Catastrophic Health Coverage Act

Operational Baseline Document

Version 1.5 — January 2026

Funding Mechanisms, Payment Flows, and Operational Design

1. Core Design Principles

1.1 Agency Principle

CHCA covers healthcare costs arising from conditions beyond individual agency: genetic/rare diseases, accidents involving innocent victims, occupational injuries and illnesses, and environmental exposures. Conditions attributable to individual lifestyle choices remain personal responsibility.

1.2 Operational Design Philosophy

Principle	Implementation
Minimal Infrastructure	Leverage existing CMS claims processing, IRS collection, and state systems. No parallel bureaucracies.
Code-Based Routing	ICD-10/CPT code determines payer. CHCA-qualifying code = CHCA pays. No coordination of benefits logic.
Flow-Through Where Possible	States continue current operations for Medicaid and Workers' Comp; federal reimburses via annotated ledger.
Rate Neutrality at Launch	Existing payment rates continue initially. Cost savings accrue from administrative efficiency over time.
Progressive Contribution	Single rate across income types is inherently progressive—risk doesn't discriminate by income.

2. Contribution Structure

CHCA contributions overlay existing federal collection infrastructure to minimize new systems and ensure all income types contribute proportionally.

2.1 Fund Structure

CHCA contributions flow to a dedicated trust fund (CHCA Trust Fund), modeled on Medicare Hospital Insurance Trust Fund. Dedicated revenue stream cannot be diverted to general fund. Fund maintains reserves and is subject to annual actuarial certification.

2.2 Contribution Streams

Income Type	Mechanism	Infrastructure
Wages	Payroll contribution	Add CHCA rate to FICA withholding; 50% employer / 50% employee split
Self-Employment	SE tax equivalent	Same rate as combined payroll, full burden on individual (like Medicare SE)
Investment Income	NIIT-style contribution	Same rate, $400 threshold (matching SE floor), applied to interest, dividends, capital gains, rental, royalties
State WC Pools	Actuarial contribution	States contribute at predicted rate; receive 100% reimbursement for qualifying claims

2.3 Verified Fiscal Baseline

The CHCA fiscal framework rests on verified baseline spending of $575–645 billion annually in agency-decorrelated catastrophic costs. This figure is derived from:

- Rare/genetic disease costs: ~$450B[1]
- Motor vehicle accident costs: ~$25B innocent victim medical costs[2]
- Occupational injury/illness costs: ~$50–65B[3]
- Environmental exposure costs: ~$50–105B (bracketed estimate)

Complete source verification and methodology documented in Gap A Verification Document v1.2[4] and CHCA Verified Data Repository v2.0.[5]

2.4 Rate Derivation Formula

The contribution rate is formula-derived, not legislatively fixed. HHS certifies the rate annually based on actuarial projection:

Element	Amount
Projected CHCA expenditures (80th percentile scenario)	$X
Less: Projected subrogation recovery	($Y)
Less: State WC pool contributions	($Z)
Plus/Minus: Reserve fund target adjustment (5–10% of annual budget)	(±$W)
Net contribution required	$N
Divided by: Projected taxable base (payroll + SE + investment)	$B
Certified CHCA contribution rate	N ÷ B

Rate-setting uses 80th percentile expenditure projections (conservative/pessimistic scenario) to ensure adequate funding. Reserve fund target of 5–10% of annual budget provides cushion for adverse experience. Rate adjusts automatically via formula; Congressional action required only to modify methodology.

2.5 ACA Tax Relationship

CHCA partially substitutes for existing ACA taxes. Approximately 40–45% of ACA's catastrophic burden shifts to CHCA, enabling corresponding reduction in ACA tax rates:

Tax	Current	Post-CHCA	Change
Additional Medicare Tax (>$200K wages)	0.9%	~0.5%	Reduced
NIIT (>$200K investment)	3.8%	~2.0–2.2%	Reduced
CHCA Contribution (all income)	N/A	~1.0–1.2%	New

Net effect for most taxpayers: approximately neutral. ACA continues funding non-agency care subsidies at reduced scale.

3. Claims Processing and Payment Flow

3.1 Core Principle: Code Determines Payer

[1] Yang, Gavin, et al. "Economic Costs of Rare Diseases in the United States." Orphanet Journal of Rare Diseases 17, no. 1 (2022): 163. PMID: 35414039. Direct medical costs: $449 billion.

