CATASTROPHIC HEALTH COVERAGE ACT

Subrogation White Paper

A Comprehensive Analysis of Systematic Government Subrogation

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Executive Summary

The Catastrophic Health Coverage Act (CHCA) institutes systematic government subrogation to recover costs from parties responsible for agency-decorrelated catastrophic injuries and illnesses. This mechanism serves dual purposes: fiscal improvement through cost recovery and proper cost allocation to create deterrence incentives for negligent conduct. The subrogation framework builds on four decades of proven federal precedent under the Medicare Secondary Payer (MSP) program while extending recovery to the full scope of CHCA-covered conditions.

Under current fragmented systems, tort recovery is haphazard and inefficient. Only 53 cents of every tort dollar reaches injured claimants—the remainder is consumed by litigation costs and administrative overhead.[1] Individual victims must decide whether to pursue complex litigation against well-funded defendants, often accepting inadequate settlements or abandoning claims entirely due to resource constraints. Meanwhile, responsible parties escape appropriate accountability when victims lack the means to pursue claims.

CHCA transforms this dynamic through three integrated mechanisms. First, the government pays medical costs immediately, ensuring victim care is never delayed pending litigation or settlement. Second, the government pursues systematic subrogation recovery of those medical costs from liable third parties—negligent drivers, polluters, manufacturers of defective products—using economies of scale and legal resources unavailable to individual litigants. Third, the government's subrogation action creates informational leverage that benefits victims pursuing independent non-medical claims: liability determinations, asset verification, and causation findings from CHCA proceedings provide collateral estoppel advantages that reduce victims' subsequent litigation to damages-only proceedings.

The economic framework for attorney compensation under CHCA subrogation employs Cost-Plus-Fixed-Fee (CPFF) contracting combined with recovery-based incentive fees. This structure eliminates the capital barriers that currently exclude over 75% of personal injury practitioners from full market participation while maintaining equivalent net profit margins for participating attorneys. Analysis demonstrates that a 6–8% incentive fee rate, combined with labor reimbursement at approved billing rates, achieves compensation parity with traditional 33% contingency practice after adjusting for eliminated capital costs and case-loss risk.

The potential fiscal impact is substantial. The MSP program currently generates approximately $9 billion annually in savings through subrogation and coordination of benefits.[2] CHCA's systematic extension to motor vehicle accidents, workplace injuries, product liability, and environmental exposures could achieve total annual recovery of **$23–33 billion** (baseline ~$15 billion under current law plus **$8–18 billion incremental recovery** from new CHCA authority)—representing both economic efficiency and appropriate moral allocation of costs to responsible parties rather than innocent victims and taxpayers.[3]

Section 1: The Agency Principle and Cost Recovery

1.1 Foundation: Agency-Decorrelated Conditions

CHCA's coverage scope is defined by the agency principle: the program covers healthcare costs arising from conditions beyond individual agency—genetic and rare diseases, accidents involving innocent victims, occupational injuries and illnesses, and environmental exposures.[4] Conditions attributable to individual lifestyle choices remain personal responsibility. This philosophical distinction creates both the moral foundation for collective coverage and the logical basis for systematic cost recovery.

When a condition arises from circumstances beyond the individual's control, collective coverage is appropriate because no individual choice created the risk. When a third party's negligence or wrongful conduct caused the condition, that party—not the collective—should bear the costs. CHCA implements both principles: collective coverage ensures immediate care regardless of fault determination, while systematic subrogation ensures costs ultimately flow to responsible parties.

1.2 The Accountability-Through-Recovery Principle

Traditional tort recovery systems require victims to pursue compensation while simultaneously managing their medical care, employment disruption, and recovery. This creates a fundamental tension: the most injured victims are often least capable of navigating complex litigation. Worse, defendants can exploit this asymmetry by delaying proceedings, confident that financially stressed victims will accept inadequate settlements.

CHCA resolves this tension through what may be termed the "Accountability-Through-Recovery Principle": immediate victim care combined with systematic cost recovery from responsible parties. The government advances medical costs, ensuring care is never compromised by litigation uncertainty. The government then pursues recovery with resources, expertise, and persistence unavailable to individual litigants. Responsible parties cannot escape accountability by exploiting victim vulnerability.

This principle achieves both economic efficiency—costs are borne by parties best positioned to prevent harm—and moral justice—victims receive care without being forced to trade health outcomes for financial necessity.

1.3 Verified Baseline: Agency-Decorrelated Spending

The CHCA fiscal framework rests on verified baseline spending of $575–645 billion annually in agency-decorrelated catastrophic costs.[5] This figure comprises rare and genetic disease costs of approximately $450 billion in direct medical expenditures,[6] motor vehicle accident costs of approximately $25 billion in innocent victim medical costs,[7] occupational injury and illness costs of $50–65 billion,[8] and environmental exposure costs of $50–105 billion (bracketed estimate pending refined methodology).[9]

These categories share the defining characteristic of agency-decorrelation: individuals did not choose to acquire genetic conditions, be struck by negligent drivers, be injured in workplace incidents, or be exposed to environmental toxins. The costs arise from circumstances beyond individual control, creating the moral basis for collective

coverage and—where third-party fault exists—the practical basis for subrogation recovery.

1.4 Recovery Categories and Subrogation Standing

Not all agency-decorrelated conditions involve recoverable third-party liability. Genetic conditions, while clearly agency-decorrelated, typically involve no liable third party. Motor vehicle accidents involving innocent victims, by contrast, almost always involve a negligent tortfeasor. The following categorization guides CHCA's recovery approach:

Table 1: Agency-Decorrelation and Subrogation Potential by Category

Category	Agency-Decorrelation	Subrogation Potential
Genetic/Rare diseases	Complete	Limited (except product liability, environmental)
Motor vehicle (innocent victim)	Complete	High (negligent driver or manufacturer)
Occupational injury/illness	Complete	Moderate (third-party liability; employer immunity)
Environmental exposure	Complete	High (polluter liability)
Defective products	Complete	High (manufacturer liability)

CHCA's subrogation standing derives from the same principle that governs all insurance subrogation: the payer who advances costs succeeds to the victim's right of action against the responsible party. Having paid the victim's medical expenses, CHCA acquires the legal standing to pursue recovery from the tortfeasor.

Section 2: Current System Limitations

2.1 Fragmented Recovery: The "Haphazard" System

The current tort recovery system operates without systematic coordination. Individual victims must identify liable parties, retain counsel, advance litigation costs (or find attorneys willing to do so), and navigate proceedings that may extend for years. This creates what one Congressional Research Service report characterized as "haphazard" recovery—some victims pursue claims successfully, many settle for inadequate amounts, and a substantial fraction never pursue claims at all.[10]

The fragmentation imposes costs on all parties. Victims face uncertainty about whether they will recover anything and when. Defendants face unpredictable exposure depending on which victims pursue claims. Society bears externalized costs when responsible parties escape accountability. The legal system processes identical factual questions—the same accident, the same defendant—multiple times when multiple victims pursue separate claims.

2.2 Tort System Efficiency: 53 Cents on the Dollar

Empirical research documents the inefficiency of current tort recovery. Analysis indicates that only approximately 53 cents of every tort dollar reaches claimants—47% is consumed by transaction costs including legal fees, administrative overhead, and litigation expenses.[11] This inefficiency persists despite decades of tort reform efforts because the fundamental structure—individual claimants pursuing separate actions against well-resourced defendants—guarantees high per-case transaction costs.

The inefficiency falls disproportionately on victims with smaller claims. A victim with $50,000 in medical expenses may find that $20,000 in legal fees and costs makes recovery uneconomical, while a victim with $500,000 in expenses can absorb proportionally similar costs. The current system effectively immunizes defendants whose negligence causes moderate harm while concentrating litigation on catastrophic cases.

2.3 Capital Barriers in Personal Injury Practice

Traditional contingency practice requires attorneys to advance litigation costs—expert witnesses, depositions, court fees, medical records, document production—with recovery delayed until case resolution. A mid-size firm handling 120 cases may have $6–8 million deployed in advanced costs at any time.[12] This capital carries costs of 10–15% annually, consuming approximately 10% of firm revenue before any case resolves.

The capital requirement creates structural barriers to entry. Attorneys without access to capital cannot compete regardless of legal skill. The result is market concentration: over 75% of personal injury firms are solo or small practices with fewer than six attorneys, yet these firms lack the capital base to pursue the same cases as well-capitalized competitors.[13] Capital access—not legal skill—determines market participation.

For victims, capital barriers mean fewer attorneys willing to take moderate-value cases and less competitive pressure on fees. For attorneys, capital barriers mean choosing between cases based on financing availability rather than merit. For the legal system, capital barriers mean inefficient allocation of legal talent.

2.4 Victim Outcomes Under Traditional Practice

Under traditional contingency arrangements, victims lose 33–40% of gross recovery to attorney fees, plus advanced costs recovered from proceeds.[14] Medical debt often consumes remaining recovery. The net result: victims with recoveries under $200,000 frequently experience negative net outcomes after fees, costs, and outstanding medical obligations are satisfied.

The timing compounds the problem. Litigation typically requires 11–31 months from filing to resolution.[15] During this period, victims must manage medical expenses, lost income, and family disruption without knowing whether or when they will receive compensation. Many accept inadequate settlements simply to resolve uncertainty.

CHCA's structure inverts this dynamic: victims receive medical care immediately (covered by CHCA), attorneys receive compensation for work performed regardless of

outcome (via CPFF), and recovery flows to the Trust Fund and victims without the current fee extraction.

Section 3: CHCA Subrogation Mechanism

3.1 Operational Flow

CHCA subrogation operates through a systematic process that begins when a qualifying claim is paid and continues through recovery allocation:

1. **Claim Payment:** Provider submits claim with CHCA-qualifying ICD-10 code. CHCA pays immediately per standard claims processing. Victim receives care without delay.
2. **Case Identification:** CHCA identifies claims involving potential third-party liability. Motor vehicle accidents, workplace injuries, product-related injuries, and environmental exposures trigger automatic screening.
3. **Asset Verification:** Government accesses tax records and financial databases to identify defendants with recoverable assets. Cases are prioritized by recovery potential.
4. **Case Assignment:** Qualifying cases are assigned to contracted legal recovery attorneys operating under CPFF plus incentive contracts.
5. **Litigation/Settlement:** Attorneys pursue recovery through negotiation, settlement, or litigation. Loser-pays structure applies: prevailing CHCA recovers costs and fees from defendant.
6. **Medical Cost Recovery Allocation:** Medical cost proceeds are distributed per the fee structure: Trust Fund receives the recovery (less attorney incentive fee), and attorneys receive incentive fees for successful recovery. CHCA's subrogation authority extends only to medical costs paid by the Trust Fund.
7. **Victim Non-Medical Claims:** Victims retain independent rights to pursue non-medical compensatory and punitive damages against the tortfeasor. These claims benefit from CHCA's liability determination through collateral estoppel—the defendant cannot relitigate fault already established in the government's case. Victims may pursue non-medical claims through coordinated prosecution (with CHCA counsel under reduced fee structure per Appendix C) or sequential prosecution (with private counsel under traditional contingency arrangements per SEC. 404(E)).

This flow ensures victim care is never delayed pending recovery, government resources are applied systematically rather than haphazardly, and costs ultimately flow to responsible parties.

3.2 Tiered Recovery Thresholds

Recovery efforts are tiered by claim value to optimize administrative efficiency. The following structure ensures that recovery costs are proportionate to recovery potential:

Table 2: Tiered Recovery Thresholds

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	Government-initiated litigation: sue or settle

Small claims are resolved through streamlined processes that avoid full litigation costs. Large claims justify full adversarial proceedings with government resources applied to maximize recovery. The specific threshold values are appropriately set by the CHCA Administrative Authority based on claims data analysis.

3.3 Recovery Priority and Victim Rights

When CHCA pays a victim and the victim also pursues claims against the tortfeasor, recovery priority ensures appropriate allocation:

- CHCA recovers compensatory medical costs first—this payment was for the victim's immediate medical need
- Amounts above compensatory recovery (punitive damages, pain and suffering) flow to the victim
- CHCA may subrogate against the victim's settlement to recover its expenditure, but only to the compensatory portion

This priority structure ensures CHCA's fiscal sustainability while preserving victim access to non-medical damages. A victim injured by a drunk driver receives immediate medical care from CHCA. The government then pursues subrogation recovery of those medical costs, establishing defendant liability in the process. The victim can subsequently pursue punitive damages and pain-and-suffering compensation from the tortfeasor through either pathway: under coordinated prosecution (Appendix C, Section C.3.1), victims benefit from reduced attorney fees (15-25% versus 33-40%) because CHCA has already established liability and borne litigation risk; under sequential prosecution (SEC. 404(E)), victims engage private counsel at traditional contingency rates but still benefit from collateral estoppel—the liability finding from CHCA's case precludes the defendant from relitigating fault.

3.4 Statute of Limitations and Jurisdictional Uniformity

CHCA establishes a nationalized statute of limitations for subrogation claims, superseding state variation. This uniformity serves multiple objectives: it eliminates forum-shopping based on outlier state policies, provides defendants with predictable exposure periods, and ensures government recovery rights are not defeated by jurisdictional technicalities.

The government has standing as claimant for recovery of CHCA expenditures regardless of whether the victim pursues independent claims. This standing derives from the same legal principle that governs insurance subrogation: having paid the claim, the payer succeeds to the victim's rights against the tortfeasor.

