

The Case for Catastrophic Health Coverage Reform

A White Paper on the Catastrophic Health Coverage Act

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Executive Summary

Health insurance is supposed to protect families from financial ruin. For catastrophic illness, it fails. A 2024 American Cancer Society survey of 1,284 patients found that **98% of cancer patients who incurred medical debt were insured at the time of diagnosis**. Peer-reviewed research confirms cancer patients are 2.5 times more likely to declare bankruptcy than those without the disease; 42% deplete their life savings within two years of diagnosis; one in four with medical debt have declared bankruptcy or lost their homes. These are not uninsured Americans—they are workers with employer coverage doing everything right. Current insurance cannot protect against conditions that, through no fault of the patient, generate costs exceeding annual out-of-pocket maximums year after year. The Catastrophic Health Coverage Act addresses this structural gap.

The Catastrophic Health Coverage Act delivers **immediate, automatic, first-dollar coverage** for catastrophic illness and injury arising from circumstances beyond individual control. The legislation rests on the **agency principle**—distinguishing what people can change from what they cannot. This creates a bright line: complete personal responsibility for lifestyle choices; mutual protection against genuine misfortune. Qualifying categories include genetic conditions (cystic fibrosis, sickle cell, Huntington's), occupational injuries (construction accidents, mesothelioma, repetitive stress), environmental exposures (lead poisoning, PFAS contamination, toxic waste sites), and accidental injury not caused by the victim (motor vehicle crashes, violent crime, medical error).

CHCA is **consolidation, not expansion**. Americans already spend \$575–645 billion annually on these conditions through fragmented systems—private insurance, Medicare, Medicaid, workers' compensation—with duplicative administration, conflicting eligibility rules, and systematic cost-shifting from perpetrators to victims and taxpayers. CHCA unifies existing expenditure streams while generating \$41–46 billion in annual administrative savings by eliminating redundant billing, eligibility verification, and claims processing. This is fiscal stewardship: existing resources managed efficiently rather than scattered across disconnected bureaucracies. No new spending is required.

Wrongdoers pay—not taxpayers, not victims. When drunk drivers cause accidents, negligent employers injure workers, or corporations poison communities, CHCA ensures systematic federal recovery of all costs. Under current systems, insurers recover only 0.2–0.3% of expenditures through subrogation, and the tort system delivers just 53 cents of every dollar to claimants—the rest consumed by litigation overhead. Victims lack resources to pursue complex cases; most never try. CHCA reverses this failure through comprehensive subrogation to recover costs, proven through Medicare Secondary Payer mechanisms that have recovered over \$63 billion since 2015. The federal government cannot be outwaited or outspent; every qualifying incident triggers recovery proceedings.

The legislation **preserves individual responsibility**. CHCA covers only conditions arising from circumstances substantially beyond individual control. Conditions attributable to lifestyle choices remain explicitly outside its scope. This distinction, operationalized through existing ICD-10 diagnostic codes, maintains moral hazard where appropriate: Americans remain accountable for their choices while receiving protection against misfortune no one can prevent. Personal responsibility is strengthened, not weakened, by principled boundaries.

Private insurance is preserved for routine care. CHCA removes catastrophic tail risk—the unpredictable high-cost cases that drive premium volatility—while leaving the ordinary healthcare market intact. Employers gain predictable contributions in place of volatile catastrophic premiums; catastrophic exposure is removed from employer responsibility entirely. For insurers, premiums become more stable by eliminating the cost of outlier cases. The legislation complements rather than replaces existing market mechanisms.

CHCA corrects a seventy-year government distortion. The employer tax preference for health insurance—a 1943 wartime accident, not deliberate policy—created job lock that constrains labor markets. Sixteen percent of American workers remain trapped in jobs primarily for health insurance; for workers earning under \$48,000, that figure reaches **28**. Business ownership surges 13.8% in the single month Americans turn sixty-five and gain Medicare when catastrophic risk is finally addressed. Under CHCA, workers with qualifying conditions can change jobs, start businesses, or pursue opportunities without fear of losing catastrophic coverage.

Medical bankruptcy destroys what families earned through prudent behavior. Currently, 66.5% of bankruptcies involve medical bills—and **78% of those who filed had insurance**.

Accumulated savings, home equity, retirement funds can be wiped out by a genetic diagnosis or accident through no fault of the victim. CHCA protects property against uncontrollable catastrophic events while preserving accountability for controllable choices.

Fiscal Framework (All Figures in Billions)

Component	Annual	10-Year
Administrative Efficiency Savings	\$41–46	\$372–561
Systematic Subrogation Recovery	\$23–33	\$260–380
Total Fiscal Improvement	\$64–79	\$538–758

Note: Ten-year range reflects nominal dollars (high) and constant 2026 dollars (low) per CBO conventions.

Complementary to Patient-Directed Care. Health Savings Accounts effectively address routine healthcare expenses. However, maximum HSA contributions (\$8,750 annually for families) cannot mathematically close the gap when catastrophic patients hit their out-of-pocket maximum (\$18,400) year after year. CHCA and HSA expansion are complementary tools: HSAs smooth routine costs; CHCA addresses catastrophic tail risk that savings accounts cannot cover.

What CHCA Is Not. CHCA is not universal healthcare and is not Medicare expansion. It does not cover routine care, elective procedures, or lifestyle-related conditions. Private insurance remains the primary vehicle for ordinary healthcare. CHCA creates a targeted safety net for Americans struck by catastrophic illness through no fault of their own—applying principles of fiscal discipline, individual responsibility, and systematic accountability to solve a problem the current system cannot address.

