CATASTROPHIC HEALTH COVERAGE ACT

No Time Bombs

Designing Catastrophic Health Coverage That Self-Corrects Instead of Exploding

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Executive Summary

Nearly every major federal healthcare program carries a familiar failure mode: political promises outrun financial mechanics, and costs accumulate invisibly until crisis forces blunt, painful intervention. Static benefit definitions, politically frozen contribution rates, and optimistic assumptions produce programs that function well initially and destabilize later. The Medicare Hospital Insurance Trust Fund has seen its projected depletion date shift repeatedly over four decades, most recently to 2033, requiring periodic legislative rescue.[1] The Affordable Care Act's premium subsidies, structured around legislated income thresholds, create abrupt eligibility cliffs that produce dramatic premium increases for households whose income crosses arbitrary boundaries.[2]

The Catastrophic Health Coverage Act (CHCA) is explicitly designed to avoid this trajectory. CHCA is not a fixed promise. It is a bounded, actuarially governed system that adjusts automatically to experience, maintains explicit reserves, and restricts benefit scope by design. Its financial integrity does not depend on sustained political discipline or optimistic projections. It depends on mechanics written into statute.

This paper explains why CHCA avoids the failure modes that plague other healthcare programs, how its architecture prioritizes durability over rhetorical ambition, and why the specific design choices embedded in statute create a program capable of surviving pessimistic scenarios without crisis intervention.

I. How Healthcare Programs Fail Over Time

Healthcare programs rarely fail because their goals are wrong. They fail because their internal control systems are inadequate to maintain equilibrium between promises and resources. Understanding these failure modes is essential to understanding why CHCA's architecture differs from conventional program design.

1.1 The Four Recurring Pathologies

Static Benefit Definitions. Benefits are fixed in statute while medical practice, costs, and utilization evolve. A benefit structure that was actuarially sound when enacted becomes progressively misaligned as medicine advances, treatment patterns shift, and demographic composition changes. The original Medicare program, designed for a 1965 healthcare system, now covers treatments and technologies its designers could not have imagined, with costs correspondingly unimaginable to its framers.

Politically Frozen Funding Rates. Contribution or tax rates become politically untouchable even as obligations grow. The Medicare Hospital Insurance payroll tax has remained at 2.9% (combined employer-employee) since 1986, with only a modest Additional Medicare

Tax of 0.9% added for high earners in 2013.[3] Meanwhile, per-beneficiary costs have grown substantially, creating a structural gap between revenues and expenditures that widens with each passing year.

Hidden Cross-Subsidies. Costs are shifted across populations or generations without explicit acknowledgment. Medicare Part B and Part D are financed primarily through general revenues, meaning current taxpayers subsidize current beneficiaries without any dedicated funding stream that would make the subsidy visible.[4] This opacity enables expansion without apparent cost—until the general fund claims become unsustainable.

Deferred Insolvency. Short-term affordability masks long-term imbalance until crisis becomes unavoidable. The Medicare Trustees have repeatedly projected Hospital Insurance Trust Fund depletion within 10-15 years, a projection that has shifted forward multiple times through legislative intervention rather than structural correction.[5] Each rescue defers the problem without resolving it.

1.2 Case Study: The ACA Subsidy Cliff

The Affordable Care Act's premium subsidy structure illustrates how static thresholds create instability. Under the original ACA design, households with income below 400% of the federal poverty level qualified for premium tax credits; those above received nothing. A household earning $62,600 might receive substantial subsidies; a household earning $62,601—one dollar over the 400% threshold—received zero assistance. This 'subsidy cliff' created dramatic premium discontinuities for households near the threshold.[6]

The American Rescue Plan Act temporarily addressed this by capping premiums at 8.5% of income for all enrollees, regardless of income level. But this enhancement was legislated with a sunset date, creating a new form of instability: enrollees who made coverage decisions based on enhanced subsidies now face dramatic premium increases. The enhancements expired at the end of 2025, returning the cliff.[7]

CHCA avoids this pattern entirely. Its funding mechanism adjusts automatically to experience. Its benefit scope is defined by clinical categories, not income thresholds. Its rates are certified annually by an independent Board, not frozen in statute. The system cannot accumulate hidden imbalances because imbalances trigger visible correction.