[2] National Highway Traffic Safety Administration. The Economic and Societal Impact of Motor Vehicle Crashes, 2019. DOT HS 813 403. Washington, DC: NHTSA, February 2023. Table 1-9: Medical Costs $30.9B.

[3] Leigh, J. Paul. "Economic Burden of Occupational Injury and Illness in the United States." Milbank Quarterly 89, no. 4 (2011): 728-772. PMC3250639; National Safety Council. Work Injury Costs. 2023.

[4] CHCA Working Documents. Gap A Verification Document. Version 1.2. December 2025. Baseline spending methodology.

[5] CHCA Working Documents. Verified Data Repository. Version 2.0. December 2025. Complete source documentation.

There are no "private insurance claims" for CHCA-covered codes. The ICD-10 code determines the payer. A CHCA-qualifying diagnosis code routes the claim to CHCA for payment. Private insurers simply stop receiving claims for those codes.

Nearly all providers of catastrophic care already file claims through Medicare/Medicaid systems. Providers continue using the existing CMS claims infrastructure—the only change is routing rules based on diagnosis codes.

3.2 Payment Flow by Current Payer

Current Payer	CHCA Mechanism	Rate	Infrastructure Change
Medicare	1:1 redirect	Medicare rates	None—CMS pays from CHCA fund
Medicaid	Flow-through	Medicaid rates	State ledger portal
Workers' Comp	Flow-through	WC rates	State ledger portal (shared)
Private Insurance	Direct via CMS	Commercial rates initially	Routing rules update
VA/TRICARE	1:1 redirect	Existing rates	None—appropriation redirect

3.3 Flow-Through Mechanics (Medicaid and Workers' Comp)

States continue their current operations with no provider-facing changes:

1. State receives claim and pays provider (no delay to provider or patient)
2. State tags claims with CHCA-qualifying ICD-10 codes
3. State submits periodic annotated ledger to CHCA portal
4. Federal reimburses 100% of qualifying expenditures (not FMAP share—full reimbursement)

3.4 Commercial Rate Baseline Methodology

Claims previously paid by private insurance are initially paid at commercial rates established as follows:

- Baseline: Per-state, per-prior-approved-policy rates from state insurance commission filings
- Transition: Rates maintained at launch to ensure provider revenue neutrality
- Convergence: Over time, government payment pressure moves rates toward uniformity (Medicare model)
- Review: HHS reviews rates annually; target 5–7% reduction as administrative efficiencies are realized

4. Coordination of Benefits

There is no coordination of benefits for CHCA-qualifying codes. CHCA is the sole payer for any claim with an agency-decorrelated diagnosis code. There is no primary/secondary logic, no COB determination, no split payments.

This eliminates an entire category of administrative overhead that exists in the current system where Medicare, Medicaid, and private insurance must determine payment order.

5. Eligibility and Fault Determination

5.1 Code List Authority

HHS maintains the authoritative list of CHCA-qualifying ICD-10 and CPT codes. HHS reviews and updates the list annually, with authority to add or remove codes based on

clinical evidence and agency-decorrelation criteria. Annual review incorporates feedback from appeals and litigation outcomes from the prior year.

5.2 Category-Specific Determination

Category	Determination Method	Standard
Genetic/Rare Disease	ICD-10 diagnosis codes from rare disease registries	Code presence is determinative
Motor Vehicle (victim)	Leverage property damage insurance adjudication for fault	Not-at-fault per property damage determination
Occupational	Existing Workers' Compensation adjudication	WC determination is determinative
Environmental	Z77 codes + causation investigation	Civil standard (preponderance of evidence)

5.3 Motor Vehicle Fault Determination

CHCA leverages existing property damage insurance adjudication for fault determination. The goals of assigning fault are agnostic to injury versus property loss—the same factual inquiry applies. This approach:

- Uses established insurance industry processes with decades of precedent
- Avoids creating parallel fault-finding bureaucracy
- Provides HHS oversight appeals process for disputed determinations
- Normal litigation remains available for parties disputing fault allocation

In comparative negligence states, standard litigation and arbitration determine appropriate cost allocation until a more efficient scheme is formulated.