Part I: The American Healthcare Paradox

When Medical Success Creates Economic Constraints

1.1 The Historical Context: America's Risk-Taking Heritage

America was built by risk-takers who abandoned the security of known systems for the promise of economic freedom and opportunity. From the Pilgrims seeking religious liberty to waves of immigrants pursuing economic advancement, American prosperity emerged from the willingness to accept uncertainty in pursuit of transcendent achievement. The westward expansion exemplified this spirit—each generation pushing beyond established settlements to create new opportunities, driving unprecedented economic growth and innovation.

This risk-taking heritage created the world's largest economy precisely because individuals felt free to pursue entrepreneurial ventures, change employment for better opportunities, and relocate for economic advancement. Economic mobility and business formation flourished when people could make decisions based on opportunity rather than security constraints. Our ancestors accepted that disease and injury were 'acts of God'—you either survived or you didn't, but these weren't economic calculations that entered into entrepreneurial risk assessment.

1.2 The Modern Constraint: Surviving Catastrophe as the New Risk

Today's healthcare financing system has fundamentally altered this calculus. Medical advances that can save lives and treat previously fatal conditions have created a new category of economic risk unknown to previous generations. Unlike the 'acts of God' that frontier Americans accepted as uncontrollable, modern catastrophic health events represent treatable but financially devastating circumstances that rational individuals must consider in every major economic decision.

The bitter irony of modern medicine: we've conquered death only to create a new category of financial risk. *Surviving catastrophe has become the risk.* A car accident, a genetic disorder, a workplace injury—these acts of God that once killed quickly now financially destroy slowly. The very success of American medicine has created a new Old World-style systematic financial constraints unknown to previous generations.

The result is a systematic constraint on the entrepreneurial behavior that historically drove American prosperity. When a software engineer won't start a company because her daughter has asthma, when a mechanic won't open his own shop because his wife survived breast cancer, when entire generations choose security over opportunity because medical bankruptcy looms—we've betrayed the very essence of American exceptionalism.

1.3 Verified Evidence: The Scope of Healthcare-Driven Economic Constraint

The empirical evidence documenting healthcare-driven economic constraint is extensive and comes from high-pedigree sources. The following findings represent systematically verified data from government sources and peer-reviewed research.

Healthcare Cost Avoidance and Delay:

- 28% of adults delay or forego healthcare due to cost^[14]
- 78% of those who filed bankruptcy due to medical expenses had health insurance^[15]

- \$220 billion in accumulated medical debt^[5]

Job Lock and Labor Market Distortion:

- 16% of workers stay in unwanted jobs solely for health insurance ^[7]
- 28% rate among workers in households earning <\$48,000 vs. 10% for >\$120,000 ^[7]
- 25% reduction in voluntary job turnover attributable to employer-provided insurance ^[10]
- 2022 Treasury Report explicitly identified health insurance extension as priority policy for reducing job lock

Healthcare Spending Concentration:

- Top 5% of patients account for 49.7% of total healthcare expenditures ^[1]
- Top 1% average \$166,980 annually; top 5% average \$71,067 ^[1]
- Medicare Fee-for-Service: top 5% account for 46% of spending (MedPAC Data Book, July 2024)^[11]
- 90% of the nation's \$4.9 trillion in healthcare expenditures are for people with chronic and mental health conditions^[3]

1.4 The Natural Experiment: What Medicare Eligibility Reveals

The most compelling evidence for understanding what drives job lock—and what would eliminate it—comes from a natural experiment occurring at age 65. Fairlie, Kapur, and Gates^[6] employed a regression discontinuity design using matched monthly Current Population Survey data to identify exact birth months, comparing business ownership rates in the months immediately before and after workers turn 65 and become Medicare-eligible.

KEY FINDING: Business ownership rates jump from 24.6% to 28.0% in the single month workers turn 65 and qualify for Medicare—a 3.4 percentage point absolute increase representing a 13.8% relative increase. No similar discontinuity occurs at any other age between 55 and 75.

The study methodology provides high confidence in these findings. The researchers analyzed 102,027 workers aged 55—75 from matched CPS surveys spanning 1996—2006, using a novel procedure to identify age in months rather than years. Controls included age function, year fixed effects, demographics, and industry. The regression discontinuity design isolates the effect of Medicare eligibility from other age-related factors.

This finding carries profound implications for policy design. Workers don't stay in unwanted jobs worried about routine care costs—they stay worried about catastrophic exposure. The moment universal catastrophic coverage becomes available through Medicare, entrepreneurship surges. CHCA would extend this liberation to all working-age Americans, eliminating the artificial barrier that currently forces workers to wait until age 65 to pursue entrepreneurship free from catastrophic health cost fear.

1.5 Why the Affordable Care Act (ACA) Did Not Fully Eliminate Job Lock

The Affordable Care Act attempted to reduce job lock by making comprehensive insurance available for purchase outside employment. The Urban Institute and Robert Wood Johnson Foundation projected 1.5 million additional self-employed Americans from ACA implementation. While Bailey and Dave^[2] found statistically significant self-employment increases of 3—4%, and the ACA demonstrably helped some entrepreneurs, the full projected gains were not realized. Understanding why illuminates CHCA's distinct value proposition.