3.5 Environmental and Complex Causation Cases

Environmental exposure cases present special challenges: causation is often complex, onset is delayed, and responsible parties may contest liability aggressively. CHCA addresses these challenges through several mechanisms:

- **Standard of Proof:** Civil standard (preponderance of evidence)—government has standing as civil complainant
- **Diagnostic History:** Slow-onset diseases have documentation trails supporting CHCA code qualification
- **Healthcare Continuity:** Care is paid regardless during diagnostic periods—coverage is not delayed pending causation determination
- **Mixed Causation:** Where diagnosis was wrong or causation is mixed, litigation or medical arbitration determines appropriate cost allocation

The government-paid litigator advocates for the victim who generally has no fault for slow-onset environmental injury. This adversarial process, backed by government resources, ensures that polluters and other responsible parties cannot escape accountability simply by contesting causation aggressively.

Section 4: Stakeholder Alignment

4.1 Attorney Compensation Framework

CHCA subrogation contractors operate under Federal Acquisition Regulation (FAR)-compliant contracts combining Cost-Plus-Fixed-Fee (CPFF) structure with performance incentives.[16] This model, proven in defense and government contracting, separates cost reimbursement from profit generation:

- **Direct Costs:** All allowable litigation costs reimbursed at audited actuals (expert witnesses, court fees, depositions, travel, document production)
- **Labor Costs:** Attorney and staff time reimbursed at approved billing rates with embedded margin
- **Incentive Fee:** Percentage of net recovery, calibrated to achieve compensation parity with traditional practice
- **Audit Compliance:** All costs subject to Defense Contract Audit Agency (DCAA) standards

The critical distinction from traditional contingency: under CPFF, attorneys are paid for all hours worked at approved billing rates regardless of case outcome. The incentive fee represents profit rather than total compensation. This structure eliminates the capital requirements and case-loss risk that currently exclude most practitioners from full market participation.

4.2 Compensation Parity Demonstration

Analysis demonstrates that a CHCA incentive fee in the 6–8% range achieves net profit margin parity with traditional 33% contingency practice after adjusting for eliminated capital costs and risk. The derivation proceeds through explicit steps:

Traditional contingency fees compensate attorneys for multiple functions: legal expertise, labor, capital provision (advancing costs until recovery), risk bearing (absorbing losses on unsuccessful cases), and administrative overhead. Under CHCA, capital provision and risk bearing transfer to the government. The fee reduction corresponding to these transferred functions—approximately 10% for capital costs plus 2–3% for risk premium—reduces the parity-equivalent fee from 33% to approximately 15–18%.

However, CPFF labor reimbursement covers what contingency fees cover through the "attorney compensation" component. The incentive fee need only cover profit, which—adjusted for eliminated capital costs—falls to approximately 6–8% of recovery. Detailed derivation appears in Appendix B.

4.3 Victim Outcomes

Under CHCA, victims experience dramatically improved outcomes compared to traditional practice:

Table 3: Victim Outcome Comparison

Outcome Metric	Traditional Practice	CHCA Structure
Medical costs	Paid from recovery (reducing victim share)	Paid by Trust Fund (victim share unaffected)
Attorney fees (on medical recovery)	33–40% of gross recovery	6–8% incentive (medical recovery only)
Non-medical attorney fees	33–40% of gross recovery	15–25% under coordinated prosecution; 33–40% under sequential prosecution
Litigation costs	Often deducted from recovery	Government-funded for medical; loser-pays recovery
Victim retention (non-medical)	5–25% of recovery	65–80% under coordinated prosecution; improved under sequential via collateral estoppel
Wait time for care	Delayed pending litigation	Immediate

Note: "CHCA Structure" figures for non-medical recovery assume coordinated prosecution pathway (Appendix C, Section C.3.1). Under sequential prosecution (SEC. 404(E)), victims engage private counsel at traditional fee rates but benefit from CHCA's prior liability determination through collateral estoppel.

The improvement derives from structural changes, not subsidy. By separating medical cost coverage (Trust Fund) from attorney compensation (CPFF), CHCA eliminates the bundled fee extraction that consumes victim recovery under traditional practice.

4.4 Market Access and Competition

The elimination of capital barriers transforms market dynamics for legal practitioners:

Table 4: Market Access Comparison

Factor	Traditional Practice	CHCA Practice
New firm formation	Difficult (capital requirements)	Open to all qualified attorneys
Competition basis	Capital access + brand	Skill + efficiency
Solo/small firm access	Constrained by capital	Full participation
Case selection	Firm discretion (capital-driven)	Government assignment (merit-driven)
Price discovery	Opaque (bundled fees)	Transparent (audited costs)

Over 75% of personal injury practitioners operate as solo or small-firm attorneys who currently lack capital to compete with larger firms.[17] CHCA enables these practitioners to compete based on legal skill rather than financing capacity, expanding effective supply while creating price competition that benefits victims.

4.5 Defendant Incentive Effects

The loser-pays structure creates powerful defendant incentives that shift optimal strategy from "litigate aggressively, force cost-based settlement" to "evaluate liability honestly, settle fairly, avoid costs."

Under traditional systems, defendants can force settlement by threatening litigation costs that financially stressed victims cannot bear. Under CHCA loser-pays, defendants pay all costs if found liable—eliminating cost leverage as a settlement tactic. Victims have no cost risk and can await fair settlement. Government resources ensure pursuit regardless of victim circumstances.

This shift serves deterrence objectives: tortfeasors face consistent accountability rather than variable enforcement based on victim resources. The expected cost of negligent conduct increases, creating appropriate incentives for risk reduction.

Section 5: Implementation Framework

5.1 Transition Timeline

CHCA 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, and 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 established, and public confidence demonstrated. Full implementation aligns with federal fiscal year to coordinate budgetary processes.

5.2 Contractor Qualification and Selection

Attorneys seeking CHCA subrogation contracts must demonstrate: bar membership in good standing, professional liability coverage, DCAA-compliant accounting systems (or willingness to implement same), and capacity to handle assigned case volume. Critically, no capital requirements apply—removing the barrier that currently excludes most practitioners.

Contract awards incorporate past performance weighting based on recovery rate (percentage of pursued claims resulting in recovery), cycle time (average time from case assignment to resolution), audit findings (clean audits weighted positively), and victim satisfaction (for cases with non-medical recovery components).

5.3 Small Business Set-Asides

To ensure market access for small and solo practitioners, CHCA subrogation contracts include small business set-asides consistent with federal acquisition policy. A target of 40% of contract value reserved for small businesses creates a constituency of practitioners whose market access depends on CHCA continuation—building political durability into the program structure.

5.4 Audit and Compliance Infrastructure

The subrogation portal provides case intake, assignment, tracking, and DCAA-auditable payment processing. Contractors must comply with FAR cost allowability/unallowability definitions, contemporaneous timekeeping requirements, incurred cost submission and audit rights, and truthful cost representations (subject to False Claims Act liability).

Direct cost categories include record retrieval, expert witnesses, laboratory analysis, court fees, and travel. All costs require contemporaneous documentation sufficient to verify that the expense was incurred, that the amount claimed matches the amount paid, and that the expense relates to contract performance.

5.5 Rate Calibration Authority

The CHCA Administrative Authority sets incentive fee rates within the analytically-derived 6–8% range based on observed market conditions. Rate-setting criteria include demonstrated market compensation levels for comparable legal services, contractor participation rates and market competitiveness indicators, recovery performance metrics across the contractor pool, and public interest in maximizing victim recovery share.

The statute establishes the framework and ranges; the Administrative Authority sets specific values and adjusts them as experience accumulates. This delegation enables calibration based on actual data rather than legislative prediction.

Section 6: Legal Foundation and Precedent

6.1 Medicare Secondary Payer Program

CHCA's subrogation framework builds on established federal precedent. The Medicare Secondary Payer (MSP) program has conducted systematic subrogation recovery since 1980, demonstrating both legal authority and operational feasibility for government-initiated recovery from liable third parties.[18]

Table 5: Medicare Secondary Payer Program Performance

MSP Performance Metric	Value	Source
FY2024 savings	$9.04 billion	CMS MLN006903
FY2021 savings	$9.7 billion	CRS RL33587
Cumulative savings FY2015–2021	$63 billion	CRS RL33587

MSP establishes that federal programs can: pay medical costs immediately to ensure victim care; pursue liable third parties for cost recovery; use subrogation to stand in the victim's shoes for recovery purposes; and engage contractors for recovery operations. CHCA extends this proven model to all agency-decorrelated catastrophic costs.

6.2 Subrogation Doctrine

Subrogation as a legal doctrine has ancient origins and is recognized across American jurisdictions. The doctrine operates through two primary forms: conventional (contractual) subrogation arising from agreement between parties, and equitable (legal) subrogation arising by operation of law when one party pays an obligation that should properly be borne by another.

CHCA's subrogation operates through both forms. Statutory provision creates explicit government subrogation rights (conventional), while equitable principles support government recovery of amounts paid on behalf of tort victims. The doctrine is well-established, frequently litigated, and provides clear legal framework for CHCA implementation.

6.3 Constitutional Foundation

Federal authority for CHCA derives from the same constitutional foundations that support Medicare, Medicaid, and other federal health programs: the spending power (Article I, Section 8, Clause 1) and the commerce power (Article I, Section 8, Clause 3). The subrogation component adds no novel constitutional questions—it simply extends established federal authority to pursue recovery for amounts expended under an authorized program.

The nationalized statute of limitations for subrogation claims rests on federal preemption authority. Where federal programs operate, federal law may establish uniform procedures that supersede state variation. This authority is routinely exercised in Medicare, ERISA, and other federal benefit programs.

Conclusion

CHCA's systematic subrogation framework represents a fundamental improvement over current haphazard tort recovery systems. By separating immediate victim care from subsequent cost recovery, the framework ensures that medical needs are addressed without delay while responsible parties bear appropriate costs. By applying government resources to medical cost recovery efforts, the framework overcomes the resource asymmetries that currently allow defendants to escape accountability. By restructuring attorney compensation for medical recovery through CPFF plus incentive fees, the framework maintains practitioner compensation parity while creating informational leverage—liability determinations, asset verification, and causation findings—that benefits victims pursuing non-medical claims through either coordinated or sequential prosecution pathways.

The economic analysis demonstrates that the framework achieves these objectives without requiring attorney sacrifice—properly calibrated incentive rates preserve equivalent net profit margins for practitioners while eliminating capital barriers and case-loss risk. The **$23–33 billion in total annual recovery opportunity** (baseline ~$15 billion under current law plus **$8–18 billion incremental** from new CHCA authority) represents both fiscal improvement for the CHCA Trust Fund and appropriate moral allocation of costs to parties whose conduct caused harm.

Implementation builds on four decades of MSP precedent, adapting proven mechanisms to the expanded scope of CHCA-covered conditions. The phased rollout ensures administrative systems are tested and refined before full implementation, while small business set-asides create a constituency invested in program continuation.

The Accountability-Through-Recovery Principle embedded in CHCA's subrogation framework ensures that collective coverage of agency-decorrelated conditions does not mean collective absorption of costs properly attributable to negligent parties. Victims receive immediate care and fair compensation. Responsible parties bear appropriate costs. Attorneys participate on the basis of skill rather than capital. The legal system processes claims efficiently rather than redundantly. These outcomes represent both economic efficiency and moral justice—a framework that serves all stakeholders while holding accountable those whose conduct caused harm.

Endnotes

[1] Institute for Legal Reform and Brattle Group, "Costs and Compensation of the U.S. Tort System" (2022). Analysis indicates approximately 53 cents of each tort dollar reaches claimants.

[2] Centers for Medicare & Medicaid Services, "Medicare Secondary Payer," MLN Fact Sheet MLN006903 (Baltimore, MD: CMS, July 2025), 1. FY2024 savings of $9.04 billion.

[3] CHCA Quantitative Data Repository v1.22, Derived-Subrogation v2.0 sheet (January 2026). Recovery framework separates baseline (~$15B under current law) from CHCA incremental recovery ($8–18B net after 20% administrative costs).

[4] CHCA Operational Baseline v1.4, §1.1.

[5] CHCA Operational Baseline v1.4, §2.3; Quantitative Data Repository v1.22, CHCA Baseline Summary sheet.

[6] Gavin Yang et al., "The National Economic Burden of Rare Disease in the United States in 2019," Orphanet Journal of Rare Diseases 17, no. 163 (2022). Direct medical costs: $449 billion.

[7] 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: $30.9 billion; innocent victim portion estimated at approximately $25 billion.

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

[9] Bracketed estimate per CHCA Technical Evidence Compendium v2.0. Total health damages from environmental exposure estimated at $820 billion (NRDC 2025, VSL methodology); direct medical portion subject to ongoing refinement.

[10] Congressional Research Service, "Medicare Secondary Payer: Coordination of Benefits," Report RL33587 (Washington, DC: CRS, August 2023).

[11] Institute for Legal Reform and Brattle Group, "Costs and Compensation of the U.S. Tort System" (2022).

[12] CHCA Subrogation Compensation Framework v1.0, §2.2.

[13] Embroker, "50 Solo Law Firm Statistics for 2025" (March 2025); Verified Market Reports, "Personal Injury Law Software Market Size" (June 2025).

[14] Nora Freeman Engstrom, "Attorney Advertising and the Contingency Fee Cost Paradox," Stanford Law Review 65 (2013): 636. Modal contingency rate of 33%, ranging to 40% or higher.

[15] Bureau of Justice Statistics, Civil Bench and Jury Trials in State Courts, 2005, NCJ 223851 (Washington, DC: U.S. Department of Justice, 2009), 4.

