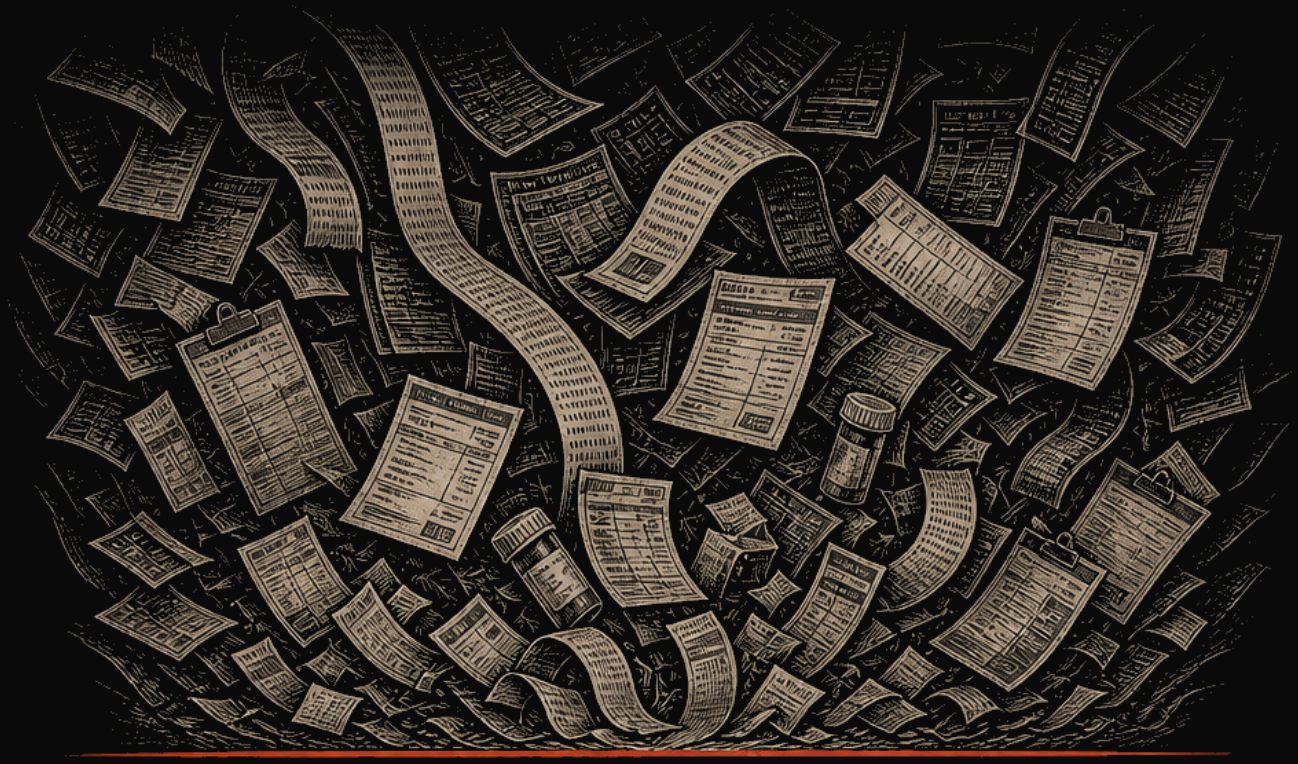
Something for Something

Capping Americans' Exposure to Healthcare Risk



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Abstract

The United States asks individuals to absorb uncertainty twice: through healthcare bills whose upper limit can be difficult to know, and through a tax system that often reconciles income, credits, dependents, and withholding only after the year has ended. *Something for Something* replaces those uncertainties with one coordinated bargain.