First, the ACA did not eliminate catastrophic cost exposure. Marketplace plans include deductibles, out-of-pocket maximums, and coverage limitations that leave substantial catastrophic risk. A family facing cancer treatment may still face tens of thousands in out-of-pocket costs even with ACA coverage. The *fear* of catastrophic exposure persists because the *reality* of catastrophic exposure persists.

Second, ACA entrepreneurship effects proved sensitive to political uncertainty. Bailey, Colman, and Dave (2022) documented that gains were partially reversed during periods of political threat to the ACA. Workers considering entrepreneurship factor in the durability of coverage guarantees; uncertainty about the ACA's future reduced its effectiveness in encouraging risk-taking. Medicare, by contrast, carries no such political uncertainty—it has been stable for 60 years.

Third, the ACA's comprehensive coverage mandate creates costs that offset its benefits for entrepreneurs. Small business owners must either provide comprehensive coverage or pay penalties, and individual market premiums for comprehensive coverage can be substantial. CHCA's targeted catastrophic-only approach provides the protection entrepreneurs actually need—against events beyond their control—without the costs of comprehensive coverage mandates.

The Medicare age-65 natural experiment demonstrates that catastrophic coverage—not comprehensive government healthcare—unlocks entrepreneurship. Business ownership increases 13.8% when workers gain protection against catastrophic hospital costs, even though Medicare Part A does not cover comprehensive routine care. CHCA applies this insight to working-age Americans through a fundamentally different approach than Medicare expansion or comprehensive coverage mandates.

Part II: Foundational Principles

Agency, Consolidation, and American Values

2.1 The Agency Principle: Distinguishing Control from Circumstance

The cornerstone of effective catastrophic healthcare reform lies in the principle of **individual agency**—the capacity to control outcomes through personal choices and actions. In healthcare contexts, this principle provides the philosophical foundation for distinguishing between medical conditions that arise from individual decisions versus those arising from circumstances substantially beyond individual control.

Medical science already recognizes this fundamental distinction through established disease classification systems. The International Classification of Diseases (ICD-10), used worldwide for medical coding and insurance reimbursement, categorizes conditions by etiology and causation. Category Q covers congenital malformations and genetic disorders—clearly beyond individual agency. Category V covers external causes of injury—accidents and environmental exposures beyond individual control. Category Z covers lifestyle factors and behavioral risks—within individual agency.

Conditions arising from circumstances substantially beyond individual control—**agency-decorrelated conditions**—include:

- Genetic and hereditary disorders (approximately 80% of rare diseases have genetic origin)
- Environmental hazards and toxic exposures (PFAS, lead, industrial pollutants)
- Accidents caused by external parties (motor vehicle crashes involving innocent victims)

- Occupational injuries and illnesses arising from workplace hazards
- Infectious diseases contracted despite reasonable precautions
- Birth defects and congenital conditions

Conversely, conditions influenced substantially by individual lifestyle choices remain individual responsibilities: diet-related diabetes and cardiovascular disease, tobacco and alcohol-related conditions, preventable infectious diseases where vaccines or precautions were readily available, and similar conditions where individual behavior significantly influences outcomes.

2.2 The Agency Principle and American Values

The agency-based framework serves all three foundational American imperatives that justify catastrophic healthcare reform:

The Moral Imperative: Religious traditions across American denominations emphasize both compassion for neighbors in crisis and individual responsibility for personal choices. Agency-based coverage criteria align with these values by ensuring comprehensive assistance for genuinely uncontrollable circumstances while preserving individual accountability for lifestyle decisions. This eliminates moral hazard concerns while fulfilling collective obligations to help neighbors facing random catastrophic events. No American should face financial ruin from health conditions beyond their control—and the agency principle identifies exactly which conditions meet that criterion.

The Economic Imperative: Agency-based criteria optimize risk pooling by including only genuinely uncontrollable risks while preserving market incentives for individual health responsibility. This creates efficient insurance mechanisms that eliminate free-rider problems and moral hazard while ensuring comprehensive protection against truly random catastrophic events. The concentration of healthcare costs—with the top 5% of patients accounting for nearly 50% of spending^[1]—represents precisely the catastrophic tail risk that individuals cannot efficiently self-insure against.

The Patriotic Imperative: Individual agency represents a core American value—the belief that personal responsibility and individual choice drive prosperity and freedom. Agency-based catastrophic coverage preserves this value system while removing barriers to entrepreneurial risk-taking that arise from fear of uncontrollable catastrophic health events. The Catastrophic Health Coverage Act restores the original American bargain: take risks on your dreams, not on whether surviving cancer will bankrupt you.

2.3 The Consolidation Principle: Redirecting Existing Expenditures

The second foundational principle underlying effective catastrophic healthcare reform involves consolidating existing expenditures rather than creating new government spending. Analysis through systematic gap closure research reveals that Americans currently spend approximately **\$575—645 billion annually** on agency-decorrelated catastrophic healthcare through fragmented, inefficient systems.