[16] Federal Acquisition Regulation § 16.306, "Cost-Plus-Fixed-Fee Contracts," 48 C.F.R. § 16.306.

[17] Embroker, "50 Solo Law Firm Statistics for 2025"; American Bar Association, Lawyer Demographics Year-by-Year (Chicago: ABA, 2016).

[18] CMS MLN006903; CRS RL33587. MSP program operational since 1980.

Appendix A: Glossary of Terms

Agency-Decorrelation: The defining principle of CHCA coverage eligibility. A condition is agency-decorrelated if it arises from circumstances outside individual control, where personal choices and behaviors did not contribute to the condition's occurrence.

CPFF (Cost-Plus-Fixed-Fee): A contract type established under FAR 16.306 where the contractor is reimbursed for allowable costs plus a fixed fee representing profit. Under CHCA, attorneys receive cost reimbursement for labor and litigation expenses, with an incentive fee tied to recovery outcomes.

Loser-Pays: A cost allocation model (also called "fee-shifting" or the "English Rule") where the losing party pays the prevailing party's litigation costs and reasonable attorney fees. CHCA applies this model to subrogation actions.

NPM (Net Profit Margin): The percentage of revenue remaining after all costs are deducted. The Rule of Thirds benchmark targets approximately 33% NPM for well-managed law firms.

Subrogation: A legal doctrine by which one party who pays an obligation succeeds to the rights of action of the original creditor against the party who caused the obligation. Under CHCA, the government acquires subrogation rights upon paying medical costs for injuries caused by third parties.

Appendix B: CHCA Fee Structure Derivation

This appendix presents the analytical basis for CHCA's attorney compensation structure, demonstrating that the proposed 6–8% incentive fee rate achieves compensation parity with traditional contingency practice after adjusting for eliminated capital costs and risk exposure. The analysis proceeds from industry benchmarks through explicit derivation to policy conclusions, with all numerical claims sourced or transparently derived.

B.1 Parity Principle

B.1.1 Objective Statement

CHCA's attorney compensation framework pursues a specific objective: equivalent net compensation for equivalent legal skill and effort. The framework does not seek to reduce attorney compensation; rather, it restructures the components of compensation to reflect the different economic conditions under which CHCA contractors operate compared to traditional contingency practitioners.

Traditional contingency practice requires attorneys to deploy capital, bear case-loss risk, and finance extended litigation timelines. These functions command economic returns that are embedded in the 33–40% contingency fee structure.[1] When CHCA assumes these capital and risk functions, the economic justification for the corresponding fee components disappears—but the justification for compensating legal skill and effort remains intact.

The parity principle thus holds: CHCA incentive rates should be calibrated such that attorneys contributing equivalent skill and effort receive equivalent net profit, regardless of which economic functions (capital provision, risk bearing) are performed by the attorney versus the government.

B.1.2 The "Rule of Thirds" Benchmark

Industry consensus identifies healthy law firm economics through the "Rule of Thirds": allocate gross revenue approximately equally across attorney compensation (33%), overhead expenses (33%), and profit (33%).[2] This framework has proven durable across practice areas and firm sizes, representing the equilibrium that competitive markets produce for professional services. The Rule of Thirds implies a target net profit margin (NPM) of approximately 33% for well-managed firms, where NPM equals revenue minus all costs divided by revenue.

Industry surveys confirm this benchmark. Legal industry sources indicate net profit margins consistent with the Rule of Thirds framework, with variation reflecting firm size, case mix, and market position.[3] Solo practitioners typically achieve margins in the 25–35% range, while small firms (6–10 attorneys) achieve 35–45%.[4] The 33% figure represents a reasonable central estimate for parity targeting.

B.1.3 EBITDA Margin Versus Net Profit Margin

A critical distinction governs the parity analysis: the difference between EBITDA margin (earnings before interest, taxes, depreciation, and amortization) and net profit margin after capital costs. Traditional contingency firms must generate EBITDA margins substantially above their target NPM because capital costs consume a portion of

operating earnings. A firm targeting 33% NPM while bearing 10% capital costs requires approximately 43% EBITDA margin. The following table illustrates how CHCA's elimination of capital requirements allows EBITDA margin and NPM to converge, establishing the analytical foundation for reduced gross fee rates:

Component	Traditional Practice	CHCA Practice
Target EBITDA margin	~43%	~33%
Less: Capital carrying costs	(~10%)	0%
Net Profit Margin	**~33%**	**~33%**

Table B.1: Margin Parity Analysis

Because capital costs are eliminated under CHCA, gross fees can be reduced by the amount previously required to cover those costs while maintaining equivalent net compensation.

B.1.4 What Parity Means in Practice

Parity does not mean identical gross revenue. It means identical risk-adjusted, capital-adjusted net profit for equivalent work. Consider an attorney who, under traditional practice, handles a case generating $300,000 recovery. At 33% contingency, gross fee revenue is $100,000. After firm overhead allocation and capital cost burden, net profit might be $33,000 (33% NPM on gross fee).

Under CHCA, the same attorney handling the same case receives labor compensation (all hours reimbursed at approved billing rates, which is revenue, not profit) plus an incentive fee (a percentage of net recovery that generates profit). If the incentive structure is properly calibrated, net profit remains approximately $33,000—achieved through different revenue components but delivering equivalent economic outcome. The following sections derive the specific parameters required to achieve this parity.

B.2 Capital Cost Quantification

B.2.1 The Capital Requirement in Traditional Practice

Traditional contingency practice requires attorneys to function as financiers as well as legal practitioners. Before any recovery occurs, the attorney must advance all litigation costs from firm capital—expert witnesses, court fees, depositions, medical record acquisition, document production, travel, and trial preparation expenses. The following table establishes typical cost ranges by case complexity, drawing on court fee schedules, court reporter rates, provider charges, and expert witness fee studies:

Cost Category	Typical Range	Source Basis
Court filing fees	$100–$400	Court fee schedules
Depositions	$500–$1,500 per deposition	Court reporter rates
Medical records retrieval	$500–$2,000	Provider charges

Expert witness retainer	$2,000 median initial	SEAK Expert Witness Fee Study
Expert hourly rate (non-medical)	$245/hour median	Expert Institute survey
Expert hourly rate (medical)	$350–$500/hour	SEAK, Expert Institute
E-discovery (complex cases)	$5,000–$50,000+	Vendor pricing
Typical total (routine case)	**$5,000–$15,000**	Aggregated
Typical total (complex/trial)	**$40,000–$80,000+**	Aggregated

Table B.2: Litigation Cost Components[5]

A personal injury practice handling a mixed portfolio of routine and complex matters will experience weighted average costs per case in the $40,000–$65,000 range, depending on case mix and litigation intensity.

B.2.2 Deployed Capital Derivation

The total capital a firm must deploy depends on active case inventory and average cost per case. For a mid-size firm with 10 attorneys handling 12 active cases each (industry-typical caseload), total active cases equal 120. With average advanced costs per case of $50,000–$67,000 (reflecting a mix of routine and complex matters), the derivation yields:

Deployed Capital = Active Cases × Average Cost per Case

Deployed Capital = 120 × $50,000 to 120 × $67,000

Deployed Capital = $6,000,000 to $8,000,000

This capital remains deployed throughout case duration. With average case timelines of 11–31 months from filing to resolution,[6] capital turns over slowly. A firm cannot redeploy funds advanced on one case until that case resolves—which may be two or more years after initial advancement.

B.2.3 Cost of Capital

Capital deployed in litigation carries both explicit and implicit costs. Explicit costs include interest on borrowed funds or returns required by outside investors. Implicit costs include opportunity cost of capital that could be deployed elsewhere and illiquidity premium for funds locked in contingent outcomes.

The Government Accountability Office's 2022 report on third-party litigation financing documents that commercial litigation funders charge interest rates "up to 18%" for capital provided to law firms.[7] This rate reflects the specialized risks of litigation investment: binary outcomes (win/lose), extended timelines, and limited collateral. For firms financing litigation from internal capital rather than external funders, the relevant cost is the firm's weighted average cost of capital (WACC). Personal injury firms—typically organized as partnerships or professional corporations with concentrated ownership—face capital costs reflecting higher equity risk premiums, limited access to

debt financing, and illiquidity of partnership interests. Industry analysis suggests internal cost of capital for plaintiff firms in the 10–15% range.[8]

B.2.4 Capital Cost as Percentage of Revenue

Combining the capital deployment and cost of capital estimates yields the capital cost burden. For a 10-attorney firm with $6–8 million deployed at 10–15% cost of capital, annual carrying cost ranges from $600,000 to $1,200,000. Against estimated revenue of $8–10 million (industry benchmarks suggest $800,000–$1,000,000 revenue per attorney for established practices[9]), capital cost as a percentage of revenue falls in the 6–15% range. The midpoint of approximately 10% is used as the working estimate for capital cost burden. The following table summarizes the capital cost comparison between traditional and CHCA practice:

Capital Cost Component	Traditional Practice	CHCA Practice
Capital deployed (10-attorney firm)	$6–8 million	$0
Cost of capital	10–15% annually	0%
Annual carrying cost	$600,000–$1,200,000	$0
Case-loss risk exposure	15–30% of advanced costs	0% (government bears)
Cash conversion cycle	18–30 months	~30 days
Capital cost as % of revenue	**~10%**	**0%**

Table B.3: Capital Cost Comparison

Under CHCA, the government reimburses litigation costs within standard federal payment cycles (approximately 30 days). Attorneys advance no capital, bear no case-loss risk (cases are pre-screened for viability), and require no capital reserves for cash flow volatility. The entire capital cost burden—approximately 10% of traditional firm revenue—transfers from attorney to government. This transfer has direct implications for fee structure: fees can be reduced by the amount previously required to cover capital costs while maintaining equivalent net compensation.

B.3 Incentive Rate Derivation

B.3.1 The Derivation Objective

This section derives the CHCA incentive fee rate that achieves net profit margin parity with traditional contingency practice. The derivation proceeds through explicit steps, with each adjustment factor quantified and justified. The starting point is the traditional contingency fee of 33% (the modal rate for pre-litigation settlements).[10] The derivation identifies components of this fee that compensate for functions CHCA assumes, then subtracts those components to arrive at a parity-equivalent CHCA rate.

B.3.2 Decomposing the Traditional Fee

The 33% contingency fee compensates attorneys for multiple distinct functions: legal expertise (case evaluation, legal strategy, negotiation, litigation skill), labor (hours of attorney and staff time applied to the case), capital provision (advancing litigation costs until recovery), risk bearing (absorbing 100% loss on unsuccessful cases), case selection (evaluating and declining non-viable matters), and administrative overhead (firm operations, facilities, support staff).

Under traditional practice, all functions are bundled into a single percentage. The attorney provides everything; the fee compensates for everything. Under CHCA, functions are unbundled. Legal expertise, labor, and administrative overhead remain the attorney's responsibility and are compensated through CPFF cost reimbursement plus incentive fee. Capital provision is assumed by the government with costs reimbursed at actuals. Risk bearing is assumed by the government with cases pre-screened for viability. Case selection is performed by the government through systematic screening. The functions CHCA assumes no longer require attorney compensation. The fee reduction corresponding to these transferred functions is quantified below.

B.3.3 Quantifying the Capital Cost Component

From §B.2, capital costs consume approximately 10% of traditional firm revenue. In a 33% contingency fee, this translates to roughly 30% of the fee compensating capital costs rather than legal work. Expressed alternatively: of every dollar in contingency fees, approximately 30 cents covers capital costs rather than compensating legal work. The fee reduction for capital transfer is approximately 10 percentage points (from 33% to 23%).

B.3.4 Quantifying the Risk-Bearing Component

Traditional contingency attorneys bear complete loss exposure on unsuccessful cases. Industry experience suggests win rates of approximately 70–85% for cases that attorneys agree to pursue after screening; attorneys lose the balance of advanced costs across their portfolios. This risk requires compensation in the form of a risk premium—higher expected returns on successful cases to offset losses on unsuccessful ones. For a firm with $7 million deployed capital and 20% annual loss exposure, the expected loss is $1.4 million per year, requiring approximately 2–3 percentage points of additional fee to maintain equivalent expected value. However, this calculation overlaps partially with the capital cost calculation (losses increase effective cost of capital). To avoid double-counting, a conservative estimate of 2–3 percentage points is attributed to risk premium beyond capital costs already quantified.

B.3.5 Quantifying Efficiency Gains

CHCA contractors operate with structural advantages that reduce per-case effort compared to traditional practice. Case screening (traditionally consuming 15–20% of attorney time evaluating matters that will be declined) is performed by the government, which screens cases and provides pre-qualified assignments. Administrative processing (billing, collections, cost tracking) is simplified through government support and standardized systems. Portfolio diversification (individual firms bear concentrated case risk under traditional practice) is achieved at the government level, aggregating across

thousands of cases and reducing required margins for volatility. A conservative estimate attributes 3–5 percentage points to efficiency gains.

B.3.6 Cumulative Fee Reduction Derivation

The following table summarizes the cumulative fee reduction from the 33% traditional baseline:

Factor	Reduction	Cumulative Fee
Traditional contingency baseline	—	33%
Less: Capital cost transfer	(10%)	23%
Less: Risk bearing transfer	(2–3%)	20–21%
Less: Efficiency gains	(3–5%)	15–18%
CHCA Parity-Equivalent Range	—	**15–18%**

Table B.4: Cumulative Fee Reduction Derivation

This derivation suggests a parity-equivalent fee in the 15–18% range. However, this rate applies to gross recovery before considering the CPFF labor reimbursement component—a critical distinction that fundamentally changes the parity calculation.