II. What CHCA Refuses to Do

CHCA begins with negative design commitments—things it deliberately does not attempt. These refusals are not limitations imposed by political constraints. They are architectural choices that preserve fiscal sustainability and political durability.

2.1 Explicit Limitations

CHCA does not promise universal coverage for all medical care. It covers catastrophic costs arising from agency-decorrelated conditions—a defined, bounded category. Routine care, preventive services, and conditions substantially attributable to individual lifestyle choices remain the responsibility of private insurance and individual financial planning. This constraint is not an oversight to be corrected later; it is the foundation of fiscal sustainability.

CHCA does not expand benefits without funding. The statute explicitly ties benefit scope to revenue adequacy through the Board of Trustees' annual certification process. If projected expenditures exceed projected revenues plus reserves, the contribution rate adjusts. Benefits cannot grow faster than the system's capacity to fund them because the mechanism that would permit such growth does not exist.

CHCA does not rely on politically fixed contribution rates. Section 225 of the statute specifies that the contribution rate shall be 'formula-derived based on actuarial projections, not legislatively fixed.'[8] This is not a policy preference; it is a structural commitment. Congress cannot freeze rates without amending the statute itself.

CHCA does not assume continuous economic growth or treat optimistic projections as a safety margin. Section 213(d) mandates that rate-setting use '80th percentile expenditure projections (conservative/pessimistic scenario) to ensure adequate funding.'[9] The system is designed for bad outcomes. If outcomes prove better than projected, reserves accumulate; if outcomes match projections, the system remains solvent; only outcomes worse than the 80th percentile require extraordinary adjustment.

2.2 Why Constraints Create Credibility

Programs that promise everything eventually deliver nothing. The history of healthcare reform is littered with ambitious proposals that collapsed under their own weight or were dismantled by subsequent Congresses hostile to their cost implications. Programs that promise one thing and do it well endure.

Social Security has survived nine decades not because it provides comprehensive retirement income, but because it provides a defined benefit within a constrained scope. Medicare has survived six decades not because it covers all healthcare needs, but because it addresses a specific population's catastrophic vulnerability. CHCA follows this pattern: narrow scope, rigorous mechanics, visible tradeoffs.

III. Dynamic Funding Architecture

CHCA's funding model is formula-driven, not legislated as a static rate. This distinction is fundamental to understanding why the program does not contain hidden time bombs.

3.1 Annual Actuarial Certification

Each year, the Board of Trustees certifies the contribution rate necessary to maintain Trust Fund solvency. Section 213(a) requires that the Board '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).'[10] This certification is not advisory; it is the legal basis for the rate that takes effect.

The certification process incorporates projected expenditures using conservative (80th percentile) assumptions, expected subrogation recovery under Title IV, reserve fund status relative to the 5-10% target, and the net contribution required across the taxable base of wages, self-employment income, and investment income above threshold.[11] The Board does not exercise discretion about whether to certify; it certifies the rate that emerges from the formula.

3.2 The Social Security COLA Precedent

CHCA's automatic adjustment mechanism is not unprecedented. Social Security has operated with automatic cost-of-living adjustments since 1975, when Congress enacted automatic COLAs under Section 215(i) of the Social Security Act.[12] These adjustments occur without annual congressional action; they are ministerial calculations implementing a statutory formula.

CHCA explicitly invokes this precedent for ministerial calculation. Section 226(a) provides that rate adjustments not exceeding 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)).'[13]

Note: The Social Security COLA precedent applies specifically to the ministerial nature of formula-based calculations—benefits adjust automatically without congressional vote. CHCA extends this principle to contribution rates, which is structurally novel. Social Security's payroll tax rate has been legislatively fixed at 6.2% since 1990; CHCA's contribution rates, by contrast, adjust automatically through the formula.[14] This is not CHCA inventing mechanisms from nothing; it is CHCA adapting a proven approach that has maintained Social Security benefit adjustments for five decades.