The following table presents the verified breakdown of agency-decorrelated spending by category:

Category	Amount	Source
Genetic/Rare Diseases (direct medical)	~\$449 billion	[13]
Motor Vehicle (victim portion)	~\$25 billion	[12]
Occupational Injury/Illness	~\$67 billion	[9]
Environmental Exposure	\$50—105 billion	Bracketed estimate (see §7.3)

Category	Amount	Source
TOTAL AGENCY-DECORRELATED	~\$575—645 billion	Verified Data Repository v2.0

These existing expenditure streams already flow toward agency-decorrelated catastrophic healthcare but operate through disconnected systems with different rules, administrative structures, and cost recovery mechanisms. Private insurance companies bear approximately 47% of rare disease costs. Medicare bears 43%. Medicaid bears 10%. For motor vehicle crashes, private insurers pay 54% of costs, government pays 9%, individual victims pay 23%, and third parties pay 14%. The inefficiency lies not in inadequate resources but in poor coordination, duplicative bureaucracies, and systematic under-recovery of costs from liable parties.

Consolidating these existing streams eliminates duplication while enhancing coverage through economies of scale, systematic cost recovery, and administrative streamlining. The approach achieves conservative fiscal responsibility by avoiding new government spending while accomplishing progressive coverage goals through comprehensive catastrophic protection.

2.4 The Accountability-Through-Recovery Principle

The third foundational principle—and one that emerged as central through systematic analysis—involves transforming cost recovery from catastrophic events caused by liable parties. This is not merely an economic optimization; it represents a **superior moral framework** that aligns economic efficiency with justice.

Current fragmented systems recover less than 30% of healthcare costs from responsible parties. Health insurers recover only 0.2—0.3% of their expenditures through subrogation, according to Department of Labor surveys. Individual victims lack resources to pursue complex litigation against well-funded defendants. Even when recovery occurs, legal fees typically consume 40—60% of settlements, leaving victims with insufficient funds to cover care costs.

The result is systematic socialization of costs that should be borne by liable parties—drunk drivers, negligent employers, polluting corporations—creating perverse incentives for negligent behavior while imposing costs on innocent victims and taxpayers. This current system fails on every dimension: it fails to provide adequate care for victims, fails to recover appropriate costs from responsible parties, and fails to create deterrent effects against negligent behavior.

The Accountability-Through-Recovery Principle transforms this failure into a system that serves both economic efficiency and moral justice:

1. **Immediate Victim Care:**
Victims receive comprehensive treatment immediately, without waiting for litigation resolution or worrying about personal financial resources. Care decisions are made on medical merit, not financial constraints.
2. **Proper Cost Allocation:**
Responsible parties bear the costs their negligence created. Drunk drivers, negligent employers, and polluting corporations pay for the harm they cause rather than externalizing costs to innocent victims and taxpayers.
3. **Systematic Deterrence:**
Unlike fragmented individual recovery that depends on victim resources and attorney availability, systematic government subrogation creates consistent accountability. Every qualifying incident triggers recovery proceedings, creating predictable consequences for negligent behavior.
4. **Economic Efficiency:**
Government subrogation achieves economies of scale that individual litigation cannot.

The Medicare Secondary Payer program^[4] demonstrates this potential, achieving savings of \$9.04 billion in FY2024 with documented ROI substantially exceeding costs. Systematic expansion could recover \$23—33 billion annually (baseline ~\$15 billion under current law; CHCA adds \$8—18 billion net incremental recovery).

The Accountability-Through-Recovery Principle is not merely a funding mechanism—it is a statement of American values. When a drunk driver causes a catastrophic accident, the victim should receive immediate care, the drunk driver should bear the costs, and the system should create deterrent effects against drunk driving. Current systems fail all three objectives. CHCA succeeds on all three. This is a **win-win both economically and morally**.

Part III: The Fiscal Framework

Ten-Year Projections Under Conservative and Nominal Assumptions

3.1 Methodology and Assumption Framework

The fiscal projections presented in this section follow Congressional Budget Office (CBO) scoring conventions, presenting figures in both nominal dollars (actual dollars spent or saved in each year, including inflation) and constant 2026 dollars (inflation-adjusted to show real economic impact). Two scenarios are modeled to stress-test CHCA's fiscal claims.

Conservative Scenario: 'Conservative' in fiscal analysis means *pessimistic for the program*—assumptions that stress-test claims by projecting higher costs and lower savings. This scenario assumes 6.5% nominal cost growth (versus Centers for Medicare and Medicaid Services (CMS) baseline of 5.6%), only 5.0% administrative savings (versus 7.0% potential), and \$23 billion subrogation base with 2.0% real growth.

Nominal Scenario: Uses CMS and CBO baseline projections: 5.6% nominal cost growth, 7.0% administrative savings rate, and \$33 billion subrogation base with 3.0% real growth.

The following table compares key assumptions across scenarios:

Parameter	Conservative	Nominal
Admin Savings Rate	5.0%	7.0%
Subrogation Base (Year 1)	\$23 billion	\$33 billion
Subrogation Real Growth	2.0%	3.0%

3.2 Ten-Year Projection Summary

The following table presents the aggregated 10-year fiscal results across both scenarios and dollar bases:

Scenario / Dollar Basis	10-Year Baseline	Fiscal Improvement
Conservative — Constant 2026 \$	\$7,443 billion	\$538 billion
Nominal — Nominal \$	\$8,020 billion	\$758 billion
Nominal — Constant 2026 \$	\$7,141 billion	\$675 billion

KEY FINDING: Even under pessimistic 'conservative' assumptions that stress-test CHCA's claims, the program generates ~\$538—600 billion in 10-year fiscal improvement. Under nominal CMS/CBO baseline assumptions, fiscal improvement reaches ~\$675—758 billion. For CBO scoring purposes, the relevant figures are the nominal dollar projections.