B.3.7 Adjusting for CPFF Labor Reimbursement

Under CPFF, attorneys are paid for all hours worked at approved billing rates. This labor reimbursement is separate from and additional to the incentive fee. In traditional contingency, attorney time is not separately compensated—the 33% fee must cover labor costs as well as profit. Under CHCA, labor is a reimbursed cost; the incentive fee represents pure profit margin on recovery.

The relevant comparison is therefore not "Traditional 33% fee vs. CHCA X% incentive" but rather "Traditional 33% fee vs. CHCA (Labor Reimbursement + X% Incentive)." Since CHCA labor reimbursement covers what contingency fees cover through the "attorney compensation" third of the Rule of Thirds (~11% of recovery), the incentive fee need only cover the "profit" third (~11% of recovery) adjusted for eliminated capital costs. With capital costs eliminated, the profit component drops from ~11% to approximately 6–8% of recovery.

B.3.8 Final Rate Derivation

The following table presents the component analysis for the final rate derivation:

Component	Traditional	CHCA
Attorney compensation	~11% of recovery (embedded in fee)	Covered by CPFF labor reimbursement

Overhead allocation	~11% of recovery (embedded in fee)	Partially covered by CPFF; partially from incentive
Profit	~11% of recovery (embedded in fee)	From incentive fee
Less: Capital costs	(~3–4% of recovery equivalent)	$0 (transferred to government)
Net profit from fee	**~7–8% of recovery**	**~6–8% of recovery**

Table B.5: Component Analysis for Rate Derivation

The derivation indicates that a CHCA incentive fee in the **6–8% range** achieves profit parity with traditional practice when combined with CPFF labor reimbursement. This rate is appropriately delegated to the CHCA Administrative Authority for calibration based on observed market conditions, with 6–8% established as the analytically-derived target range.

B.3.9 Sensitivity to Assumptions

The derived rate depends on several assumptions. If assumptions vary, the parity-equivalent rate adjusts accordingly. Higher capital cost burden than the assumed 10% would allow lower CHCA rates to achieve parity (more savings from transfer). Higher traditional NPM targets than 33% would require higher CHCA rates. If CPFF billing rates do not fully cover labor costs, rate adjustment would be needed. These sensitivities underscore the value of delegating rate-setting to the Administrative Authority, which can calibrate based on observed market conditions. Initial implementation at the higher end of the range (8%) provides margin for uncertainty; subsequent adjustment toward the lower end (6%) is appropriate as the market stabilizes and assumptions are validated.

B.4 CPFF Mechanism Detail

This section explains the Cost-Plus-Fixed-Fee (CPFF) contracting structure as applied to CHCA legal services, clarifying how this proven government contracting model achieves compensation parity while eliminating capital barriers. The critical insight is that CPFF fundamentally restructures attorney compensation: all labor is reimbursed at approved rates, with the incentive fee representing profit rather than total compensation.

B.4.1 CPFF Fundamentals

Cost-Plus-Fixed-Fee contracting is established under Federal Acquisition Regulation (FAR) 16.306, which specifies that this contract type "permits contracting for efforts that might otherwise present too great a risk to contractors."[11] The structure separates cost recovery from profit generation. Direct costs (litigation expenses) are reimbursed at audited actuals with the government bearing cost risk. Labor costs are reimbursed at approved billing rates with embedded margin. The incentive fee (profit component) is calculated as a percentage of recovery, providing outcome alignment. All elements are subject to government audit standards.

The CPFF model is well-established in defense and government contracting, where it has evolved over decades to balance government interests (cost control, performance incentives) with contractor interests (reasonable profit, manageable risk). CHCA adapts this proven framework to legal services.

B.4.2 Attorney Labor Under CPFF

A fundamental clarification distinguishes CPFF from contingency practice: under CPFF, attorneys are paid for all hours worked at approved billing rates regardless of case outcome. This is not contingent compensation—it is cost reimbursement. The attorney bills hours worked; the government reimburses at the approved rate; the attorney receives payment within the standard billing cycle.

Consider an attorney who works 200 hours on a case that ultimately does not result in recovery. Under traditional contingency, that attorney receives nothing—200 hours of professional time with zero compensation. Under CHCA CPFF, the same attorney working 200 hours receives compensation for all 200 hours at the approved billing rate regardless of case outcome. The government, not the attorney, bears the risk that some cases will not result in recovery. This risk transfer is precisely why the incentive fee can be dramatically lower than traditional contingency percentages while still achieving compensation parity.

B.4.3 Billing Rate Structure

CHCA billing rates follow government contracting conventions, with rates established through negotiation and subject to audit verification. A typical billing rate includes direct labor (attorney salary and benefits) at 35–45% of the rate, indirect costs (facilities, support staff, technology, insurance, professional development) at 35–45%, general and administrative allocation at 10–15%, and embedded margin at 5–10%. The embedded margin within labor rates provides baseline profit on labor even before considering the recovery-based incentive fee. This structure ensures that attorneys operating efficiently—completing cases in fewer hours—retain the same incentive fee while generating higher effective margins on labor.

B.4.4 Cost Reimbursement Categories

Beyond labor, CHCA reimburses allowable direct costs at audited actuals. The following table identifies the major cost categories and documentation requirements:

Cost Category	Allowable	Documentation Required
Expert witness fees	Yes	Engagement letter, invoices, testimony records
Court filing fees	Yes	Receipt from court clerk
Deposition costs	Yes	Court reporter invoices, transcript copies
Medical record retrieval	Yes	Provider invoices, HIPAA-compliant request records

Document production	Yes	Vendor invoices, volume documentation
Travel (case-related)	Yes	Per federal travel regulations; receipts required
Legal research databases	Yes (allocated)	Subscription cost allocated by usage

Table B.6: Allowable Direct Cost Categories

Costs are reimbursed upon submission of proper documentation, typically within 30 days. This rapid reimbursement cycle eliminates the cash flow burden that traditional contingency practice imposes—attorneys need not finance litigation costs for months or years awaiting case resolution.

B.4.5 Audit Standards and Compliance

CHCA cost reimbursement operates under audit standards comparable to those applied in defense contracting. Allowability requires that costs be necessary and reasonable for contract performance; excessive costs, costs for unrelated purposes, or costs prohibited by regulation are disallowed. Allocability requires that costs charged to CHCA contracts benefit CHCA work; costs benefiting multiple contracts must be allocated proportionally using consistent, documented methods. Reasonableness requires that cost amounts reflect what a prudent business person would pay in similar circumstances. Documentation requires contemporaneous records sufficient to verify that the expense was incurred, that the amount claimed matches the amount paid, and that the expense relates to contract performance.

These standards protect against cost inflation while ensuring legitimate expenses are fully reimbursed. Attorneys accustomed to documenting time and expenses for client billing will find the requirements familiar; the primary difference is the rigor of third-party audit verification rather than client-accepted invoices.

B.4.6 The Incentive Fee as Profit Component

With labor and costs reimbursed, the incentive fee represents the attorney's profit on case outcomes. This is the component calibrated in §B.3 to achieve compensation parity. The following table illustrates the contrast:

Traditional Contingency	**CHCA CPFF + Incentive**
33% fee covers: labor, overhead, capital costs, risk premium, profit	Labor: covered by hourly reimbursement
	Overhead: covered by billing rate structure
	Capital costs: eliminated (government advances)
	Risk premium: eliminated (government bears)
	Profit: 6–8% incentive fee

Table B.7: Fee Component Comparison

The incentive fee is earned upon successful recovery. Unlike traditional contingency where the entire fee is at risk, CHCA attorneys have already been compensated for labor regardless of outcome—the incentive fee provides additional profit tied to results, aligning attorney interests with recovery maximization without imposing total-compensation risk.

B.4.7 Why This Structure Works

The CPFF plus incentive structure achieves multiple policy objectives simultaneously. For attorneys, it eliminates capital requirements and case-loss risk while maintaining equivalent profit opportunity. Attorneys can enter CHCA practice without accumulated capital, compete based on skill rather than financing capacity, and earn equivalent returns through the combination of labor reimbursement and incentive fees.

For victims, the structure reduces fee extraction from recovery proceeds. Because attorneys are separately compensated for labor, the incentive fee extracts only profit margin from recovery—not the labor costs, overhead, capital burden, and risk premium embedded in traditional contingency fees.

For the government, the structure aligns contractor incentives with program objectives. Attorneys profit more from higher recoveries, creating incentive to maximize recovery rather than settle quickly for lower amounts. Audit standards ensure cost reimbursement is not inflated to compensate for lower percentage fees.

For the legal market, the structure democratizes access to personal injury practice. The 75%+ of personal injury practitioners operating as solo or small-firm attorneys gain competitive access to CHCA work without capital barriers that currently constrain their traditional practice capacity.[12]

B.5 Attorney Outcome Comparison

This section demonstrates compensation parity through worked examples comparing attorney outcomes under traditional contingency practice and CHCA CPFF contracting. The analysis shows that attorneys receive equivalent net profit under both models when adjusted for the capital and risk functions that CHCA assumes.

B.5.1 Modeling Assumptions

To enable direct comparison, the following assumptions are held constant across models: case recovery (gross) of $300,000 (illustrative mid-range recovery), litigation costs of $50,000 (typical complex case), net recovery of $250,000 (gross less costs), attorney billing rate of $250/hour (market rate for experienced PI attorney), and hours to resolution of 120 hours (industry-typical for complex case). These assumptions represent a single case for clarity; portfolio-level analysis in §B.6 demonstrates that conclusions hold across case mixes.

B.5.2 Traditional vs. CHCA Outcome Comparison

The following consolidated table presents the complete comparison between traditional contingency and CHCA CPFF models, showing revenue components, cost structures, and net profit outcomes:

Element	Traditional Contingency	CHCA CPFF
Revenue Components		
Contingency fee (33% of gross)	$99,000	—
Labor reimbursement (120 hrs × $250)	—	$30,000
Cost reimbursement	—	$50,000
Incentive fee (8% of net recovery)	—	$20,000
Total revenue	**$99,000**	**$100,000**
Cost Allocations		
Advanced litigation costs	($50,000)	$0 (reimbursed)
Attorney compensation (~33% of net fee)	($16,170)	—
Labor cost (internal, ~40% of billing)	—	($12,000)
Overhead allocation (~33% of net fee)	($16,170)	($12,000)
Capital carrying cost (~10% of fee)	($4,900)	$0
Risk premium allocation	(~$3,000)	$0
Total costs	**~$40,240**	**$24,000**
Net Profit	**~$8,760**	**$76,000**

Table B.8: Traditional vs. CHCA Outcome Comparison

The apparent profit disparity ($8,760 vs. $76,000) reflects an important distinction: under CPFF, labor reimbursement at billing rates includes embedded margin, not just cost recovery. Additionally, the CHCA model eliminates capital costs and risk allocations entirely. The more appropriate comparison examines profit as a percentage of the revenue base—and capacity effects that allow CHCA attorneys to handle more cases.

B.5.3 Efficiency-Adjusted Outcomes

The critical insight from the CPFF structure is that profit in absolute dollars is constant regardless of hours worked, but net profit margin varies with efficiency. An attorney cannot increase profit by padding hours (labor is cost-neutral to profit); an attorney can

only increase effective margin by completing work efficiently. The following table demonstrates outcomes across efficiency tiers for a $240,000 net recovery with 8% incentive fee ($19,200 profit):

Attorney Efficiency	Hours	Labor Revenue	Incentive Fee	Total Revenue	Profit	NPM
Excellent	80	$20,000	$19,200	$39,200	$19,200	49.0%
Good	100	$25,000	$19,200	$44,200	$19,200	43.4%
Average	120	$30,000	$19,200	$49,200	$19,200	39.0%
Below average	150	$37,500	$19,200	$56,700	$19,200	33.9%
Poor	200	$50,000	$19,200	$69,200	$19,200	27.7%

Table B.9: Attorney Outcomes by Efficiency Tier

Profit is identical ($19,200) regardless of hours worked. NPM differs because the revenue base (labor reimbursement + incentive) differs. Efficient attorneys achieve higher margins; inefficient attorneys achieve lower margins—but all earn the same absolute profit on the same recovery. This structure rewards efficiency through margin improvement rather than profit reduction.

B.5.4 Volume Effect on Annual Earnings

Efficiency affects not just margin but annual earning capacity. Attorneys who complete cases faster can handle more cases. An excellent attorney working 80 hours per case can handle 25 cases annually (at 2,000 hours) versus 10 cases for a poor attorney at 200 hours per case. At $19,200 profit per case, the excellent attorney earns $480,000 annually while the poor attorney earns $192,000—a 2.5× difference achieved not through higher per-case fees but through volume capacity.

This creates powerful self-selection: attorneys who thrive under CHCA are those who work efficiently, while those who cannot complete cases within reasonable hours will find traditional contingency (where they can select easier cases) more attractive. The CHCA attorney's higher potential earnings reflect real economic value created by eliminating capital barriers—not extraction from victims or government subsidy. Victims receive higher net recovery (reduced fee extraction); attorneys receive higher potential earnings (expanded capacity); the government recovers costs through subrogation.

B.6 Case Type Distribution Model

This section develops the case mix model used for portfolio-level revenue projections, establishing the distribution of recovery types that CHCA subrogation contractors will encounter.

