAULT-ATTRIBUTION STUDY.

(a) STUDY REQUIRED.—Not later than 3 years after the effective date of this Act, the Comptroller General shall conduct a comprehensive study on fault attribution in occupational injuries and illnesses covered under this Act.

(b) CONTENTS.—The study shall examine—

(1) the proportion of occupational injuries attributable to—

(A) employer negligence, including failure to provide safe working conditions, inadequate training, or violation of safety regulations;

(B) worker fault, including willful safety violations, intoxication, or deliberate disregard of safety protocols; and

(C) circumstances beyond the control of either employer or worker, including equipment failures, acts of third parties, or unforeseeable accidents;

(2) the accuracy of the agency-decorrelation percentage used for CBO scoring purposes under section 311(b)(3);

(3) recommendations for refining agency-decorrelation criteria for occupational injuries and illnesses;

(4) analysis of subrogation recovery patterns by fault category from CHCA case adjudication data; and

(5) international comparisons of workplace injury fault determination methodologies, to the extent such data exists.

(c) DATA SOURCES.—The Comptroller General shall utilize—

(1) CHCA claims and subrogation case adjudication records;

(2) workers' compensation determination outcomes coordinated through section 522;

(3) OSHA inspection and citation data;

(4) peer-reviewed occupational health literature on injury causation; and

(5) such other sources as the Comptroller General determines appropriate.

(d) NOVEL RESEARCH.—Congress finds that—

(1) no workers' compensation system globally tracks fault attribution for occupational injuries because all developed economies deliberately adopted no-fault approaches to ensure prompt benefit delivery;

(2) this universal adoption of no-fault systems created a global data gap regarding the actual distribution of fault in workplace injuries;

(3) CHCA's case-by-case subrogation adjudication framework, which necessarily determines fault for recovery purposes, will generate the first systematic empirical data on fault attribution in occupational settings; and

(4) the study required under this section would constitute genuinely novel research establishing the first empirical basis for fault-attribution percentages in occupational settings.

(e) REPORT.—

(1) IN GENERAL.—The Comptroller General shall submit a report containing the study findings and recommendations to—

(A) the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate; and

(B) the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives.

(2) DEADLINE.—The report shall be submitted not later than 3 years after the effective date of this Act.

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(3) INTERIM REPORT.—The Comptroller General shall submit an interim report not later than 18 months after the effective date of this Act describing preliminary findings and methodology.

(f) REGULATORY ADJUSTMENT AUTHORITY.—

(1) IN GENERAL.—Following receipt of the report required under subsection (e), the Secretary may, through notice-and-comment rulemaking, adjust the agency-decorrelation criteria for occupational injuries and illnesses based on the study findings.

(2) FACTORS.—In adjusting such criteria, the Secretary shall consider—

- (A) the empirical fault distribution identified in the study;
- (B) the fiscal impact of any adjustment on CHCA Trust Fund solvency;
- (C) the effect on subrogation recovery incentives and employer safety behavior; and
- (D) comments received through the notice-and-comment process.

(3) CONGRESSIONAL NOTIFICATION.—The Secretary shall notify the committees specified in subsection (e)(1) not less than 60 days before any adjustment takes effect.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

TITLE X—MISCELLANEOUS PROVISIONS

SEC. 1001. SEVERABILITY.

If any provision of this Act, or an amendment made by this Act, or the application of such provision to any person or circumstance, is held to be invalid, the remainder of this Act, and the application of such provision to other persons not similarly situated or to other circumstances, shall not be affected.

SEC. 1002. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided, this Act shall take effect on January 1 of the second calendar year following the date of enactment.

(b) REGULATORY AUTHORITY.—The authority to promulgate regulations under this Act shall take effect on the date of enactment.

(c) CONTRIBUTION AUTHORITY.—The authority to collect contributions under title VII shall take effect on the effective date specified in subsection (a).

(d) PHASED CLAIMS.—Claims acceptance shall proceed according to the phase-in schedule specified in section 804.

SEC. 1003. RULEMAKING AUTHORITY.

(a) IN GENERAL.—The Secretary shall promulgate such regulations as are necessary to carry out this Act.

(b) INTERIM FINAL RULES.—The Secretary may promulgate interim final rules as necessary to ensure timely implementation during the transition period.

(c) NOTICE AND COMMENT.—Except as provided in subsection (b), regulations under this Act shall be promulgated through notice-and-comment rulemaking under section 553 of title 5, United States Code.

SEC. 1004. AUTHORIZATION OF APPROPRIATIONS.

(a) ADMINISTRATIVE EXPENSES.—There are authorized to be appropriated such sums as are necessary to carry out the administrative functions of this Act during the transition period and thereafter.

(b) TRANSITION COSTS.—There are authorized to be appropriated such sums as are necessary to carry out the transition activities under title VIII, estimated at \$110,000,000 to \$210,000,000 in one-time costs.

(c) INITIAL TRUST FUND CAPITALIZATION.—There are authorized to be appropriated such sums as are necessary to provide initial capitalization of the CHCA Trust Fund pending collection of contributions.

(d) ONGOING ADMINISTRATIVE COSTS.—Ongoing administrative costs are estimated at \$15,000,000 to \$30,000,000 annually, which are immaterial relative to annual fiscal improvement. — END OF PHASE 2 LEGISLATIVE TEXT —*Document Version: 4.2*

Date: January 1, 2026

Status: Phase 4 Step 3 Complete — Cross-References Verified

**Placeholders in [blue italics] indicate values to be*

*determined by legislative committee.**

**Source documentation: Operational Baseline v1.5, Subrogation White*

*Paper v1.2, Technical Evidence Compendium v1.3, Policy Paper Rev 5.6, Constitutional Hardening Amendments v1.3, Placeholder Resolutions v1.3**

*Appendices B, C, D**

CHCA Legislative Draft - Phase 3

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**Title IV Enhanced from Subrogation White Paper v1.1 Appendices B, C,*

*D, Constitutional Hardening Amendments v1.3**

CATASTROPHIC HEALTH COVERAGE ACT

Phase 4 Step 1 Integration completed January 1, 2026

Phase 4 Step 2 Integration completed January 1, 2026

Phase 4 Step 3 Cross-Reference Audit completed January 2, 2026