3.3 Tiered Adjustment Procedures

CHCA recognizes that not all adjustments are routine. Section 226 establishes tiered procedures calibrated to adjustment magnitude. Adjustments not exceeding 0.25 percentage points are ministerial. Adjustments between 0.25 and 0.50 percentage points require standard notice-and-comment rulemaking and are subject to the Congressional Review Act. Adjustments exceeding 0.50 percentage points require enhanced procedures including 90-day public comment, detailed congressional submission, and enhanced notification.[15]

This tiered structure balances automaticity against accountability. Routine adjustments reflecting normal actuarial variance proceed without friction. Large adjustments reflecting significant program changes receive appropriate scrutiny. But in all cases, the default is adjustment, not paralysis. If Congress does not enact a joint resolution of disapproval within 60 days, the certified rate takes effect.[16]

3.4 Explicit Reserve Requirements

Section 211(e) requires the Trust Fund to '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.'[17] This requirement is unique among major federal healthcare programs. Medicare's Hospital Insurance Trust Fund has no statutory reserve target; its reserves fluctuate based on the difference between inflows and outflows, with the Trustees recommending but not requiring minimum reserves.

The explicit reserve requirement serves multiple functions. It absorbs short-term volatility without requiring rate adjustments for every variance. It provides a visible indicator of program health that triggers early warning before crisis. It creates a buffer that permits deliberate response to adverse trends rather than emergency intervention.

IV. Transition Realism: Modeling the Bad Case

CHCA does not assume a frictionless launch. The statute explicitly anticipates implementation challenges and designs around them.

4.1 Anticipated Challenges

The statute anticipates delayed subrogation recovery in early years as the Recovery Contractor Program establishes operations and builds case inventory. It anticipates appeals volume spikes as coverage boundaries are tested through the administrative appeals process established under Title V. It anticipates administrative learning curves as the Clearinghouse develops operational capacity. It anticipates provider behavior adaptation as the healthcare system adjusts to the new routing rules under Section 302.

None of these conditions threaten solvency. Why? Because contributions adjust annually to experience. Because benefits are bounded by the Code List, not by open-ended promises. Because coverage is categorical, not subject to expansion pressure. Because the 80th percentile methodology already assumes adverse scenarios.

4.2 Why Pessimistic Design Enables Optimistic Outcomes

Programs designed for optimistic scenarios fail when reality proves harsher than projected. Programs designed for pessimistic scenarios succeed when reality proves milder—and survive when reality matches projections.

CHCA's initial contribution rate of 1.2% reflects conservative assumptions: 80th percentile expenditure projections, delayed subrogation recovery, and reserve accumulation requirements.[18] If experience proves favorable—lower expenditures, faster recovery, smoother implementation—the Board can reduce rates as actuarial experience confirms lower requirements. The political dynamics of reducing a tax are far more favorable than increasing one.

The alternative—launching with optimistic assumptions and hoping for the best—has failed repeatedly. The Medicare Catastrophic Coverage Act of 1988 was repealed within sixteen months after its financing assumptions proved untenable. CHCA's designers learned from that history.

V. Continuous Improvement as Law, Not Promise

Many programs promise 'continuous improvement' administratively while remaining legally static. CHCA does the opposite: improvement mechanisms are written into statute.

5.1 Annual Code List Review

Section 303(c) requires the Secretary to 'review and update the Code List annually,' incorporating new ICD-10-CM codes adopted by the World Health Organization or CMS, clinical evidence regarding agency-decorrelation criteria, feedback from appeals and litigation outcomes from the prior year, and recommendations from the CHCA Medical Advisory Committee.[19]

This is not discretionary improvement; it is mandatory review. The Code List cannot ossify because the statute requires annual reconsideration. Medical advances that create new agency-decorrelated conditions can be incorporated. Conditions that prove not to meet the criteria can be removed. The system learns from experience because learning is required, not optional.