B.6.1 Case Type Categories and Distribution

CHCA subrogation cases fall into three broad categories based on recovery components. Medical-only cases involve clear liability with minimal non-economic

damages, recovering primarily medical costs with nominal compensatory amounts. Medical-plus-compensatory cases involve established liability with significant victim damages, including lost wages, pain and suffering, and property damage. Full recovery cases involve egregious conduct warranting punitive damages in addition to medical and compensatory components. The following distribution is used for modeling purposes:

Case Type	Portfolio Mix	Avg Medical	Avg Non-Med Comp	Avg Punitive	Total Recovery
Medical-only	50%	$150,000	$10,000	$0	$160,000
Medical + compensatory	35%	$200,000	$75,000	$0	$275,000
Full (with punitive)	15%	$250,000	$100,000	$200,000	$550,000

Table B.10: Case Type Distribution and Recovery Parameters

Important caveat: This distribution is a modeling assumption, not an empirically verified parameter. Actual distributions will depend on case screening criteria, jurisdictional variations in punitive damage availability, and the types of agency-decorrelated conditions that generate subrogation claims. The medical cost figures ($150,000–$250,000) reflect the catastrophic coverage scope of CHCA. Punitive damages, where available, often exceed compensatory amounts in cases of egregious conduct; the $200,000 average for the "full recovery" category is conservative.[13]

B.6.2 Weighted Average Recovery

The weighted average recovery per case determines expected portfolio economics. Applying the distribution weights yields the following per-case and portfolio-level projections:

Component	Weighted Average Per Case	Per 100 Cases	% of Total
Medical recovery	$182,500	$18,250,000	70.5%
Non-medical compensatory	$46,250	$4,625,000	17.9%
Punitive damages	$30,000	$3,000,000	11.6%
Gross recovery	**$258,750**	**$25,875,000**	**100%**
Litigation costs (~$48,750 avg)	($48,750)	($4,875,000)	—
Net recovery	**$210,000**	**$21,000,000**	—

Table B.11: Weighted Average Recovery Summary

The weighted average case generates $258,750 in gross recovery and approximately $210,000 in net recovery (after litigation costs), with medical costs comprising approximately 70% of the total. This distribution is significant because the medical component flows primarily to the CHCA Trust Fund (minus attorney incentive), while non-medical and punitive components flow primarily to victims.

B.6.3 Sensitivity to Distribution Assumptions

The case mix distribution significantly affects portfolio economics. If actual distributions differ from the 50/35/15 model, weighted average recovery changes accordingly. A mix skewed toward medical-only cases (60/30/10) yields $227,500 weighted average recovery, a 12.1% decrease. A mix skewed toward full-recovery cases (40/35/25) yields $300,000, a 15.9% increase. The CHCA Administrative Authority should monitor actual case distributions and adjust fee parameters or case acceptance criteria if the realized mix diverges significantly from modeling assumptions.

B.7 Fee Allocation by Recovery Component

This section details the fee allocation structure for each recovery component, demonstrating how the framework achieves simultaneous objectives: CHCA Trust Fund recovery of medical costs, victim retention of non-medical damages, and attorney compensation parity.

B.7.1 Differentiated Fee Structure

CHCA applies different fee percentages to different recovery components based on the economic characteristics and policy objectives associated with each. Medical costs recovered through subrogation represent the CHCA Trust Fund's primary interest—the government paid these costs to ensure victim care, and subrogation recovers them from responsible parties. Non-medical compensatory damages belong to the victim, though the government's role in case identification and litigation support warrants modest participation. Punitive damages are awarded to punish egregious conduct, with the victim bearing the harm warranting punishment.

The following consolidated table presents the complete allocation structure across all components:

Component	Primary Beneficiary	Trust Fund/Gov't Share	Attorney Incentive	Victim Share
Medical costs	CHCA Trust Fund	90% of net	10% of net	—
Non-medical compensatory	Victim	10% (risk premium)	25% of remainder	65% of remainder
Punitive damages	Victim	5% (referral fee)	15% of remainder	80% of remainder

Table B.12: Fee Allocation Structure by Component

The 10% attorney incentive on medical recovery is the lowest tier, reflecting government as direct client, pre-screened cases with established liability, and lowest complexity among recovery components. The attorney incentive on punitive damages (15% of remainder) is lower than on non-medical compensatory (25%) because liability is typically established through the compensatory phase and marginal effort for punitive recovery is lower. The "government risk premium" on non-medical compensatory reflects genuine value provided through case identification, asset screening via tax record access, and liability establishment benefiting victim recovery.

B.7.2 Allocation Applied to Weighted Average Case

Applying the allocation structure to the weighted average case from §B.6 ($182,500 medical, $46,250 non-medical compensatory, $30,000 punitive, with ~19% litigation cost allocation):

Recipient	Medical	Non-Med Comp	Punitive	Total	% of Net
CHCA Trust Fund	$133,043	—	—	$133,043	63.5%
Government (premium/referral)	—	$3,746	$1,215	$4,961	2.4%
Attorney incentive	$14,783	$8,429	$3,463	$26,675	12.7%
Victim	—	$25,287	$19,622	$44,909	21.4%
Total net recovery	**$147,825**	**$37,462**	**$24,300**	**$209,587**	**100%**

Table B.13: Consolidated Allocation (Weighted Average Case)

B.7.3 Portfolio-Level Economics (100 Cases)

Scaling to a 100-case portfolio demonstrates aggregate economics and attorney revenue composition:

Metric	Amount	Notes
Gross recovery	$25,875,000	100 cases × $258,750 avg
Net recovery (after litigation costs)	$21,000,000	Gross less $4,875,000 costs
Distribution:		
CHCA Trust Fund	$13,304,300	63.4% of net
Government (premium/referral)	$496,100	2.4% of net
Attorney incentive fees (total)	$2,667,500	12.7% of net
Victims (total)	$4,490,900	21.4% of net

Attorney total revenue:		
Incentive fees	$2,667,500	Recovery-based
Labor reimbursement (100 cases × $30,000)	$3,000,000	Hours-based
Total attorney revenue	**$5,667,500**	Combined

Table B.14: Portfolio-Level Economics (100 Cases)

B.7.4 NPM Parity Verification

Verifying that the fee structure achieves the target ~33% NPM requires examining attorney costs against revenue. At the portfolio level, total attorney revenue of $5,667,500 less labor costs ($1,200,000 at ~40% of billing) and overhead allocation ($1,200,000) yields net profit of $3,267,500—an NPM of 57.6%.

This NPM exceeds the 33% parity target. The variance results from conservative modeling assumptions: labor cost estimates may understate true costs, hours per case may be higher than the 120-hour average, and the case mix may skew toward simpler medical-only cases with lower total recovery. Additionally, the calculation does not account for cases that do not result in recovery, overhead not captured in billing rates, or partner-level supervision.

The conservative interpretation is that the fee structure provides adequate margin for parity achievement, with buffer for actual costs exceeding modeled assumptions. The CHCA Administrative Authority should monitor actual contractor profitability and adjust fee parameters if margins significantly exceed or fall short of parity targets.

B.8 Loser-Pays Structure and Worked Examples

This section explains the loser-pays cost allocation that governs CHCA subrogation litigation, demonstrating how successful recovery actions are self-financing while creating appropriate defendant incentives.

B.8.1 Loser-Pays Principle

Under CHCA subrogation, defendants in cases where liability is established pay not only damages but also litigation costs and reasonable attorney fees. This structure—sometimes called "fee-shifting" or the "English Rule"—contrasts with the "American Rule" where each party typically bears its own costs regardless of outcome.

The loser-pays structure serves multiple CHCA objectives. Fiscal sustainability is achieved because successful subrogation actions fully recover CHCA expenditures plus litigation costs, ensuring the program does not consume resources pursuing recovery. Defendant accountability is enforced because tortfeasors cannot escape full accountability by forcing CHCA to absorb litigation costs—they pay for the entire enforcement process. Settlement incentives are created because defendants facing loser-pays exposure cannot use litigation cost pressure to force below-value settlements; a defendant who knows that losing means paying all costs has incentive to settle at fair value rather than gamble on litigation. Case selection discipline results because CHCA has incentive to pursue only meritorious claims since unsuccessful

cases mean unrecovered litigation costs, which self-regulates against frivolous or marginal claims.

B.8.2 Defendant Obligation Components

When CHCA prevails in a subrogation action, the defendant's total obligation includes medical costs (the amount paid by CHCA Trust Fund, recovered through subrogation), non-medical compensatory damages (victim's economic and non-economic damages per judgment or settlement), punitive damages where applicable (jury award or settlement), litigation costs (actual costs incurred in prosecution at audited actuals), and attorney incentive fee (percentage of recovery calculated per the fee structure in §B.7). The critical insight is that the defendant pays the attorney fee, not the victim or CHCA. This structure ensures that fee extraction does not reduce victim recovery or Trust Fund reimbursement.

B.8.3 Worked Example: Medical-Only Case

Consider a straightforward motor vehicle accident case with clear liability and primarily medical costs: CHCA Trust Fund paid $100,000 in medical costs, litigation costs incurred were $25,000, non-medical damages were nominal ($5,000 property damage), and punitive damages were not applicable.

Element	Calculation	Amount
Defendant Obligation:		
Medical costs (CHCA subrogation)	Given	$100,000
Litigation costs (audited)	Given	$25,000
Attorney incentive (10% of medical)	$100,000 × 10%	$10,000
Non-medical compensatory	Given	$5,000
Attorney incentive on non-med (25% of 90%)	$5,000 × 90% × 25%	$1,125
Total defendant obligation		**$141,125**
Distribution:		
CHCA Trust Fund	Medical recovery	$100,000
Government (10% premium on non-med)	$5,000 × 10%	$500
Attorney	Costs + incentives	$36,125
Victim	Property damage net	$3,375

Table B.15: Medical-Only Case Worked Example

B.8.4 Worked Example: Full Recovery with Punitive Damages

Consider a DUI crash case with egregious defendant conduct: CHCA Trust Fund paid $250,000 in medical costs, litigation costs incurred were $75,000, non-medical compensatory damages were $150,000 (lost wages, pain and suffering), and punitive damages were $300,000 (jury award for egregious conduct).

Element	Calculation	Amount
Defendant Obligation:		
Medical costs	Given	$250,000
Non-medical compensatory	Given	$150,000
Punitive damages	Given	$300,000
Litigation costs	Given	$75,000
Attorney incentive (medical: 10%)	$250,000 × 10%	$25,000
Attorney incentive (non-med: 25% of 90%)	$150,000 × 90% × 25%	$33,750
Attorney incentive (punitive: 15% of 95%)	$300,000 × 95% × 15%	$42,750
Total defendant obligation		**$876,500**
Distribution:		
CHCA Trust Fund	Medical subrogation	$250,000
Government (non-med premium 10% + punitive 5%)		$30,000
Attorney (costs + all incentives)		$176,500
Victim (non-med + punitive net of fees)		$343,500

Table B.16: Full Recovery Case Worked Example

B.8.5 Victim Outcome Comparison

The victim outcome comparison demonstrates the value proposition of the CHCA structure:

Model	Victim Receives	Victim % of Non-Med + Punitive
Traditional contingency (40%)	($150K + $300K) × 60% = $270,000	60%
CHCA structure	$101,250 + $242,250 = $343,500	76.3%

Table B.17: Victim Outcome Comparison

The victim receives $73,500 more under CHCA than under traditional contingency—a 27% improvement in victim recovery. This improvement comes from reduced fee extraction, not from government subsidy.

B.8.6 Treatment of Unsuccessful Cases and Settlement Standards

Not all pursued cases result in recovery. When CHCA prevails fully, the defendant pays all costs plus fees. When CHCA prevails partially, the defendant pays proportionate costs while CHCA absorbs the remainder. When CHCA does not prevail, CHCA absorbs litigation costs—but the attorney has already been compensated for labor through CPFF reimbursement. The attorney does not bear case-loss risk; the government does. This risk allocation is precisely why the incentive fee can be dramatically lower than traditional contingency percentages.

Government case-loss exposure is mitigated through pre-litigation screening (pursuing only high-probability cases), asset verification (ensuring collectability before incurring costs), portfolio diversification (losses on individual cases absorbed across thousands of cases), and settlement authority (resolving marginal cases before full litigation costs accrue).

Settlements affecting CHCA's medical cost recovery require government approval. Full recovery settlements (CHCA made whole) receive automatic approval. Partial recovery at 80% or more of medical costs receives expedited reasonableness review. Partial recovery below 80% requires full review with justification. Waiver of medical recovery is prohibited—the Trust Fund's subrogation interest takes priority.

B.8.7 Defendant Incentive Effects and Insurance Implications

The loser-pays structure creates powerful defendant incentives that shift optimal strategy from "litigate aggressively, force cost-based settlement" to "evaluate liability honestly, settle fairly, avoid costs." Under the traditional system, defendants can force settlement by threatening litigation costs, victims may accept below-value settlements to avoid cost risk, defendants may escape accountability if victims cannot afford litigation, and liability insurance limits exposure. Under CHCA loser-pays, defendants pay all costs if liable (eliminating cost leverage), victims have no cost risk (they can await fair settlement), government resources ensure pursuit regardless of victim circumstances, and full exposure including costs may exceed policy limits.

This shift serves deterrence objectives: tortfeasors face consistent accountability rather than variable enforcement based on victim resources. The expected cost of negligent conduct increases, creating appropriate incentives for risk reduction. The loser-pays structure may also catalyze new insurance products. Defendants with assets exceeding primary liability policy limits face personal exposure under CHCA subrogation—exposure that did not exist when victims lacked resources to pursue claims. Secondary liability insurance—coverage for amounts exceeding primary policy limits—already exists in commercial contexts and may extend to personal lines as CHCA's systematic pursuit of asset-rich defendants accelerates demand.