3.3 Fiscal Improvement Components

CHCA's fiscal improvement derives from two primary sources: administrative efficiency savings from consolidation and systematic subrogation recovery from responsible third parties.

Administrative Efficiency Savings:

The United States spends 34.2% of health expenditures on administration versus 17.0% in Canada, according to Himmelstein et al.^[8]. This represents \$2,497 per capita in U.S. administrative costs versus \$551 per capita in Canada—a differential of \$1,946 per person. Applied to the agency-decorrelated catastrophic segment of ~\$575—645 billion, consolidation could achieve administrative savings of 7% (consistent with the U.S.—Canada differential applied to the relevant spending category), generating \$41—46 billion annually. Under conservative assumptions reducing the savings rate to 5%, annual administrative savings would be \$30—33 billion.

Systematic Subrogation Recovery:

The Medicare Secondary Payer (MSP) program^[4] demonstrates that systematic government subrogation works. CMS reports MSP savings of \$9.04 billion in FY2024, with Congressional Research Service documenting \$9.7 billion in FY2021 savings. The current recovery system remains fragmented and case-by-case—individual victims must decide whether to pursue complex litigation against well-funded defendants, and most never do. Systematic government subrogation across 100% of qualifying incidents—motor vehicle accidents, workplace injuries, product liability, environmental exposures—could recover \$23—33 billion annually based on the corrected subrogation framework: baseline recovery (~\$15 billion) continues under current law operations, while CHCA adds \$8—18 billion in net incremental recovery through enhanced motor vehicle recovery, workers' compensation employer liability expansion, and systematic environmental/product liability pursuit. Over 10 years, this generates ~\$260—380 billion in total subrogation recovery.

3.4 What CHCA Does NOT Do: Cost Shifting Clarification

CHCA consolidates existing spending—it does not create new spending or shift costs to the federal government. The \$575—645 billion in agency-decorrelated catastrophic spending is *already being spent* through fragmented systems: private insurance companies pay approximately \$280 billion, Medicare pays approximately \$200 billion, Medicaid pays approximately \$60 billion, workers' compensation pays approximately \$50 billion. CHCA redirects these existing expenditure streams into a unified program while generating additional resources through administrative efficiency and systematic cost recovery.

The contribution structure overlays existing federal collection infrastructure. Payroll contributions (50% employer / 50% employee split) replace private insurance catastrophic premiums that employers and employees already pay. Self-employment contributions replace individual market catastrophic premiums. Investment income contributions follow the existing Net Investment Income Tax (NIIT) model. State workers' compensation pools contribute at actuarial rates and receive 100% reimbursement for qualifying claims. The net effect for most taxpayers is approximately neutral—a new CHCA contribution rate of approximately 1.0—1.2% is offset by reduced private insurance premiums and reduced ACA tax rates.

Part IV: Stakeholder Impact Analysis

Universal Benefits Through Principled Reform

CHCA creates unusual stakeholder alignment through genuine value creation rather than zero-sum redistribution. Unlike traditional healthcare legislation that creates winners and losers, the

consolidation approach generates benefits across all major stakeholder groups while imposing costs only on inefficient administrative practices and negligent actors.

4.1 Insurance Industry: Improved Profitability Through Risk Transfer

Private health insurance companies represent primary beneficiaries of agency-based catastrophic care consolidation. Industry financial data reveals that catastrophic claims generate the largest losses and greatest unpredictability in insurance operations, violating actuarial principles while creating systematic underwriting losses.

By transferring catastrophic coverage obligations to the consolidated program, insurance companies eliminate their most problematic business segment while retaining profitable routine care coverage. Actuarial uncertainty decreases dramatically when catastrophic risk is removed from private insurance portfolios. Current systems require insurance companies to price coverage for genetic disorders, environmental exposures, and random accidents—events genuinely beyond individual control that violate insurance risk pooling principles because they cannot be diversified away or predicted at the individual level.

Claims processing costs decline as complex catastrophic cases move to the government system. Insurance companies currently maintain expensive administrative functions for catastrophic coverage determination, often involving lengthy disputes over coverage limitations and lifetime benefit caps. Eliminating catastrophic coverage responsibilities reduces administrative overhead while improving customer satisfaction through clearer coverage boundaries.

4.2 Healthcare Providers: Fair Compensation and Reduced Administrative Burden

Healthcare providers—hospitals, physicians, and ancillary services—gain significantly from consolidated catastrophic coverage. Current fragmented systems often result in inadequate reimbursement for catastrophic care, particularly from Medicare and Medicaid programs that underpay for complex cases while private insurance creates administrative burdens through prior authorization and coverage disputes.

Emergency departments particularly benefit from consolidated catastrophic coverage. These facilities currently provide uncompensated catastrophic care for patients facing financial barriers, generating systematic losses that threaten emergency care availability. Consolidated catastrophic coverage eliminates these losses while ensuring immediate payment for all catastrophic care services regardless of patient insurance status.

Rural and community hospitals receive particular benefits from catastrophic coverage consolidation. These facilities currently face financial pressure from catastrophic cases that exceed their capacity to absorb losses while serving communities with limited resources. Guaranteed reimbursement for catastrophic care provides financial stability that enables continued operation and community service.

4.3 Legal Profession: Market Expansion Through Systematic Recovery

The legal profession experiences dramatic expansion of opportunities through systematic government subrogation combined with preserved private rights to punitive damages. Current tort systems exclude most catastrophic victims from legal representation due to financial constraints, while those who obtain representation lose 40—60% of recoveries to legal fees.