Every taxpayer, spouse, and dependent would receive a $5,000 annual ceiling on personal liability for nationally covered medical care. This is not a deductible everyone must satisfy, nor does it replace private insurance. Existing public programs, employer coverage, individual plans, provider networks, and ordinary cost sharing continue below the ceiling. For commercially insured people, the insurer absorbs covered patient liability above $5,000. A separate accumulator determines federal reimbursement: the insurer carries recognized allowed claims through a $10,000 attachment and shares only claims above it with the federal government under contract. At $5,000, the patient exits the financial dispute. Insurers, providers, and government settle the rest.

In return, Tax Day becomes an annual Household Account check-in. Most wage-based taxpayers confirm filer status, spouse, dependents, coverage, and material changes rather than reconstructing information government and employers already possess. Withholding and benefits then update prospectively. Anyone who misses or cannot use the simplified process retains a full filing and appeal path. The tax account verifies household and coverage facts but never contains diagnoses, procedures, or clinical records.

The proposal is a three-way trade. Individuals receive a known medical maximum, easier enrollment, and larger take-home pay where premium relief passes through. Employers receive lower and more predictable health-benefit costs. Insurers gain a broader customer funnel and federal protection against part of the upper claims layer while retaining responsibility for price, care management, and claims integrity. Government assumes a bounded role and gains more precise withholding, standardized claims information, and stronger tools against improper payment and fraud.

A provisional fiscal model using the 2024 Medical Expenditure Panel Survey estimates a Base gross federal cost of approximately $483.7 billion annually, with a modeled range of $377.3 billion to $620.0 billion. No offset has yet been verified, so the current internal net remains $483.7 billion. Candidate offsets total approximately $81.4 billion in the Base case and would produce an illustrative provisional net cost of $402.3 billion if validated. These are planning estimates, not a formal federal score. The model uses AHRQ's HC-256 Full-Year Consolidated File and preserves the paper's existing policy and scenario assumptions.

Something for Something does not promise free healthcare. It promises that healthcare can no longer become financially endless. The state guarantees certainty. The public supplies accurate participation. The institutions fight over the remainder.

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Executive Summary

Americans should know the maximum medical damage one year can do to their finances.

Today, that answer is obscured by premiums, deductibles, coinsurance, copayments, networks, formularies, prior authorization, uncovered services, and billing disputes. Insurance may protect a person well, badly, or incompletely. Even insured adults skip care because of cost, and medical debt remains common.[1][20]

Something for Something proposes a simple national guarantee:

> No taxpayer, spouse, or dependent will owe more than $5,000 in one year for covered medical care.

The $5,000 figure is an absolute ceiling, not a universal deductible. No one must spend $5,000 before receiving care. Existing insurance can continue to provide lower deductibles, copayments, preventive care, better networks, employer contributions, dental or vision benefits, and other protection. The federal guarantee is the last line of defense beneath every qualifying arrangement.

For a commercially insured person, current plan rules continue until recognized patient liability reaches $5,000. The patient then owes no more for covered care that year. A separate commercial-claims accumulator determines institutional payment. The insurer retains full responsibility through $10,000 in recognized allowed claims; above that attachment, the leading model divides the upper layer evenly between the insurer and federal government. The share is set by annual or multiyear contract, not renegotiated for each patient.

For someone enrolled in Medicare, Medicaid, the Children's Health Insurance Program, or another public program, that program remains primary and the federal policy fills covered patient liability above $5,000. For an uninsured person, the federal backstop pays nationally covered care above the ceiling while the annual tax process offers a direct route into optional private coverage.

At $5,000, the individual leaves the financial dispute.

Providers, insurers, and government may still dispute coding, reimbursement, medical necessity, fraud, or which institution owes what. Those conflicts do not disappear. They move away from the ill person and into institutions with the time, data, staff, contracting power, and legal tools to resolve them.

The guarantee is paired with a tax-administration bargain.