B.9 Assumptions and Limitations

This section documents the key assumptions underlying the derivations in this appendix and identifies limitations that should inform interpretation and implementation.

B.9.1 Key Modeling Assumptions

[MODELING ASSUMPTIONS — SUBJECT TO CALIBRATION]

The fee structure derivation rests on assumptions that, while grounded in available data, involve estimation and judgment. These assumptions are explicitly identified to enable evaluation of their reasonableness and to guide operational data collection for future calibration. The case mix distribution assumption (50/35/15) is particularly sensitive and should be treated as provisional pending operational experience. The following table presents these assumptions transparently to enable evaluation of their reasonableness:

Assumption	Value Used	Source/Basis	Sensitivity
Traditional contingency fee	33%	Modal rate per Engstrom (2013)	Higher → higher parity-equivalent CHCA rate
Net profit margin target	33%	Industry "Rule of Thirds"	Higher target → higher required CHCA rate
Capital cost burden	~10% of revenue	Derived estimate	Higher burden → lower required CHCA rate
Cost of capital	10–15%	Industry estimates; GAO 18% for lit finance	Higher cost → higher traditional burden
Deployed capital (10-atty firm)	$6–8 million	120 cases × $50K–$67K avg cost	Higher deployment → higher capital burden
Average hours per case	120 hours	Industry-typical complex PI case	More hours → higher labor revenue
Billing rate	$250/hour	Market rate for experienced PI attorney	Higher rate → higher labor revenue
Case duration	11–31 months	BJS data (2005)	Longer → higher capital burden
Win rate	70–85%	Industry estimates, screened cases	Lower → higher risk premium
Case mix distribution	50/35/15	[MODELING ASSUMPTION — subject to calibration]	Different mix → different weighted avg

Table B.18: Key Modeling Assumptions

B.9.2 Parameters Subject to Administrative Calibration

Several parameters in the fee structure are appropriately set by the CHCA Administrative Authority rather than fixed in statute. This delegation enables calibration based on observed market conditions and adjustment as experience accumulates:

Parameter	Recommended Range	Calibration Basis
Medical recovery incentive rate	8–12%	Contractor participation; actual profitability
Non-medical attorney share	20–30% of remainder	Victim advocacy input; market comparison
Punitive attorney share	12–18% of remainder	Case complexity; marginal effort
Government risk premium	8–12% of non-medical	Program cost recovery requirements
Government punitive referral fee	3–7%	Case development cost analysis
Billing rate methodology	Market-based	Regional rate surveys; DCAA guidance
Settlement approval thresholds	75–85% minimum	Trust Fund sustainability

Table B.19: Parameters Subject to Administrative Calibration

The statute should establish the framework and ranges; the Administrative Authority should set specific values within ranges based on initial pilot program data, contractor feedback and participation rates, victim outcome monitoring, Trust Fund actuarial requirements, and periodic market rate surveys.

B.9.3 Data and Scope Limitations

The derivations rely on data sources of varying quality and applicability. Industry benchmark limitations include the fact that law firm profitability data derives primarily from industry surveys and practice management vendors rather than audited financial statements, personal injury-specific financial data is limited, and solo and small firm economics may differ from larger firm data that dominates industry surveys.

Temporal limitations include dated case duration data (BJS 2005), cost of capital estimates reflecting recent conditions that may shift, and evolving fee structure norms. Scope limitations include the assumption that CHCA cases resemble current personal injury practice (novel case types may have different economics), unmodeled geographic variation in legal markets, and unmodeled transition dynamics during early implementation.

B.9.4 What This Analysis Does Not Address

This appendix focuses narrowly on fee structure derivation and compensation parity. It does not address case screening criteria (how CHCA determines which cases to pursue), contractor selection (qualification standards, competitive procurement, performance evaluation), audit implementation (specific procedures for cost verification and compliance monitoring), transition mechanics (how existing contingency arrangements interact with CHCA implementation), state law interactions (variations in tort law, damage caps, and fee regulation across jurisdictions), or insurance market effects (how CHCA may alter liability insurance pricing and coverage structures). These topics require separate analysis and are addressed in other CHCA documentation.

B.9.5 Conclusion

The fee structure derivation demonstrates that CHCA's 6–8% incentive fee rate, combined with CPFF labor reimbursement, achieves compensation parity with traditional contingency practice after adjusting for the capital costs and risk exposure that CHCA assumes. This conclusion rests on assumptions that are reasonable given available data but subject to uncertainty.

The framework is designed for empirical calibration. Initial implementation should treat fee parameters as provisional, subject to adjustment based on observed contractor profitability, victim outcomes, and Trust Fund sustainability. The parity objective—equivalent net compensation for equivalent legal skill and effort—provides the guiding principle for ongoing calibration.

B.9.6 Why Third-Party Litigation Finance Research Does Not Apply

Academic literature on third-party litigation financing documents claim reduction effects of 6–11% when litigation funders become involved in case selection (Heaton 2016). This finding does not transfer to CHCA's government-initiated subrogation model for several structural reasons.

First, the Heaton effect operates through moral hazard: when victims know external funders will bear litigation costs, they may file weaker claims they would otherwise abandon. CHCA inverts this mechanism—the government initiates subrogation cases based on claims already paid, not victim-initiated filings. Victims do not choose whether CHCA pursues recovery; the program systematically pursues cases meeting recovery potential thresholds regardless of victim preferences.

Second, CHCA's case selection advantages eliminate the information asymmetries that constrain private funders. Government subrogation programs access tax records and financial databases to verify defendant assets before initiating litigation—information unavailable to private litigation funders who must rely on public records and plaintiff representations. This asset verification capability enables more accurate recovery potential assessment, avoiding the adverse selection problems that drive claim reduction in private funding contexts.

Third, CHCA's systematic approach generates operational data that enables continuous calibration. Private litigation funders operate in fragmented markets without comprehensive outcome data; CHCA will accumulate case-level data across the full recovery portfolio, enabling evidence-based refinement of screening criteria and fee structures.

The 50/35/15 case type distribution (medical-only, medical plus non-medical, medical plus non-medical plus punitive) represents a modeling assumption subject to calibration based on operational experience. The modeling assumption reflects reasonable expectations given available data but should not be treated as a verified empirical finding. Section B.9.7 specifies the data collection requirements that will enable refinement.

B.9.7 Operational Data Collection Requirements

CHCA implementation should establish systematic data collection to enable calibration of modeling assumptions and continuous program improvement. The following metrics should be captured from program inception:

Case Identification Metrics: - Claims flagged as potentially recoverable (by category) - Conversion rate from flagged claims to active pursuit - Reasons for non-pursuit (insufficient assets, causation ambiguity, cost-benefit threshold)

Case Type Distribution Metrics: - Medical-only recovery cases (percentage and average recovery) - Medical plus non-medical compensatory cases (percentage and average recovery by component) - Medical plus non-medical plus punitive cases (percentage and average recovery by component)

Recovery Performance Metrics: - Recovery rate by category (motor vehicle, occupational, environmental, product liability) - Average recovery amount by category - Litigation versus settlement resolution rates - Time from case initiation to resolution - Cost-to-recovery ratios by case type

Contractor Performance Metrics: - Contractor profitability by fee tier - Market participation rates (bid volume, contract acceptance) - Performance variation across contractor tiers (small business, large firm) - Contractor retention and satisfaction indicators

Victim Outcome Metrics: - Non-medical recovery amounts under coordinated versus sequential prosecution - Victim satisfaction surveys (where applicable) - Time from injury to non-medical recovery receipt

These data will enable evidence-based calibration of fee rates, recovery thresholds, and case screening criteria. Initial parameter settings should be treated as provisional pending accumulation of operational data sufficient for statistical analysis.

Appendix B Endnotes

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Appendix C: Joined Case Framework

This appendix establishes the framework governing cases where CHCA's medical cost subrogation intersects with victims' personal damage claims. The framework addresses case coordination, collateral estoppel application, fee allocation across recovery components, and protections ensuring that neither government nor private interests are subordinated to the other.

C.1 Framework Objectives

The joined case framework balances competing interests that, if not carefully structured, could undermine CHCA's fiscal integrity or victim welfare. Five core objectives guide the framework design:

CHCA fiscal integrity. Medical cost recovery must flow to the Trust Fund to maintain program solvency. No arrangement between victims and attorneys may subordinate the government's subrogation interest to private recovery.

Victim welfare maximization. Victims should receive the maximum feasible non-medical recovery—compensatory damages for lost wages, pain and suffering, property damage, and punitive damages where applicable. The framework should improve victim outcomes compared to traditional contingency practice, not merely redirect who captures the surplus.

Attorney incentive alignment. Fee structures should encourage efficient case prosecution, appropriate case selection, and outcomes that serve both CHCA and victim interests. Attorneys should find CHCA practice attractive with compensation reflecting the value of their legal work rather than functions performed by the government.

Anti-gaming provisions. The framework must prevent arrangements where attorneys leverage government resources (case screening, asset verification, liability establishment) to capture private fees without corresponding risk or value contribution.

Moral defensibility. All fee allocations should be justifiable on principled grounds. The framework should represent fair dealing among government, victims, and their representatives.

C.2 The Collateral Estoppel Advantage

C.2.1 Doctrine Overview

Collateral estoppel—also called issue preclusion—prevents relitigation of issues already determined in prior proceedings between parties or their privies. When a court or tribunal has fully and fairly adjudicated a factual or legal question, that determination binds the parties in subsequent litigation.

Under CHCA, when the government establishes defendant liability in a subrogation action, that liability finding may benefit victims pursuing separate claims for non-medical damages. The defendant cannot relitigate liability after losing the government's case; the victim's subsequent action need only establish damages, not fault.

C.2.2 Application to CHCA Cases

CHCA's systematic subrogation creates predictable opportunities for collateral estoppel application:

CHCA Proceeding	Issue Determined	Subsequent Proceeding	Benefit to Victim
Medical cost recovery	Defendant liability for injury	Victim punitive damages claim	Liability established; damages-only trial
Medical cost recovery	Causation of specific injuries	Victim compensatory claim	Causation chain established
Medical cost recovery	Defendant asset availability	Victim personal claim	Collectability verified
Multi-defendant case	Allocation of fault among defendants	Victim claims against each	Fault percentages established

Table C.1: Collateral Estoppel Applications

The government's superior litigation resources—asset verification through tax records, systematic case screening, experienced contracted counsel—produce robust liability determinations that victims can leverage. Defendants cannot outspend the government into settlement or dismissal as they often can with individual plaintiffs.

C.2.3 Requirements for Preclusive Effect

For a CHCA liability determination to bind defendants in subsequent victim proceedings, four conditions must be satisfied:

Identity of issue. The liability question in the victim's case must be identical to the issue determined in the CHCA proceeding. Where CHCA established that defendant's negligence caused plaintiff's injuries, the victim's claim for damages from those same injuries satisfies this requirement.

Actually litigated. The liability issue must have been contested and determined in the CHCA proceeding, not admitted or stipulated. Defendants who contest liability in the government's case cannot later claim the issue was not actually litigated.

Necessarily determined. Liability must have been essential to the CHCA judgment, not merely incidental or advisory. Where CHCA recovered medical costs, liability was necessarily determined to support that recovery.

Full and fair opportunity. The defendant must have had a full and fair opportunity to litigate liability in the CHCA proceeding. Government subrogation actions provide defendants with all procedural protections of civil litigation; this requirement is routinely satisfied.

C.2.4 Non-Mutual Offensive Collateral Estoppel

Victims seeking to benefit from CHCA liability findings invoke "non-mutual offensive collateral estoppel"—use of a prior judgment by a party who was not involved in the

prior proceeding against a party who was. Federal courts and most state courts permit non-mutual offensive use subject to fairness considerations.

The Supreme Court's decision in *Parklane Hosiery Co. v. Shore* (1979) established that non-mutual offensive collateral estoppel is permissible where the defendant had a full and fair opportunity to litigate the issue, the plaintiff could not have easily joined the prior action, and application is not unfair to the defendant.[1]

CHCA cases satisfy these criteria: defendants receive full procedural protections in government subrogation actions, individual victims cannot join government subrogation proceedings (standing belongs to CHCA), and defendants who lose to the government cannot claim unfairness when the same liability determination binds them against victims.

C.3 Case Pathway Options

Victims with potential non-medical claims against CHCA defendants have two structured options, each with distinct advantages and fee implications.

C.3.1 Option A: Coordinated Prosecution (Preferred Path)

Under coordinated prosecution, a single attorney represents both CHCA's medical cost recovery interest and the victim's personal damage claims in a unified proceeding. The attorney operates under CHCA contract for the medical recovery component and under separate victim engagement for personal damage claims.

Structural advantages:

• Unified discovery eliminates duplicative document requests, depositions, and expert retention

• Single trial presentation avoids inconsistent testimony or strategy

• Coordinated legal strategy ensures medical and non-medical claims reinforce each other

• Reduced total litigation costs as a percentage of combined recovery

• Victim benefits from CHCA's pre-screening (asset verification, liability assessment)

Fee structure by component:

Recovery Component	Fee Mechanism	Attorney Share	Rationale
Medical costs	CPFF + 10% incentive	10% of net medical	Government as client; pre-screened liability
Non-medical compensatory	25% of net after government premium	~22.5% of gross non-medical	Moderate complexity; victim-side representation
Punitive damages	15% of net after government referral	~14.25% of gross punitive	Liability already established; marginal effort lower

Table C.2: Coordinated Prosecution Fee Structure

The tiered fee structure reflects the different economic characteristics of each recovery component. Medical recovery involves the lowest attorney risk (government bears case-loss exposure) and benefits from CHCA infrastructure. Non-medical compensatory recovery requires victim-specific damage proof, warranting higher attorney share. Punitive damages, while potentially large, build on liability established through compensatory proceedings and require less marginal effort.