The government contractor system for cost recovery provides attorneys with guaranteed compensation at 10% of recovery amounts, eliminating contingency risk while ensuring steady income streams from systematic subrogation operations. This enables legal professionals to

pursue cases that are currently uneconomical, dramatically expanding the market for legal services related to catastrophic events caused by liable parties.

Simultaneously, private legal rights remain fully preserved for non-medical compensatory, punitive damages, pain and suffering, and other non-compensatory claims. Attorneys maintain access to the highest-value aspects of catastrophic litigation while gaining government-backed compensation for medical cost recovery. The combination expands both the quantity and profitability of legal work related to catastrophic events.

4.4 Workers and Families: Economic Freedom Restored

Workers and their families receive the most transformative benefits from CHCA: restoration of the economic freedom that healthcare anxiety currently constrains. The 16% of workers currently trapped in unwanted jobs for health insurance—rising to 28% for lower-income workers—gain the ability to pursue optimal employment opportunities without catastrophic coverage concerns.

Portable catastrophic coverage enables workers to pursue better opportunities without healthcare coverage constraints, strengthening individual negotiating position while improving overall labor market efficiency. Workers facing family members with chronic conditions—diabetes, heart disease, genetic predispositions—can consider entrepreneurship or career changes without the calculus of catastrophic cost exposure.

Medical bankruptcy prevention protects family stability while enabling continued economic participation. The 66.5% of bankruptcies involving medical bills—most affecting families who *had* health insurance—would be prevented when the underlying catastrophic costs arise from agency-decorrelated conditions.

4.5 American Enterprise: From Entrepreneurs to Established Businesses

The benefits of catastrophic coverage reform extend beyond individual workers to American businesses of all sizes. CHCA removes from employer responsibility one specific component of healthcare coverage: catastrophic costs arising from agency-decorrelated conditions. This targeted reform mitigates the most severe volatility, the most unpredictable planning disruptions, and the most significant distortion of employment decisions—while preserving employer-based coverage for routine care, dental, vision, and lifestyle-related conditions.

4.5.1 The Accidental Healthcare Administrator

The American employer-based healthcare system emerged from a historical accident—World War II wage controls that led employers to compete on benefits rather than wages. Eight decades later, this system forces every American business owner into a role none of them sought: healthcare benefits administrator. A machine shop owner, a software startup founder, a restaurant chain CEO—all dedicate time and resources to healthcare decisions that have nothing to do with their core competencies.

CHCA does not propose to dismantle this system. Employer-based coverage for routine care, dental, vision, and lifestyle-related conditions would continue. Many employees value these benefits, and employers use them effectively for talent attraction and retention. What CHCA does is remove one component from employer responsibility entirely: catastrophic costs arising from agency-decorrelated conditions. This portion—currently embedded in employer coverage and driving much of the volatility and risk—would become a universal, portable benefit tied to the individual, not the job.

4.5.2 How Catastrophic Claims Drive the Worst Volatility

Annual healthcare cost increases are a fact of business life, and CHCA does not change that reality for routine care. However, the most severe premium volatility—the 30—40% renewal spikes that upend business planning—often traces to catastrophic claims. When a small group's renewal spikes dramatically, it frequently reflects a \$400,000 cancer treatment, a premature infant requiring months of NICU care, or a severe accident with prolonged rehabilitation.

Many of these devastating claims arise from agency-decorrelated conditions: the genetic disorder no one could have predicted, the rare disease that struck without warning, the catastrophic accident caused by a third party. Under CHCA, these costs would no longer flow through employer plans at all. They would be covered by the CHCA program from the first dollar, routed by ICD-10 diagnosis code before ever reaching the employer's risk pool.

This would mitigate—not eliminate—premium volatility. Routine care costs would still fluctuate. Lifestyle-related conditions would still affect renewals. Dental and vision utilization would still vary. But the specific tail risk from agency-decorrelated catastrophic events—the component that transforms a manageable renewal into a crisis—would be removed from employer exposure for working-age employees and their dependents.

4.5.3 Scale Creates Different Exposures—CHCA Addresses the Common

Problem

The catastrophic tail risk problem manifests differently across business sizes, but the underlying vulnerability is shared:

Small Businesses (Under 50 Employees): In a 25-person company, one employee's child diagnosed with a rare genetic condition can move renewal rates dramatically. The owner faces an agonizing situation: absorb costs that strain the business, pass increases to employees who may leave, or change plans and disrupt everyone's care relationships. Under CHCA, that child's rare genetic condition would be covered by the CHCA program, not the employer's insurance. The claim would never enter the employer's risk pool. The reputational risk also changes—when a rare disease treatment is denied by the company's insurer, the business owner currently becomes the face of that decision. Under CHCA, agency-decorrelated catastrophic coverage decisions would be made outside the employer relationship entirely.

Medium Businesses (50—500 Employees): HR departments exist but catastrophic claims still move renewal economics and consume disproportionate attention. Under CHCA, agency-decorrelated cases would be covered outside the employer plan. Benefits planning could focus on routine care design, employee preferences for dental and vision options, and wellness program effectiveness—rather than catastrophic risk management for events no employer decision could have prevented.

Large Businesses (500+ Employees): Even with sophisticated benefits teams, self-insurance arrangements, and stop-loss coverage, catastrophic cost management consumes executive attention. CHCA would not eliminate employer healthcare administration—large employers would still manage substantial routine care programs. But agency-decorrelated catastrophic costs would no longer factor into self-insurance calculations, stop-loss purchasing decisions, or reserve requirements.