5.2 Recovery Feedback Loops

Section 214(b)(4) requires annual reporting on subrogation recovery performance, including total amounts recovered, recovery rates by agency-decorrelated category, contractor performance metrics, and comparison to projected recovery amounts.[20] This data feeds back into the rate determination formula: if recovery exceeds projections, rates can decrease; if recovery falls short, rates adjust upward.

The system also learns where recovery is efficient and where it is not. Categories with high recovery rates receive enforcement priority; categories with low recovery potential receive appropriately calibrated effort. Resource allocation follows experience, not initial assumptions.

5.3 Transparency by Default

Section 214(c) requires that all Board reports 'be made available to the public on the websites of the Department of the Treasury and the Department of Health and Human Services.'[21] This transparency serves a function beyond public accountability: it makes hidden imbalances impossible.

Political pressure to defer difficult decisions depends on opacity. When program finances are visible, when projections are public, when variances from plan are documented, pressure to act follows naturally. CHCA's transparency requirements do not merely inform the public; they create political incentives for timely correction.

VI. Comparison to Known Failure Modes

CHCA's architecture specifically addresses the failure modes exhibited by existing programs. This section examines how CHCA differs from programs that have experienced or face fiscal instability.

6.1 ACA Subsidy Cliffs

The ACA's original subsidy structure created discontinuities at the 400% of federal poverty level threshold. A household earning $62,600 (the threshold for a single individual in 2026) received subsidies; a household earning one dollar more received nothing. This cliff structure was temporarily addressed through enhanced subsidies capping premiums at 8.5% of income regardless of income level, but the enhancements expired at the end of 2025, returning the cliff.[22]

CHCA has no income thresholds for eligibility. Coverage is determined by diagnosis code, not by income. A qualifying condition qualifies regardless of the patient's financial

circumstances. The contribution rate applies uniformly across the taxable base. There are no cliffs because there are no income-based eligibility boundaries to create them.

6.2 Medicare Hospital Insurance Trust Fund Dynamics

The Medicare Hospital Insurance Trust Fund depends on payroll taxes set by statute. The combined employer-employee rate has been 2.9% since 1986—nearly four decades without adjustment despite substantial growth in per-beneficiary costs. The 2025 Trustees Report projects that the Trust Fund will be depleted by 2033, at which point revenues would cover only 89% of scheduled benefits.[23]

CHCA's rates adjust automatically. The Board certifies whatever rate is necessary to maintain solvency over the 10-year projection period. If healthcare costs grow faster than wages, rates rise. If costs moderate, rates can decrease. The mechanism that permits Medicare's structural gap—a legislatively frozen rate facing rising costs—does not exist in CHCA.

6.3 Employer-Sponsored Insurance Volatility

Employers who self-insure absorb catastrophic risk directly. A single employee with a premature infant, a serious cancer diagnosis, or a catastrophic accident can generate medical costs exceeding $1 million—costs that flow directly to the employer's bottom line if self-insured or to dramatically increased premiums if fully insured. This volatility creates perverse incentives around hiring, retention, and coverage design.

CHCA removes catastrophic tail risk from employer calculations entirely. Agency-decorrelated catastrophic conditions route to the Trust Fund, not to employer health plans. Employers face predictable, bounded exposure for routine and lifestyle-related care. The unpredictable spike that can destabilize a self-insured plan or trigger dramatic premium increases disappears from the employer risk pool.

6.4 What CHCA Shares with Social Security

Social Security has operated for nine decades with fewer and less frequent crisis cycles than Medicare. While Social Security required emergency intervention in 1983—when the OASI Trust Fund faced imminent depletion, prompting the Greenspan Commission reforms—that crisis prompted structural changes that have maintained solvency for over four decades since.[24] Several structural features explain Social Security's relative stability: benefits adjust automatically through COLAs that track inflation, the program serves a specific function (retirement income replacement) rather than attempting comprehensive coverage, and the 1983 reforms demonstrated that structural correction is possible when designed into law.