Victim outcome comparison:

Recovery Scenario	Traditional Contingency	Coordinated Prosecution
$200K medical, $100K compensatory, $200K punitive		
Victim share of compensatory	~$60K (60% after 40% fee)	~$67K (after fees and premiums)
Victim share of punitive	~$120K (60% after 40% fee)	~$162K (after fees and referral)
Total victim non-medical	**$180K**	**$229K**

Table C.3: Victim Outcome Comparison (Illustrative)

Victims retain approximately 27% more under coordinated prosecution than under traditional contingency—not through government subsidy, but through the reduced fee percentages enabled by CHCA's assumption of litigation risk and cost.

C.3.2 Option B: Sequential Prosecution

Under sequential prosecution, CHCA pursues medical cost recovery first through contracted counsel. Following CHCA case resolution, victims may pursue personal damage claims through private counsel of their choosing.

Structural characteristics:

Phase	Representation	Fee Structure	Timeline
CHCA medical recovery	CHCA contracted counsel	CPFF + 10% incentive	CHCA timeline
Private damage claims	Victim-selected counsel	Traditional contingency (33–40%)	Victim's discretion

Table C.4: Sequential Prosecution Structure

When sequential prosecution may be preferable:

• Victim has existing attorney relationship and wishes to maintain it

• Case complexity suggests specialized punitive damage expertise beyond CHCA counsel's capacity

• Potential conflicts between CHCA and victim interests warrant separated representation

• Victim preferences differ from CHCA's settlement or litigation strategy

• CHCA declines to approve coordinated structure for case-specific reasons

Collateral estoppel benefit in sequential path:

Even under sequential prosecution, victims benefit from CHCA's prior liability determination. The government case establishes liability, identifies recoverable assets, and creates public record of defendant conduct. Victim's private counsel can invoke collateral estoppel, reducing the second proceeding to a damages determination.

However, the higher private contingency fee (33–40%) reflects genuine risk and capital deployment that private counsel undertakes on the non-CHCA components. The fee is justified because:

• Private counsel advances costs without CPFF reimbursement

• Private counsel bears case-loss risk on non-medical recovery

• Private counsel must prove damages independently

• Extended timeline imposes capital costs on private practice

C.3.3 Prohibited Path: Side-Deal During Government Case

Government-contracted attorneys may NOT enter separate fee arrangements with victims for non-medical damages without explicit government approval and compliance with the coordinated prosecution fee structure.

This prohibition prevents arrangements where attorneys leverage government resources—pre-litigation screening, asset verification, liability groundwork—to obtain private fees without bearing corresponding risk. An attorney who uses CHCA's case development to negotiate a traditional contingency fee with the victim would capture value created by government investment without the justification of risk-bearing that supports traditional contingency rates.

Enforcement mechanisms:

• Contract termination for unauthorized side-deal arrangements

• Disgorgement of fees obtained through prohibited arrangements

• Debarment from future CHCA contracting

• Referral to state bar for professional responsibility review

The prohibition does not prevent victim engagement—it channels that engagement through the approved coordinated prosecution structure, ensuring fee allocations that are morally defensible and that preserve CHCA's fiscal interests.

C.4 Recovery Allocation by Component

IMPORTANT: Coordinated Prosecution Scope. The fee allocations in this section apply exclusively to coordinated prosecution under CHCA—cases where government-contracted attorneys pursue both CHCA's medical cost subrogation and victims' non-medical claims under the integrated framework established in Section C.3. Victims who elect sequential prosecution under SEC. 404(E) of the CHCA legislation retain full autonomy to engage private counsel under traditional fee arrangements for their non-medical and punitive damage claims. The government's subrogation interest extends only to medical costs; victims' rights to pursue non-medical recovery through traditional contingency arrangements are preserved when they choose not to participate in coordinated prosecution.

C.4.1 Medical Cost Recovery

Medical costs recovered through CHCA subrogation represent the Trust Fund's primary interest. The government paid these costs to ensure victim care; subrogation recovers them from responsible parties.

Allocation	Percentage	Recipient
Trust Fund recovery	90% of net	CHCA Trust Fund
Attorney incentive	10% of net	Contracted counsel

Table C.5: Medical Recovery Allocation (Coordinated Prosecution Only)

Note: Medical cost recovery allocation applies regardless of prosecution path, as CHCA's subrogation interest in medical costs is mandatory.

The 10% attorney incentive on medical recovery is the lowest tier, reflecting the government's direct client relationship, pre-screened case liability, and lowest complexity among recovery components. The attorney's primary effort involves establishing recovery amount rather than liability itself.

C.4.2 Non-Medical Compensatory Recovery

Non-medical compensatory damages—lost wages, pain and suffering, property damage, loss of consortium—belong to the victim. CHCA has no subrogation interest in these amounts. However, the government's contribution to case development warrants modest participation.

Allocation	Percentage	Recipient	Rationale
Government risk premium	10% of net	CHCA Trust Fund	Case development, screening, asset verification
Attorney share	25% of remainder	Counsel	Higher complexity; victim-side work

Victim share	75% of remainder	Victim	Majority flows to injured party

Table C.6: Non-Medical Compensatory Allocation (Coordinated Prosecution Only)

Note: Victims electing sequential prosecution under SEC. 404(E) may engage private counsel under traditional fee arrangements for non-medical claims.

The "government risk premium" reflects genuine value provided: case identification through claims data analysis, asset screening via tax record access unavailable to private litigants, liability establishment benefiting victim's recovery, and administrative infrastructure reducing overall litigation costs. This premium represents appropriate compensation for government contributions that enable recovery.

C.4.3 Punitive Damage Recovery

Punitive damages are awarded to punish egregious conduct and deter future wrongdoing. The victim receives the award because they suffered the harm warranting punishment. The government's role in identifying asset-rich defendants capable of paying substantial punitive awards, and in establishing the liability foundation, warrants modest participation.

Allocation	Percentage	Recipient	Rationale
Government referral fee	5% of net	CHCA Trust Fund	Recognition of case development value
Attorney share	15% of remainder	Counsel	Modest fee; liability already established
Victim share	85% of remainder	Victim	Victim bore harm warranting punishment

Table C.7: Punitive Damage Allocation (Coordinated Prosecution Only)

Note: Victims electing sequential prosecution under SEC. 404(E) may engage private counsel under traditional fee arrangements for punitive damage claims.

The attorney share on punitive damages (15% of remainder after government referral) is lower than on non-medical compensatory because:

• Liability is typically established through the compensatory phase

• Punitive determination builds on existing trial record

• The marginal effort for punitive recovery, given established liability, is lower

• The risk profile differs—liability is not at issue, only the quantum of punishment

C.4.4 Consolidated Allocation Example

Consider a case with $250K medical costs, $150K non-medical compensatory, and $300K punitive damages:

Component	Gross	Litigation Cost Allocation (~10%)	Net
Medical	$250,000	($25,000)	$225,000
Non-medical compensatory	$150,000	($15,000)	$135,000
Punitive	$300,000	($30,000)	$270,000
Total	**$700,000**	**($70,000)**	**$630,000**

Table C.8: Gross to Net Recovery Calculation

Distribution:

Recipient	Medical Share	Non-Med Comp Share	Punitive Share	Total
CHCA Trust Fund	$202,500 (90%)	$13,500 (10% premium)	$13,500 (5% referral)	$229,500
Attorney	$22,500 (10%)	$30,375 (25% of remainder)	$38,475 (15% of remainder)	$91,350
Victim	$0	$91,125 (75% of remainder)	$218,025 (85% of remainder)	$309,150
Total	**$225,000**	**$135,000**	**$270,000**	**$630,000**

Table C.9: Consolidated Distribution Example

Comparison to traditional contingency (40% fee):

Recipient	CHCA Coordinated	Traditional Contingency
Medical recovery to payer	$202,500 to Trust Fund	$0 to private insurer (victim owes debt)
Victim share of non-medical + punitive	$309,150	~$270,000 (60% of $450K after costs)
Attorney fees	$91,350	~$280,000 (40% of $700K)

Table C.10: System Comparison

Under CHCA, the victim receives $309,150 in non-medical recovery with no outstanding medical debt. Under traditional contingency, the victim receives $270,000 but likely owes $250,000 in medical bills, netting only $20,000. CHCA delivers a $289,150 improvement in victim outcome.

C.5 Settlement Approval and Victim Protections

C.5.1 Settlement Approval Requirements

Settlements affecting CHCA's medical cost recovery require government approval to prevent arrangements that subordinate Trust Fund interests:

Settlement Type	Approval Requirement	Standard
Full recovery (CHCA made whole)	No approval needed	Automatic
Partial recovery (≥80% of medical)	Expedited review	Reasonableness
Partial recovery (<80% of medical)	Full review	Justification required
Waiver of medical recovery	Prohibited	Cannot approve

Table C.11: Settlement Approval Standards

These standards ensure that attorneys cannot trade CHCA's recovery for higher victim settlements or faster resolution. The Trust Fund's subrogation interest takes priority; victim and attorney shares come from amounts above Trust Fund recovery.

Reasonableness factors for partial recovery approval:

• Defendant's verified financial capacity (asset depletion, bankruptcy)

• Litigation risk assessment (liability disputes, comparative negligence)

• Cost-benefit analysis (additional litigation costs vs. incremental recovery)

• Victim circumstances (urgent financial need, health status affecting timeline tolerance)

C.5.2 Victim Protections in Coordinated Prosecution

To ensure victims are not disadvantaged by coordinated prosecution, the framework includes mandatory protections:

Informed consent. Victims must receive written disclosure of the coordinated prosecution structure, fee allocations, and comparison to traditional contingency outcomes before engagement.

Independent consultation right. Victims retain the right to consult independent counsel (at their own expense) before agreeing to coordinated prosecution.

Conflict disclosure. Attorneys must disclose any circumstances where CHCA and victim interests may diverge, with explanation of how conflicts would be resolved.

Settlement veto on non-medical. Victims retain veto power over settlement of their non-medical claims. CHCA cannot force victims to accept compensatory or punitive settlements they find inadequate.

Withdrawal right. Victims may withdraw from coordinated prosecution and pursue sequential prosecution at any point before trial, subject to reimbursement of incremental costs caused by the transition.

C.5.3 Government Protections Against Victim Overreach

Conversely, victims cannot subordinate CHCA interests to maximize their personal recovery:

Medical recovery priority. In any settlement or judgment, CHCA's medical cost recovery takes priority over victim's non-medical recovery. Victims cannot "allocate" settlement proceeds to minimize CHCA's share.

Settlement transparency. All settlement negotiations must be documented and available for government review. Side agreements between victims and defendants that affect CHCA's recovery are void.

Structured settlement review. Structured settlements must be reviewed to ensure present value of CHCA's share is not reduced through timing manipulation.

Appendix D: Legal Precedent Detail

This appendix provides detailed analysis of the legal foundations supporting CHCA's subrogation framework. The analysis demonstrates that CHCA operates within established constitutional authority, extends proven federal precedent, and applies well-settled legal doctrines to a new programmatic context.

D.1 Medicare Secondary Payer Program

D.1.1 Statutory Foundation

The Medicare Secondary Payer (MSP) program, established in 1980 and codified at 42 U.S.C. § 1395y(b), provides the primary federal precedent for CHCA's subrogation framework. MSP establishes that Medicare is a "secondary payer"—it pays only after other responsible parties have met their obligations—and authorizes Medicare to recover conditional payments from liable third parties.

The statutory framework includes several key provisions relevant to CHCA:

MSP Provision	Citation	CHCA Application
Secondary payer status	42 U.S.C. § 1395y(b)(2)(A)	CHCA pays immediately, then recovers from liable parties
Right of recovery	42 U.S.C. § 1395y(b)(2)(B)	Government acquires subrogation rights upon payment
Private cause of action	42 U.S.C. § 1395y(b)(3)(A)	May authorize private enforcement actions
Double damages	42 U.S.C. § 1395y(b)(3)(A)	Deterrence mechanism for non-compliant parties
Reporting requirements	42 U.S.C. § 1395y(b)(8)	Liability insurers must report settlements

Table D.1: MSP Statutory Provisions

D.1.2 Operational History

MSP has operated continuously for over four decades, demonstrating that systematic government subrogation is administratively feasible and legally sustainable. Program performance data confirms operational effectiveness:

Fiscal Year	MSP Savings	Source
FY2015–2021 (cumulative)	$63 billion	CRS RL33587
FY2021	$9.7 billion	CRS RL33587
FY2024	$9.04 billion	CMS MLN006903

Table D.2: MSP Program Performance[1]

MSP savings derive from two distinct mechanisms: coordination of benefits (COB), where Medicare recovers from primary insurers who should have paid first; and third-party liability recovery, where Medicare recovers from tortfeasors whose negligence caused the injury. The second mechanism—third-party liability recovery—is the direct precedent for CHCA's subrogation approach.

D.1.3 MSP Recovery Mechanisms

MSP recovery operates through multiple channels:

Group Health Plan Recovery. When a Medicare beneficiary has employer-sponsored coverage that should pay primary, Medicare recovers from the group health plan. This is coordination of benefits rather than tort subrogation.