5.4 Environmental Causation

Environmental exposure cases use an adversarial process with government-paid litigator advocating for the victim (who generally has no fault for slow-onset environmental injury). Key elements:

- Standard of proof: Civil standard (preponderance of evidence)—government has standing as civil complainant
- Diagnostic history: Slow-onset diseases have documentation trail supporting CHCA code qualification
- Healthcare continuity: Care is paid regardless during diagnostic period—coverage not delayed pending causation
- Mixed causation: If diagnosis was wrong or causation is mixed, litigation or medical arbitrator determines balancing payments for correct cost attribution

5.5 Appeals Process

Any party with payment obligation has standing to contest attribution. Escalation follows standard litigation/arbitration model. HHS annual code review incorporates cases lost in prior year—creating self-correcting feedback loop.

6. Premium Release Mechanism

Employer and individual health insurance premiums drop because coverage scope drops—insurers no longer cover CHCA-qualifying codes. This is market-driven, not mandated.

6.1 Transparency Team

A federal transition team, housed at HHS, provides transparency and analysis:

- Analyzes actuarial value of removed coverage by insurer/plan type
- Publishes guidance on fair premium reduction amounts
- Publicly identifies insurers failing to pass through savings ("gougers")
- Advises employers and employees on expected rate reductions

The transparency team sunsets after market stabilization (approximately 3–5 years).

7. Subrogation and Cost Recovery

CHCA institutes systematic government subrogation to recover costs from responsible parties (negligent drivers, polluters, manufacturers of defective products). This serves dual purposes: fiscal improvement and proper cost allocation to create deterrence incentives.

7.1 Tiered Recovery Thresholds

Recovery efforts are tiered by claim value to optimize administrative efficiency:

Tier	Threshold	Mechanism
Administrative	<50% of annual per-capita allocation	Health account administrative recovery; no litigation
Small Claims	50–80th percentile of per-capita claims	Small claims court or binding arbitration
Full Adversarial	>80–90th percentile annualized per-capita	Government-initiated litigation: sue or settle

Specific threshold values to be set by implementation committee based on claims data analysis.

7.2 Statute of Limitations

CHCA establishes nationalized statute of limitations for subrogation claims, superseding state variation. Government has standing as claimant for recovery of CHCA expenditures. This provides uniformity and eliminates forum-shopping based on outlier state policies.

7.3 Recovery Priority

When CHCA pays a victim and the victim also pursues claims against the tortfeasor:

- CHCA recovers compensatory amount first—this payment was for the victim's immediate medical need
- Amounts above compensatory recovery are punitive/deterrent and flow to victim or general fund as appropriate
- CHCA may subrogate against victim's settlement to recover its expenditure, but only to the compensatory portion

7.4 Contractor Model and Compensation

Legal recovery contractors operate under FAR-compliant, DCAA-auditable contracts. Attorneys profiting from others' misfortune must meet the same accountability standards as defense contractors—verified not to be gouging the government or victim.

7.4.1 Cost Recovery and Fee Structure

Loser-pays model with transparent fee calculation:

Element	Amount
Medical costs recovered	$M (e.g., $100,000)
Direct litigation costs (auditable)	$L (e.g., $25,000)
Subtotal	$M + $L (e.g., $125,000)
Attorney fee (10% of subtotal)	0.10 × ($M + $L) (e.g., $12,500)

Element	Amount
Defendant pays (total)	$M + $L + fee (e.g., $137,500)

Distribution: CHCA receives full medical recovery ($M). Attorney receives auditable direct costs ($L) plus 10% fee. Defendant bears all costs when liable.

7.4.2 DCAA Audit Requirements

Subrogation contractors must comply with:

- FAR cost allowability/unallowability definitions
- Contemporaneous timekeeping requirements
- Incurred cost submission and audit rights
- Truthful cost representations (subject to False Claims Act)
- Direct cost categories: record retrieval, expert witnesses, laboratory analysis, court fees, travel

8. Transition Timeline

Implementation follows a three-phase rollout over three years to ensure smooth transition without coverage disruptions:

8.1 Phase One: High-Clarity, High-Recovery Categories

Begin with conditions having clearest agency decorrelation and highest subrogation potential:

- Motor vehicle accidents (innocent victims)
- Catastrophic workplace injuries (Workers' Compensation integration)

These cases provide immediate demonstration of system benefits while generating revenue through systematic subrogation recovery.

8.2 Phase Two: Genetic and Environmental Categories

Expand coverage to:

- Genetic conditions and hereditary diseases
- Cancers with clear environmental or genetic causation

This phase tests the ICD-10 classification system at scale while covering conditions with strong public sympathy and clear agency decorrelation.