4.5.4 Talent Decisions: Removing Catastrophic Fear from Employer Choice

Currently, workers with family members who have chronic conditions, genetic predispositions, or histories of serious illness weight employer selection heavily based on healthcare coverage robustness. The worker whose child has a rare disease, the employee whose spouse survived cancer, the prospective hire with a family history of genetic disorders—these individuals

scrutinize employer health plans intensely, often accepting lower compensation or less fulfilling work in exchange for perceived coverage security.

Under CHCA, agency-decorrelated catastrophic coverage would not be part of employer benefits at all. The worker with a family history of genetic disease would have CHCA coverage regardless of employer—whether working for a Fortune 500 company, a 20-person startup, or self-employed. The question 'does this employer's plan adequately cover genetic disorders?' would not arise, because genetic disorders would be covered by CHCA, not the employer.

This does not equalize all benefits competition. Large employers would still offer more comprehensive routine care packages, better dental and vision coverage, more generous wellness programs. Workers would still consider these factors. What changes is that catastrophic protection for agency-decorrelated conditions exits the employer comparison entirely. It becomes a non-factor in job choice—not because employers offer equivalent protection, but because this protection exists independent of employment.

4.5.5 What CHCA Does and Doesn't Change for Business

CHCA Would Remove from Employer Responsibility:

- Catastrophic costs for agency-decorrelated conditions (genetic, accidents, environmental, occupational)
- Premium volatility driven by agency-decorrelated catastrophic claims
- Risk pool exposure to rare disease, serious accidents, and similar uncontrollable events
- Coverage decisions for agency-decorrelated conditions (and associated reputational risk)
- Employee evaluation of employer catastrophic coverage for uncontrollable conditions

CHCA Would Leave Unchanged:

- Employer-based coverage for routine care, dental, vision, wellness
- Annual routine care cost fluctuations and enrollment cycles
- Benefits administration burden for non-catastrophic coverage
- Large employer advantages in comprehensive routine benefits packages
- Employer healthcare costs for lifestyle-related conditions
- The fundamental structure of American employer-based coverage

The honest case for CHCA's business benefits is bounded but genuine: it removes from employer responsibility the specific component of healthcare coverage that creates the most severe volatility, the most painful decisions, and the most significant distortion of employment choices—catastrophic costs arising from circumstances beyond anyone's control. Business owners would still administer healthcare benefits. They would still evaluate routine care plans, manage enrollments, and navigate renewals for dental, vision, and non-catastrophic medical coverage. But the scenario that haunts small business owners—the employee's child diagnosed with a \$2 million rare disease that transforms next year's renewal—would no longer be their problem to solve.

4.6 Government Programs: Improved Financial Performance

Medicare and Medicaid programs achieve substantial financial improvements through catastrophic cost transfer that aligns with agency-based principles. These programs currently bear enormous, unpredictable costs for catastrophic care while lacking systematic cost recovery mechanisms.

Medicare solvency improves as catastrophic costs transfer to the CHCA Trust Fund while systematic subrogation recovers costs from responsible parties. State Medicaid budgets receive fiscal relief from catastrophic costs that currently consume disproportionate resources. Workers' compensation systems gain predictability as catastrophic workplace injuries transfer to federal coverage.

Part V: Operational Design

Minimal Infrastructure, Maximum Leverage of Existing Systems

5.1 Core Design Philosophy

CHCA's operational design prioritizes minimal new infrastructure creation, leveraging existing CMS claims processing, IRS collection mechanisms, and state systems. The core principle is that providers already filing claims through Medicare/Medicaid systems continue using existing infrastructure—the only change is routing rules based on ICD-10 diagnosis codes.

Key design principles include:

- **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 diagnosis code routes claim to CHCA. No coordination of benefits logic required.
- **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.

5.2 Contribution Structure

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

Contribution streams by income type:

Income Type	Mechanism	Infrastructure
Self-Employment	SE tax equivalent: full burden on individual	Same rate as combined payroll
Investment Income	NIIT-style contribution: same rate, \$400k threshold (matching SE floor)	Existing NIIT infrastructure
State WC Pools	Actuarial contribution rate; receive 100% reimbursement	States contribute at predicted cost

5.3 Claims Processing Flow

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—the only change is routing rules based on diagnosis codes.

For state programs (Medicaid and Workers' Compensation), a flow-through model eliminates provider-facing changes. States continue their current operations, pay providers immediately, tag claims with CHCA-qualifying ICD-10 codes, submit periodic annotated ledgers to the CHCA portal, and receive 100% federal reimbursement (not Federal Medical Assistance Percentage (FMAP) share—full reimbursement) for qualifying expenditures.

5.4 Subrogation Operations

Legal recovery contractors operate under Federal Acquisition Regulation (FAR)-compliant, Defense Contract Audit Agency (DCAA)-auditable contracts with transparent fee structures. The loser-pays model ensures defendants bear all costs when liable: medical costs recovered plus direct litigation costs (auditable) plus attorney fee (effectively 10% through full rate billing plus award fee). CHCA receives full medical recovery; attorneys receive auditable direct costs plus 10% fee net; defendants bear all costs when found liable.

Victims retain all rights to pursue punitive damages and non-economic compensation through private attorneys. CHCA subrogation covers only the compensatory medical cost portion—the accountability principle ensures responsible parties pay for harm caused while preserving victim rights to additional recovery.