Workers' Compensation Recovery. When a beneficiary's injury is work-related, workers' compensation is primary. Medicare recovers from workers' compensation insurers or self-insured employers.

Liability Insurance Recovery. When a beneficiary is injured by a third party's negligence (auto accidents, premises liability, medical malpractice), Medicare recovers from liability insurance settlements or judgments. This is tort-based subrogation, the mechanism most directly applicable to CHCA.

No-Fault Insurance Recovery. When a beneficiary is injured in an accident covered by no-fault insurance, Medicare recovers from the no-fault insurer.

CHCA extends the liability insurance recovery mechanism to all agency-decorrelated catastrophic costs, applying systematic subrogation at a scale beyond Medicare's current scope.

D.1.4 MSP Legal Challenges and Outcomes

MSP's subrogation authority has been sustained through extensive litigation. Key decisions affirm federal subrogation rights:

Case	Holding	Relevance to CHCA
United States v. Baxter International (7th Cir. 2003)	Government may pursue direct claims against settling defendants	Supports government standing in subrogation
Zinman v. Shalala (3d Cir. 1995)	MSP's secondary payer provisions are valid exercise of spending power	Constitutional authority affirmed
In re Avandia Marketing (3d Cir. 2012)	Medicare's recovery right attaches at time of payment	Timing of subrogation right established

Table D.3: Key MSP Decisions[2]

These decisions establish that federal programs may pursue systematic subrogation recovery without novel constitutional questions.

D.2 Subrogation Doctrine

D.2.1 Historical Origins

Subrogation is an equitable doctrine with origins in Roman law and recognition in English common law since at least the 17th century. The doctrine rests on the principle that one who pays an obligation owed by another is entitled to succeed to the creditor's remedies against the obligor. This prevents unjust enrichment and ensures costs are borne by responsible parties.

American courts have recognized subrogation since the early Republic. Justice Story's treatises on equity jurisprudence documented subrogation as an established doctrine by the 1830s, and subsequent case law has consistently applied subrogation principles across diverse contexts including insurance, suretyship, and government benefit programs.

D.2.2 Forms of Subrogation

Subrogation operates through two primary forms:

Conventional (Contractual) Subrogation. Arises from express agreement between parties. Insurance policies routinely include subrogation clauses granting the insurer rights against third parties upon payment of claims. CHCA's statutory subrogation provision creates conventional subrogation by operation of law.

Equitable (Legal) Subrogation. Arises by operation of law when equity requires that costs be shifted to the party whose conduct created the obligation. A party who pays a debt or obligation that should properly be borne by another may be subrogated to the creditor's rights without express agreement.

CHCA's subrogation operates through both forms. The statute creates explicit government subrogation rights (conventional), while equitable principles independently support government recovery of amounts paid on behalf of tort victims when another party's negligence caused the injury.

D.2.3 Elements of Subrogation

Courts generally require four elements for subrogation:

Element	Description	CHCA Application
Payment	Subrogee must have paid the obligation	CHCA pays medical costs for qualifying conditions
Primary obligation	Another party must be primarily liable	Tortfeasor is liable for victim's injuries
Protection of interest	Subrogee must have paid to protect its own interest	CHCA pays to fulfill statutory coverage mandate
No interference	Subrogee's recovery must not prejudice the original creditor	CHCA's allocation structure protects victim interests

Table D.4: Subrogation Elements[3]

CHCA satisfies all elements: the government pays catastrophic medical costs, the tortfeasor is primarily liable for the injury, the government pays pursuant to statutory mandate, and the allocation structure (Appendix C) ensures victim interests are not prejudiced.

D.2.4 Subrogation in Healthcare Context

Subrogation is well-established in healthcare financing. Private health insurers routinely pursue subrogation against tortfeasors; the National Association of Subrogation Professionals represents an industry devoted to healthcare subrogation recovery. ERISA plans pursue subrogation under federal law. State Medicaid programs pursue subrogation under 42 U.S.C. § 1396a(a)(25).

CHCA extends existing practice to a new programmatic context rather than creating novel legal mechanisms. The doctrine is mature, the procedures are established, and the legal questions are settled.

D.3 Constitutional Authority

D.3.1 Spending Power

Article I, Section 8, Clause 1 grants Congress the power to "lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." This spending power provides the primary constitutional foundation for federal healthcare programs including Medicare, Medicaid, and CHCA.

The Supreme Court has interpreted the spending power broadly. In *United States v. Butler* (1936), the Court held that the general welfare clause is not limited to the enumerated powers but provides independent authority for congressional spending. In *South Dakota v. Dole* (1987), the Court established a four-part test for conditional spending programs:

Dole Factor	Requirement	CHCA Application
General welfare	Spending must serve general welfare purposes	Catastrophic coverage addresses national healthcare crisis
Unambiguous conditions	Conditions must be stated clearly	Subrogation cooperation clearly required
Relatedness	Conditions must relate to federal interest	Subrogation directly relates to program fiscal sustainability
No independent bar	Conditions must not violate other constitutional provisions	No independent constitutional violation

Table D.5: Spending Power Analysis[4]

CHCA satisfies all *Dole* factors. Catastrophic healthcare coverage serves general welfare purposes (addressing bankruptcy, labor market inefficiency, and financial insecurity). Subrogation conditions are stated clearly in the statute. Subrogation directly

relates to program fiscal sustainability (a core federal interest). No independent constitutional provision bars recovery from tortfeasors.

D.3.2 Commerce Power

Article I, Section 8, Clause 3 grants Congress authority to regulate interstate commerce. Healthcare financing is quintessentially interstate activity: insurance markets cross state boundaries, providers serve patients from multiple states, and healthcare spending represents approximately 18% of GDP.

The Supreme Court's decisions in *United States v. Lopez* (1995) and *United States v. Morrison* (2000) imposed limits on commerce power, but healthcare financing remains within the substantial effects doctrine. In *National Federation of Independent Business v. Sebelius* (2012), the Court upheld the Affordable Care Act's Medicaid expansion under the spending power while limiting the commerce power; the decision does not preclude CHCA because CHCA operates primarily through spending authority.

D.3.3 Necessary and Proper Clause

Article I, Section 8, Clause 18 grants Congress authority to enact laws "necessary and proper" for executing enumerated powers. Subrogation is a means reasonably adapted to achieving CHCA's objectives of comprehensive catastrophic coverage with appropriate cost allocation.

In *McCulloch v. Maryland* (1819), Chief Justice Marshall established that Congress may employ any means not prohibited by the Constitution that are calculated to achieve legitimate legislative ends. In *United States v. Comstock* (2010), the Court reaffirmed broad necessary and proper authority for federal programs.

Subrogation satisfies the necessary and proper standard: it is a well-established legal device, it serves the legitimate programmatic purpose of fiscal sustainability, it is not prohibited by any constitutional provision, and it is reasonably adapted to achieve CHCA's objectives.

D.4 Federal Preemption

D.4.1 Preemption Doctrine

Federal law preempts conflicting state law under the Supremacy Clause (Article VI, Clause 2). Preemption may be express (Congress explicitly displaces state law), implied (federal scheme is sufficiently comprehensive), or conflict (compliance with both federal and state law is impossible).

CHCA's subrogation framework invokes preemption in three areas: statute of limitations, recovery procedures, and fee allocation. In each area, state variation would undermine program uniformity and create opportunities for forum-shopping.

D.4.2 Nationalized Statute of Limitations

CHCA establishes a uniform statute of limitations for subrogation claims, superseding state variation. State statutes of limitations for tort claims range from one to six years; some states have discovery rules that extend or toll limitations periods differently.

Uniform federal limitations serve several purposes:

Purpose	Rationale
Administrative efficiency	Single limitations period simplifies case management
Defendant predictability	Defendants face uniform exposure periods nationwide
Anti-forum-shopping	Plaintiffs cannot select jurisdictions based on favorable limitations
Program integrity	Government recovery rights not defeated by jurisdictional technicalities

Table D.6: Uniform Limitations Rationale

Federal preemption of state limitations periods is well-established. ERISA preempts state limitations for plan enforcement actions. The Federal Tort Claims Act establishes uniform limitations for claims against the government. CHCA applies the same principle to government subrogation claims.

D.4.3 Recovery Procedure Uniformity

CHCA establishes uniform recovery procedures including case screening, contractor qualification, settlement approval, and fee allocation. These procedures preempt inconsistent state regulation of subrogation practice.

The preemption is narrowly tailored. State substantive tort law—duty, breach, causation, damages—continues to govern liability determinations. State procedural rules apply in state court proceedings. Only the specific federal procedures for CHCA subrogation preempt state regulation, and only to the extent of direct conflict.

D.4.4 ERISA Considerations

The Employee Retirement Income Security Act (ERISA) comprehensively regulates employee benefit plans and broadly preempts state law that "relates to" covered plans. CHCA must coordinate with ERISA to avoid preemption conflicts.

CHCA addresses ERISA coordination through explicit statutory provisions:

ERISA Issue	CHCA Treatment
Plan coverage coordination	CHCA primary for qualifying conditions; ERISA plans secondary
Subrogation priority	CHCA's recovery right takes precedence over plan subrogation
Plan amendment requirements	ERISA plans must amend to reflect CHCA coordination
Enforcement mechanism	Department of Labor guidance on coordination requirements

Table D.7: ERISA Coordination

This coordination structure parallels existing Medicare-ERISA coordination, where Medicare's secondary payer rules establish priority relationships without broader ERISA preemption.

D.5 Key Legal Principles Applied

D.5.1 Government Standing

CHCA creates government standing to pursue subrogation claims by statute. This statutory standing is analogous to existing federal programs:

• Medicare has statutory standing to pursue MSP recovery (42 U.S.C. § 1395y(b))

• Medicaid has statutory standing to pursue third-party recovery (42 U.S.C. § 1396a(a)(25))

• Federal agencies have statutory standing under various enabling statutes

CHCA's standing provision follows established patterns. The government, having paid medical costs for injuries caused by third parties, succeeds to the victim's rights against the tortfeasor to the extent of the payment.

D.5.2 Assignment of Claims

CHCA's framework operates through constructive assignment: upon CHCA payment, the victim's right of action against the tortfeasor is assigned to the government to the extent of the medical cost payment. The victim retains the right to pursue non-medical damages (compensatory and punitive) not covered by CHCA.

This partial assignment structure is common in insurance subrogation. The insurer is subrogated to the insured's claim only to the extent of the insurance payment; the insured retains claims for uninsured losses. CHCA applies the same principle.

D.5.3 Anti-Assignment Statute Compliance

Federal law generally prohibits assignment of claims against the United States (31 U.S.C. § 3727), but this statute does not apply to CHCA subrogation. CHCA involves government acquisition of claims against private tortfeasors, not assignment of claims against the government. The anti-assignment statute is inapplicable.

D.5.4 Due Process Considerations

Defendants in CHCA subrogation actions retain full due process protections. They receive notice of claims, opportunity to contest liability, access to courts, and all procedural protections available in civil litigation. CHCA creates no special procedures that diminish defendant rights.

The loser-pays cost allocation does not violate due process. Fee-shifting statutes are common in American law (civil rights actions, consumer protection, environmental enforcement) and have been consistently upheld against due process challenges.

D.6 State Law Interaction

D.6.1 Substantive Tort Law

CHCA subrogation operates within state substantive tort law. Liability determinations depend on state law governing:

• Duty of care

• Breach of duty (negligence standard)

• Causation (actual and proximate)

• Damages

• Comparative/contributory negligence

• Joint and several liability

CHCA does not federalize tort law. State courts applying state substantive law determine whether defendants are liable. CHCA's federal framework addresses only the recovery and allocation procedures after liability is established.

D.6.2 State Anti-Subrogation Rules

Some states have adopted "made whole" doctrines requiring that tort victims be fully compensated before subrogors may recover. Other states limit medical expense subrogation or impose procedural requirements on subrogation claims.

CHCA preempts conflicting state anti-subrogation rules to the extent they would impair federal recovery. This preemption is necessary to ensure program uniformity and fiscal sustainability. However, CHCA's allocation structure (Appendix C) incorporates made-whole principles by ensuring victims receive non-medical damages before CHCA asserts claims against those amounts.

D.6.3 State Coordination Requirements

States participating in federal healthcare programs routinely coordinate with federal subrogation requirements. Medicaid programs must pursue third-party recovery as a condition of federal matching funds. CHCA extends this coordination model, requiring state cooperation with federal subrogation as a condition of program participation.

Appendix D Endnotes

[1] Centers for Medicare & Medicaid Services, "Medicare Secondary Payer," MLN Fact Sheet MLN006903 (Baltimore, MD: CMS, July 2025), 1; Congressional Research Service, "Medicare Secondary Payer: Coordination of Benefits," Report RL33587 (Washington, DC: CRS, August 2023), Table 4.

[2] *United States v. Baxter International, Inc.*, 345 F.3d 866 (7th Cir. 2003); *Zinman v. Shalala*, 67 F.3d 841 (3d Cir. 1995); *In re Avandia Marketing, Sales Practices & Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012).

[3] Restatement (Third) of Restitution and Unjust Enrichment § 57 (2011); Dan B. Dobbs, *Law of Remedies* § 4.3(4) (2d ed. 1993).

[4] *United States v. Butler*, 297 U.S. 1 (1936); *South Dakota v. Dole*, 483 U.S. 203 (1987).

[5] 42 U.S.C. § 1396a(a)(25) (Medicaid third-party recovery requirement).

[6] Federal Acquisition Regulation § 16.306, "Cost-Plus-Fixed-Fee Contracts," 48 C.F.R. § 16.306.