8.3 Phase Three: Full Implementation

Complete rollout with all remaining qualifying catastrophic conditions. By this point:

- Administrative systems fully operational
- Provider billing processes established
- Public confidence demonstrated

Full implementation aligned with federal fiscal year to coordinate budgetary processes.

9. Transition Costs

Because CHCA leverages existing infrastructure, transition costs are substantially lower than a de novo program. The following estimates are order-of-magnitude figures requiring formal cost analysis referencing ACA Health Insurance Exchange (~$4.6B) and Medicare Part D (~$1.2B) implementation analogies.

[IMPLEMENTATION NOTE: Formal transition cost analysis to be conducted during legislative development. Figures below are rough estimates for planning purposes only.]

Component	Description	Est. Cost
CHCA Trust Fund	New trust fund at Treasury (like Medicare HI)	Minimal
CMS Code Routing	Update claims routing rules for CHCA-qualifying codes	~$10–20M
State Ledger Portal	Medicaid/WC flow-through submission and reimbursement	~$50–100M
Rate Table System	Commercial rate lookup by state/policy	~$20–40M
Subrogation Portal	Case intake, assignment, tracking, DCAA-auditable payment	~$30–50M
HHS Code Review	Annual code list review, appeals, feedback integration	~$5–10M/year
Transparency Team	Premium release monitoring (temporary, 3–5 years)	~$10–20M/year
TOTAL ONE-TIME		~$110–210M
TOTAL ONGOING		~$15–30M/year

Transition costs are immaterial relative to annual fiscal improvement ~$64–79B).

10. Claims Processing Volume

CHCA does not create new claims volume—it redirects existing claims through existing infrastructure. The critical design principle is that providers already filing through CMS systems continue doing so; the only change is routing rules based on CHCA-qualifying diagnosis codes.

[IMPLEMENTATION NOTE: Detailed claims volume analysis by payer and code category to be conducted during transition planning. Analysis will quantify the subset of existing claims that carry CHCA-qualifying codes and verify CMS processing capacity.]

11. Summary: What Changes vs. What Stays

11.1 What Changes

- New CHCA contribution line on paychecks (like FICA)
- CHCA-qualifying codes route to CHCA instead of private insurers
- Private insurance premiums drop (coverage scope reduced)
- States submit Medicaid/WC ledgers for 100% federal reimbursement
- Systematic subrogation recovery from responsible parties

11.2 What Stays the Same

- Providers file claims through existing CMS systems
- Medicare and Medicaid payment rates unchanged
- State Medicaid and WC agencies continue current operations
- Provider enrollment and credentialing unchanged
- Patient experience unchanged—same providers, same access

12. Items for Legislative Committee Resolution

The following items require political negotiation rather than policy design:

- State participation mechanics: Details of flow-through objections and accommodations

- Specific subrogation tier thresholds: Exact dollar/percentile boundaries for recovery tiers
- Nationalized statute of limitations duration: Specific year limit for subrogation claims

Verification Statement

This document establishes the operational baseline for CHCA. All design decisions prioritize minimal infrastructure creation, leverage of existing systems, and cost neutrality at launch with efficiency gains over time.

- Quantitative Data Repository v1.22: Baseline spending ($575--645B), administrative savings ($41–46B), subrogation recovery ($23–33B total; $8–18B incremental)[6]
- Gap B Verification Document v1.3: Administrative cost differential methodology[7] (Himmelstein et al. 2020)[8]
- Gap D Verification Document v2.2: Subrogation recovery methodology and MSP program data[9]
- CHCA 10-Year Projection v1.3: Fiscal improvement projections ($538--758B constant 2026 dollars, pending recalculation)
- CHCA Quantitative Data Repository. Version 1.22. January 2026.   Baseline spending methodology; Derived-Subrogation v2.0 sheet[10]

---

[7]CHCA Working Documents. Gap B Verification Document. Version 1.3. December 2025. Administrative cost differential.
[8]Himmelstein, David U., Terry Campbell, and Steffie Woolhandler. "Health Care Administrative Costs in the United States and Canada, 2017." Annals of Internal Medicine 172, no. 2 (2020): 134-142. PMID: 31905376.
[9]CHCA Working Documents. Gap D Verification Document. Version 2.2. December 2025. Subrogation recovery methodology.