Tax season remains, but its purpose changes. Most wage-based taxpayers no longer rebuild a record the government largely receives from employers and financial institutions. Instead, the Household Account presents the known record and asks the filer to confirm or update:

- filer and spouse;
- dependents;
- residence;
- months of health coverage;
- insurer and plan;
- employment and major income changes;
- payroll-deduction choices;
- other facts needed for withholding and benefits.

After confirmation, withholding and eligible benefits adjust prospectively. The account can also be updated after a birth, marriage, divorce, death, custody change, job change, move, or coverage change. People with complicated income, those who miss the check-in, and those who dispute the record retain the full filing and appeal process.

This is not the abolition of taxes. It is the attempted abolition of routine surprise.

This is a three-way trade, not a federal takeover.

Individuals receive a known medical maximum, a yearly enrollment prompt, and greater take-home pay where premium savings pass through. Employers shed part of the upper-layer cost and administrative pressure associated with health benefits. Insurers gain customers and federal protection against part of the upper claims layer while retaining the ability to sell coverage that improves on the national floor. Government gains a recurring household-verification moment, more accurate withholding, standardized claims information, and the ability to negotiate and audit at institutional scale.

The fiscal cost is substantial. The current Base model estimates approximately $483.7 billion in gross annual federal cost. Because no offset has yet been verified, the current internal net remains $483.7 billion. Candidate offsets of approximately $81.4 billion would produce a provisional net estimate of approximately $402.3 billion if validated; neither figure should be treated as a formal federal score.

The gross estimate equals approximately 6.5 percent of projected FY2026 federal outlays. The provisional net estimate equals approximately 5.4 percent of federal outlays. Against the healthcare system itself, the gross cost equals approximately 9.1 percent of the $5.3 trillion the United States spent on healthcare in 2024. It is approximately one-fifth of the federal government's existing $2.4 trillion annual health-insurance subsidy commitment.[2][16][17][23]

Those comparisons do not make the program inexpensive. They locate it. *Something for Something* is a major federal commitment, but it is a risk-allocation layer placed over an already immense public-private healthcare economy—not the construction of a new healthcare system from nothing.

Some of the commitment can return through identifiable budget channels. Lower employer health costs can become taxable wages; lower benchmark premiums can reduce premium-tax-credit spending; existing uncompensated-care funding can be displaced; and improved claims integrity can recover improper payments. The model also estimates approximately $120.1 billion in additional annual worker take-home pay, creating a broader consumption channel. But economic circulation is not a federal budget offset. The proposal should be defended for what it purchases, not made to appear self-financing by counting every social or economic benefit.

What it purchases is universal bounded risk.

Five thousand dollars is not necessarily easy to pay. In the worst medical year, it equals approximately $417 per month or $96 per week. The policy does not assume every household can absorb that amount without help. It creates a visible, finite, and insurable endpoint that insurance, employers, towns, charities, unions, supplemental products, payment plans, or future policy can improve. Individual risk falls from hundreds of thousands or millions of dollars to a number around which institutions can build practical protection.

The doctrine is simple:

The state guarantees certainty. The public guarantees accurate participation.

One known medical maximum. One annual confirmation. No unbounded medical exposure and, for routine taxpayers, no routine surprise tax balance.

Current Logic	**Something for Something Logic**
Patient carries uncertain upper risk	Patient liability ends at $5,000
Insurance product defines the final protection	National protection defines the floor
Patient fights billing disputes	Institutions resolve disputes after patient exit
Taxpayer reconstructs the record	Household confirms the known record
Withholding errors settle after year-end	Withholding updates prospectively
Enrollment is episodic and easy to miss	Every tax household receives an annual prompt
Employer bears broad benefit pressure	Government assumes part of the upper claims layer
Premium savings are hoped for	Premium relief is certified and enforced
Fragmented claims obscure patterns	Standardized claims expose anomalous patterns
Lock-in through fear	Participation through predictable value

Table: Current Logic vs. Something for Something Logic

Introduction

The American healthcare system does not lack institutions. It has public programs, private insurers, employers, hospitals, physicians, pharmacies, benefit administrators, regulators, tax credits, health savings accounts, claims standards, provider networks, and tax exclusions.