CHCA shares these features while addressing the 1983 lesson directly. Unlike Social Security, which still requires periodic legislative action to maintain solvency because its contribution rate is legislatively fixed, CHCA's contribution rates adjust automatically. Benefits are bounded by the Code List. The program serves a specific function (catastrophic coverage for agency-decorrelated conditions). The formula-driven structure removes rate decisions from political negotiation. CHCA is designed to incorporate the self-correction that Social Security had to add through emergency legislation in 1983.

VII. Bounded Scope as Political Durability

Programs that promise everything eventually collapse under their own weight. Programs that promise one thing and do it well endure. This is not merely fiscal wisdom; it is political wisdom.

7.1 What CHCA Covers

CHCA covers catastrophic medical costs arising from agency-decorrelated conditions—and nothing else. This includes genetic and rare diseases, not-at-fault motor vehicle accidents, occupational injuries and illnesses, environmental exposure conditions, and other conditions meeting the agency-decorrelation criteria. Routine care remains market-based. Lifestyle-correlated risks remain individual responsibilities.[25]

This constraint is not a concession to political opposition. It is the reason the system can work. Bounded scope permits accurate actuarial projection. Accurate projection permits formula-driven rates. Formula-driven rates permit automatic adjustment. Automatic adjustment permits fiscal sustainability. The constraint enables the mechanism.

7.2 Expansion Requires Process

Adding conditions to the Code List requires clinical justification through the Medical Advisory Committee, public notice-and-comment rulemaking, and corresponding rate certification reflecting expanded coverage costs.[26] Expansion cannot occur through rhetorical pressure or political promises. It requires evidence, process, and funding.

This structure protects against 'scope creep'—the gradual expansion of program coverage that occurs when boundaries are enforced through political discretion rather than statutory constraint. Each expansion must be justified on its merits and funded through the rate formula. The disciplines are structural, not dependent on administrative will.

7.3 Cross-Ideological Durability

CHCA's bounded architecture creates durability across political cycles. Conservatives cannot accurately characterize CHCA as 'government takeover of healthcare' because it explicitly preserves private insurance for most care. Progressives cannot accurately characterize it as 'abandoning the sick' because it provides comprehensive coverage for catastrophic conditions beyond individual control. Fiscal hawks cannot accurately characterize it as 'another unfunded entitlement' because funding mechanisms adjust automatically to maintain solvency.

The boundaries define what the program is—and equally important, what it is not. This clarity enables defense against attack from multiple directions. Opponents must engage with what the program actually does, not with caricatures of what they imagine it might become.

VIII. What CHCA Can and Cannot Promise

Honesty about limitations is essential to credibility. CHCA makes specific promises it can keep and explicitly does not make promises it cannot.

8.1 What CHCA Promises

CHCA promises that qualifying conditions will be covered without regard to individual financial circumstances. It promises that contribution rates will adjust to maintain solvency. It promises that coverage boundaries will be transparent, reviewable, and subject to evidence-based refinement. It promises that responsible third parties will be pursued for cost recovery. It promises that reserves will be maintained to absorb adverse variance.

These promises are structural, not rhetorical. They are embedded in statute, not dependent on administrative discretion or future legislative will.

8.2 What CHCA Does Not Promise

CHCA does not promise that contribution rates will never increase. If healthcare costs rise faster than projected, rates will rise. If adverse experience exceeds reserves, rates will adjust. The promise is adjustment, not stability.

CHCA does not promise that every desired condition will qualify for coverage. Conditions substantially attributable to individual lifestyle choices do not qualify. The boundary exists and will be enforced.

CHCA does not promise that political interference is impossible. Congress retains authority to amend the statute. What CHCA promises is that interference will be visible:

deviation from the formula requires explicit legislative action, not quiet administrative discretion.