5.5 Implementation Timeline

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

Phase One: High-Clarity, High-Recovery Categories. Begin with conditions having clearest agency decorrelation and highest subrogation potential: motor vehicle accidents (innocent victims) and catastrophic workplace injuries (Workers' Compensation integration). These cases provide immediate demonstration of system benefits while generating revenue through systematic subrogation recovery.

Phase Two: Genetic and Environmental Categories. Expand coverage to genetic conditions and hereditary diseases, plus 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.

Phase Three: Full Implementation. Complete rollout with all remaining qualifying catastrophic conditions. By this point, administrative systems are fully operational, provider billing processes are established, and public confidence has been demonstrated.

Part VI: Broad Appeal and Political Sustainability

6.1 Appeal to Economic Freedom and Limited Government Advocates

CHCA addresses concerns central to limited-government philosophy. The legislation eliminates a government-created distortion—the employer tax preference for health insurance—that constrains labor markets and reduces economic efficiency. It preserves market-based coverage for routine care with no comprehensive mandate. It restores the risk-taking ethos foundational to American enterprise while maintaining individual responsibility for lifestyle-related health decisions. It reduces government's role relative to comprehensive coverage alternatives by addressing only the market failure in catastrophic coverage.

Fiscal responsibility emerges through existing resource consolidation rather than new spending, addressing concerns about government expansion and debt accumulation. The approach demonstrates that government optimization can reduce costs while enhancing services. Individual responsibility remains paramount through agency-decorrelated coverage criteria that preserve personal accountability for lifestyle-related health costs.

6.2 Appeal to Workers and Working Families

CHCA directly addresses the economic constraints facing working families. It frees workers to pursue better opportunities without catastrophic exposure fear. It particularly benefits lower-income workers who face the highest job lock rates (28% versus 10% for higher-income workers). It enables career transitions, retraining, and entrepreneurship at any working age—not just after 65. It provides security against misfortunes beyond individual control while preserving the connection between effort and reward.

Healthcare access expansion particularly benefits communities currently facing catastrophic care barriers. Rural areas gain access through guaranteed reimbursement. Environmental justice communities receive comprehensive coverage for exposure-related conditions while systematic subrogation ensures cost recovery from responsible parties.

6.3 Stakeholder Coalition Durability

The legislation creates unusual stakeholder alignment through genuine value creation rather than zero-sum redistribution, enabling durable political coalition formation across traditional ideological divisions. Insurance companies gain improved profitability through catastrophic risk elimination. Healthcare providers receive enhanced reimbursement and reduced administrative burden. Legal professionals experience market expansion. Government programs achieve improved financial performance. Workers gain economic freedom.

This stakeholder alignment creates durable political coalition potential through shared interests rather than ideological agreement. Unlike traditional healthcare legislation that creates winners and losers, the consolidation approach generates benefits across all major stakeholder groups while imposing costs only on inefficient administrative practices that lack political constituency.

Part VII: Conclusion

The Choice Between Freedom and Constraint

The Catastrophic Health Coverage Act offers America a choice between continued acceptance of healthcare-driven economic constraints or restoration of the entrepreneurial freedom that built American prosperity.

The evidence is clear. Business ownership surges 13.8% the moment workers gain catastrophic coverage through Medicare—not comprehensive coverage, *catastrophic* coverage. Workers don't remain trapped in jobs worried about routine care costs; they stay worried about \$100,000+ exposure for cancer, major accidents, or chronic illness. CHCA addresses exactly this fear by providing universal coverage for events beyond individual control while preserving market-based coverage for routine care and individual responsibility for lifestyle choices.

The fiscal case is verified. CHCA consolidates \$575—645 billion in existing agency-decorrelated catastrophic spending—not creating new programs but redirecting existing fragmented expenditure streams into a unified system. Through administrative efficiency and systematic subrogation, the program generates ~\$538—758 billion in 10-year fiscal improvement depending on assumptions. Even under pessimistic stress-testing, CHCA improves the fiscal position.

The moral case is compelling. The Accountability-Through-Recovery Principle ensures that victims receive immediate care, responsible parties bear appropriate costs, and systematic deterrence reduces negligent behavior. Current systems fail all three objectives. CHCA succeeds on all three. This is a win-win both economically and morally.

The political coalition is achievable. Unlike traditional healthcare legislation that creates winners and losers, CHCA generates benefits across all major stakeholder groups: insurance companies gain improved profitability, healthcare providers receive fair compensation, legal professionals see market expansion, government programs achieve better financial performance, and workers gain economic freedom. The only losers are inefficient intermediaries and negligent actors—constituencies with limited political power.

Current healthcare financing systems have transformed productive citizens through healthcare cost anxiety rather than empowering them with economic freedom and entrepreneurial opportunity. These constraints limit the economic dynamism that historically drove American prosperity and innovation.

The Catastrophic Health Coverage Act provides the framework for breaking these artificial constraints. It consolidates existing catastrophic healthcare expenditures into an efficient, comprehensive system based on agency principles that serve American values and interests. It achieves conservative fiscal responsibility and progressive social protection simultaneously through principled system optimization rather than expansion.

The choice is clear: continue accepting systematic constraints on economic freedom for circumstances genuinely beyond individual control, or restore the American bargain that built our prosperity. Take risks on your dreams, not on whether surviving cancer will bankrupt you.

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