The problem is where uncertainty lands.

Too much uncertainty lands on the individual.

The patient is asked to distinguish a deductible from an out-of-pocket maximum, determine whether care is covered, verify a provider's network status, interpret an explanation of benefits, appeal a denial, identify coding mistakes, and decide whether an unexpected bill is valid. At the same time, the taxpayer must estimate income, dependents, credits, multiple jobs, irregular earnings, and withholding before discovering after year-end whether the calculation was right.

These are institutional calculations presented as household responsibilities.

The two burdens are already connected. The tax code subsidizes employer health benefits. Employers divide compensation between premiums and wages. Marketplace assistance depends on income and household information. Premium changes affect taxable pay, federal credits, employer costs, and take-home income. Healthcare finance already runs through the tax system; the public experiences the systems through different paperwork and at different moments of uncertainty.

The result is a peculiar insecurity. A person can have insurance without feeling protected. A worker can have taxes withheld from every paycheck without knowing whether the amount is right. An employer can spend heavily on benefits while employees still fear the bill. Government can finance large portions of healthcare without giving every person a clear statement of maximum exposure.

The United States spent $5.3 trillion on healthcare in 2024, or $15,474 per person. National health spending grew 7.2 percent that year and represented 18 percent of the economy.[2] Yet the system's public-facing promise remains difficult to explain. A system this large should be able to tell every person where their financial responsibility ends.

This paper proposes a promise that can be explained in one sentence:

> Your covered medical liability ends at $5,000 each year.

In exchange, the household keeps its tax, dependent, employment, and coverage information current through one annual confirmation and updates it when circumstances change. Government supplies a hard boundary. The public supplies accurate participation. That is the something for something.

The proposal does not abolish insurance, employer plans, Medicare, Medicaid, hospitals, private networks, or ordinary tax collection. It moves several connected levers while preserving most of the machinery already in place.

The first lever is a universal individual ceiling. The second is a separate federal commercial attachment based on total recognized claims, allowing insurers to retain meaningful responsibility before public risk sharing begins. The third is a Tax Day Household Account that turns annual filing into verification for routine taxpayers and creates a universal opportunity to review or obtain coverage. The fourth is an Employer Health Dividend that directs a portion of certified premium relief into wages while allowing employers to retain meaningful savings. The fifth is a strict separation between tax identity data and clinical claims data.

The consequences are large, but the mechanisms are familiar. Insurers already administer claims. Employers already select plans and deduct premiums through payroll. The IRS already receives wage information, and employers already adjust withholding through Form W-4. States already connect health-coverage attestations to tax returns. Federal and state governments already use reinsurance to reduce upper-layer risk. The federal government already exchanges limited tax information with health marketplaces under statutory privacy rules.[6][8][9][11]

This is a coordination reform more than an institutional replacement. What changes is the order of responsibility, the point at which federal protection attaches, the distribution of savings, and the moment when the individual leaves the dispute.

The patient should not be the residual risk holder of a system they cannot audit.

The system may retain many payers. It should retain only one public-facing limit.

Once the ceiling is reached, the patient should focus on getting better.

1. The Two Uncertainties

The proposal begins with two forms of household uncertainty that are usually treated as separate problems.

The first is medical exposure.

People know a hospital stay can be expensive, but many cannot state its maximum financial consequence. The existing system contains protections, including the Affordable Care Act's annual cost-sharing limits. For 2026, the maximum annual limitation for self-only coverage subject to those rules is $10,600.[3] Practical protection still varies with enrollment, covered benefits, network status, balance billing, plan design, and whether the person has qualifying coverage at all.

This uncertainty changes behavior before a bill arrives. In 2024, 28 percent of adults reported skipping some form of medical treatment because of cost, and 17 percent reported medical debt from their own care or that of a family member.[1] Insurance reduces risk, but an insurance card does not always produce a felt sense of protection.