8.3 Why Honest Limitations Build Trust

Programs that promise more than they can deliver eventually betray the populations they serve. The Medicare Catastrophic Coverage Act of 1988 promised comprehensive catastrophic coverage funded by beneficiary premiums; it was repealed within sixteen months when the funding mechanism proved politically untenable. The ACA promised that 'if you like your plan, you can keep it'; millions of plans were cancelled when they failed to meet new requirements.

CHCA's limitations are explicit because honesty is essential to durability. A program that delivers exactly what it promises builds trust. A program that promises more than it delivers, however well-intentioned, builds cynicism. CHCA chooses trust.

IX. Conclusion: Stability Through Design, Not Optimism

Healthcare reform fails when aspiration exceeds architecture. Programs designed around political promises rather than fiscal mechanics accumulate hidden imbalances until crisis forces painful correction. The pattern is familiar: enthusiastic launch, gradual deterioration, deferred reckoning, emergency intervention.

CHCA inverts this pattern. It begins with mechanics: formula-driven rates, explicit reserves, bounded benefits, mandatory review. It accepts constraints: narrow scope, automatic adjustment, visible tradeoffs. It rejects temptations: unfunded expansion, optimistic projections, deferred consequences.

The result is a program that does not rely on future Congresses behaving wisely, economic growth outpacing costs, or litigation recovering more than expected. It relies on mechanics: dynamic rates, explicit reserves, bounded benefits, and transparent correction. It survives pessimistic scenarios because it was designed for them.

CHCA is not exciting. It is not expansive. It is stable. In healthcare finance, stability is not the enemy of justice—it is its precondition. Programs that collapse under fiscal pressure help no one. Programs that endure across political cycles provide the reliable foundation on which citizens can build their lives.

That is what it means to have no time bombs: not perfection, but sustainability. Not promises that cannot be kept, but mechanics that ensure the promises made will be honored. Not optimism about the future, but architecture that functions regardless of what the future brings.

Endnotes

[1] Centers for Medicare & Medicaid Services, 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (June 2025). The 2025 report projects HI Trust Fund depletion in 2033, three years earlier than the 2024 report's projection of 2036. At depletion, revenues would cover only 89% of scheduled Part A benefits.

[2] Bipartisan Policy Center, "Enhanced Premium Tax Credits: Who Benefits, How Much, and What Happens Next?" (October 2025). The ACA's original subsidy cliff at 400% of federal poverty level created premium discontinuities exceeding $5,000 annually for households near the threshold. Nearly 725,000 ACA enrollees have incomes between 400% and 500% of FPL.

[3] The Medicare HI payroll tax rate was set at 2.9% (combined) in 1986. The Additional Medicare Tax of 0.9% on earnings above $200,000/$250,000 was added by the Affordable Care Act in 2013. See 26 U.S.C. § 3101(b).

[4] Center for Retirement Research, "Medicare Finances: A Perspective on the 2025 Trustees Report" (2025): "Part B is financed primarily by government general revenues (72 percent), augmented primarily by participant premiums." See also 2025 Medicare Trustees Report, Table II.B1.

[5] Amber Willink et al., "Solvency extensions to the Medicare Hospital Insurance Trust Fund: what is driving them?" PMC 12022393, Int J Health Econ Manag (2024), analyzing depletion projections across Medicare Trustees Reports 1985-2024. The Medicare Trustees have projected HI Trust Fund depletion within 15 years in 18 of the last 20 annual reports.

[6] For 2026 coverage (using 2025 poverty guidelines), 400% FPL equals $62,600 for a single individual, $84,600 for a two-person household, and $128,600 for a family of four. See HHS/ASPE 2025 Federal Poverty Guidelines; Bipartisan Policy Center analysis (October 2025).