The second is tax reconciliation.

Workers see taxes withheld from every paycheck, yet many do not know until filing whether they overpaid, underpaid, or paid the correct amount. Multiple jobs, working spouses, credits, dependents, irregular income, and midyear changes make the result harder to predict. The IRS already encourages taxpayers to revisit withholding when their lives change, and its estimator exists to reduce refunds and balances.[8]

A refund can include refundable credits and is not always evidence of excessive withholding. A balance due is not always evidence of administrative failure. But for routine wage earners, large avoidable reconciliations reveal a system that often updates too slowly and asks the household to correct information after the year has closed.

Both systems often reveal the final household obligation retrospectively.

The patient receives care and later learns the financial result. The worker receives pay and later learns whether withholding was accurate. In both cases, uncertainty persists while the household makes decisions.

They share four design failures:

- the final household obligation may remain uncertain while decisions are being made;
- relevant information is divided among several institutions;
- correction often occurs after the underlying event;
- the individual becomes responsible for resolving institutional disagreement.

Both systems also ask the individual to reconcile data already distributed across institutions. The insurer knows claims. The employer knows wages and coverage. Government receives income reports. The healthcare marketplace knows enrollment. Yet the person often becomes the messenger, translator, and dispute manager connecting those records.

Something for Something links the systems because tax administration already supplies a recurring identity, household, income, employer, and dependent spine for most of the country. Tax Day becomes the annual moment to confirm that record, review coverage, and correct withholding prospectively.

Tax administration is the principal route into the system, not the moral basis of medical protection. Children, dependents, nonfilers, and people who miss the deadline still receive a default record and an appeal path. The tax account organizes protection; it does not determine who deserves care.

The exchange is direct:

- Government guarantees a known maximum medical exposure.
- Households confirm accurate identity, dependent, income, and coverage information.
- Insurers preserve coverage choice, administer claims, and retain contractual responsibility through and above the federal attachment.
- Employers continue offering plans where valuable but receive relief from upper-layer costs.
- Providers receive payment through an institutional process rather than pursuing the patient beyond the ceiling.

The proposal does not eliminate every retrospective process. Complicated income, contested eligibility, unusual claims, and missed deadlines will still require paperwork and appeal. It changes the default: routine cases move prospectively, while the full process remains available for exceptions.

The system does not ask the public to become better experts.

It asks institutions to become better coordinated.

2. The Public Bargain

The title describes the design literally: every participant receives something and provides something in return.

At its center is a three-way trade among households, insurers, and government. Employers and providers remain essential delivery institutions and receive corresponding relief, payment certainty, and obligations.

The individual receives a known medical ceiling, an annual coverage prompt, and a more accurate paycheck. In return, the individual confirms the household record, participates in accurate withholding, and reports material changes.

The employer receives cost relief and a simpler role. In return, the employer reports wages and coverage, passes through certified premium reductions, and converts a defined share of savings into wages during the transition.

The insurer receives a recurring customer-acquisition channel and protection against part of the upper claims layer. In return, it accepts the national patient ceiling, carries recognized allowed claims through the separate $10,000 federal attachment, submits standardized claims, certifies premium effects, and remains responsible for care management and price negotiation.

Government receives a standardized point of coordination, more current household information, more precise withholding, and actionable claims data. In return, it guarantees the covered-care ceiling, funds its contracted share, protects privacy, and keeps institutional disputes away from the patient.

Providers receive a clear institutional payment path after the patient reaches the ceiling. In return, they accept covered-care definitions, standardized claims, audits, anti-upcoding rules, and a prohibition on returning disputed institutional liability to the patient.