[7] The American Rescue Plan Act of 2021 (P.L. 117-2) Section 9661 capped marketplace premiums at 8.5% of household income. The Inflation Reduction Act of 2022 (P.L. 117-169) extended this through 2025. Without congressional extension, the original ACA subsidy cliff returned in 2026. See CNBC, "ACA subsidies are expiring. Here's who the lapse will hit hardest" (January 6, 2026).

[8] CHCA Legislative Draft Phase 4 v4.3, SEC. 225(a).

[9] CHCA Legislative Draft Phase 4 v4.3, SEC. 213(d).

[10] CHCA Legislative Draft Phase 4 v4.3, SEC. 213(a).

[11] CHCA Legislative Draft Phase 4 v4.3, SEC. 225(b) specifies the methodology: project expenditures using 80th percentile scenarios, subtract projected subrogation recovery, subtract projected state WC contributions, adjust for reserve target, calculate net contribution required, divide by taxable base.

[12] Social Security Act Section 215(i), 42 U.S.C. § 415(i). Automatic COLAs were enacted in P.L. 92-603, the Social Security Amendments of 1972, with the first automatic adjustment payable in 1975. See Congressional Research Service, "Social Security: Cost-of-Living Adjustments," Report 94-803 (updated January 2025).

[13] CHCA Legislative Draft Phase 4 v4.3, SEC. 226(a).

[14] Social Security's OASDI payroll tax rate has been 6.2% (employee share) since 1990, having last increased under the Social Security Amendments of 1983 (P.L. 98-21). See Congressional Research Service, "Payroll Taxes: An Overview," Report R47062: "Combined Social Security payroll tax rates rose from 2% in 1949 to 12.4% in 1990. The last Social Security tax rate increase was part of the Social Security Amendments of 1983."

[15] CHCA Legislative Draft Phase 4 v4.3, SEC. 226(a)-(c).

[16] CHCA Legislative Draft Phase 4 v4.3, SEC. 226(d).

[17] CHCA Legislative Draft Phase 4 v4.3, SEC. 211(e).

[18] CHCA Placeholder Resolutions Working Draft v1.3. The 1.2% initial rate reflects conservative assumptions per SEC. 213(d) mandate, reserve accumulation requirements per SEC. 211(e), and projected delayed subrogation recovery in early program years.

[19] CHCA Legislative Draft Phase 4 v4.3, SEC. 303(c).

[20] CHCA Legislative Draft Phase 4 v4.3, SEC. 214(b)(4).

[21] CHCA Legislative Draft Phase 4 v4.3, SEC. 214(c).

[22] healthinsurance.org, "'Subsidy cliff' will return in 2026 if Congress doesn't act" (updated January 2026): "The federal subsidy enhancements referenced in this article expired at the end of 2025." KFF estimates that a 60-year-old earning $64,000 would pay approximately $14,900 in annual premiums without subsidies.

[23] Centers for Medicare & Medicaid Services, 2025 Annual Report of the Boards of Trustees (June 2025). The projected depletion date moved three years earlier (from 2036 to 2033) compared to the 2024 report.

[24] Social Security Administration History, "National Commission on Social Security Reform (Greenspan Commission)": "Estimates were that the Old-Age and Survivors Insurance Trust Fund would run out of money possibly as early as August 1983." Congressional Research Service Report R47040: "By April 1982, projections showed that Social Security would no longer be able to pay full benefits on a timely basis starting in mid-1983." The 1983 Amendments enacted structural reforms including raising the retirement age and accelerating tax increases.

[25] CHCA Legislative Draft Phase 4 v4.3, SEC. 105(1)(B)-(D). Qualifying categories include genetic and rare diseases, motor vehicle accidents (not-at-fault), occupational injuries and illnesses, and environmental exposures. Excluded are conditions substantially attributable to diet, tobacco (except occupational/environmental), alcohol, and substance abuse.

[26] CHCA Legislative Draft Phase 4 v4.3, SEC. 303(c)-(e). Code List changes require clinical evidence review, Medical Advisory Committee recommendation, and notice-and-comment rulemaking. Rate certification under SEC. 225 incorporates expanded coverage costs.