The exchange is intentionally asymmetric at one crucial point. The patient's protection becomes final once recognized liability reaches $5,000, while institutional reimbursement remains conditional on valid coding, covered care, contractual prices, and audit. Government may deny, reduce, recoup, or litigate an improper institutional payment without reopening the patient's liability. The guarantee protects the person; it does not guarantee every claim submitted by an insurer or provider.

This is not a one-direction transfer. It is a negotiated clearing of risks and responsibilities. No participant receives everything it would prefer, and no participant surrenders its entire existing role.

Participant	Receives	Provides
Individual	$5,000 ceiling, annual coverage offer, more accurate withholding	Accurate annual confirmation and timely updates
Employer	Lower, more predictable benefit pressure	Reporting and certified pass-through
Insurer	Customer channel and federal upper-layer protection	Patient ceiling, claims data, retained risk, certified premium reduction
Government	Better coordination, withholding, and claims visibility	Financing, contracting, privacy, audit, and ultimate guarantee
Provider	Institutional payment route after patient exit	Standardized billing, auditability, no balance billing above the patient ceiling

Table: The Something for Something Bargain

The bargain is deliberately legible. A reform this broad cannot depend on the public understanding every reimbursement formula. It requires one stable promise on the front end and clearly assigned responsibility on the back end. Institutional formulas can change through transparent contracts without changing the individual's protection.

The stable promise is $5,000.

Back-end responsibility changes by coverage type. The patient's protection does not.

The patient is the beneficiary of the bargain, not the referee among its institutions.

3. Every Taxpayer, Every Individual

The protection belongs to the individual. The tax household is the principal administrative structure used to identify and organize it.

The word *taxpayer* describes the account spine, not a limit on who receives the guarantee. A filer may establish the Household Account, but every spouse and dependent receives individual protection. People who are not required to file, lack taxable income, or temporarily fall outside an ordinary filing unit receive a default administrative record through a public program or direct federal process.

The filer, spouse, children, and other qualifying dependents are all individuals. Filing status determines how the Household Account organizes them, not whether they are protected.

A married couple filing jointly does not receive one $5,000 ceiling to divide. Each spouse has an individual $5,000 annual ceiling, as does each covered dependent. Married people filing separately retain the same individual protection. The Household Account connects identities, coverage, withholding, and dependent status; it does not pool medical liability.

The base design has no additional national family ceiling. A household of four contains four individual ceilings, although an employer plan, insurer, union, locality, or supplemental product may offer a lower family maximum. The federal rule establishes a universal floor without prohibiting better family coverage.

This distinction matters.

A household can contain people with different insurers, public programs, employers, custody arrangements, and coverage periods. One spouse may have an employer plan, another may have Marketplace coverage, and a child may be enrolled in CHIP. The tax filing unit coordinates the record while each medical ceiling remains person-specific.

The system therefore needs two related objects:

1. **The Household Account**, which records filing relationships, dependents, residence, coverage, and payroll instructions.
2. **The Individual Medical Accumulator**, which records one person's recognized covered spending and patient liability during one calendar year.

The accumulator follows the person—not the insurer, employer, address, or filing status. Changing jobs or plans cannot erase spending already credited during the year. A person also cannot create a second ceiling by entering a new household, changing filing status, or moving between public and private coverage.

The Household Account does not become a family medical chart. It needs to know whether coverage exists and which accumulator belongs to each individual. It does not need to know why anyone visited a physician.

Midyear events update the administrative relationship without restarting the protection.

Birth creates a new individual record and adds the child to the household. After death, the accumulator remains available to adjudicate covered services received during life and then closes without transferring unused protection to another person. Divorce or separation changes the filing relationship without erasing protection or restarting an accumulator. Shared custody requires one administrative household of record for enrollment and notices while preserving the child's single continuous accumulator. Aging out of dependent status creates a new administrative relationship, not a new medical year. Moving changes jurisdiction and plan availability, not the national ceiling.

The same principle applies throughout:

> Filing status organizes administration. It does not divide the human being.

4. The $5,000 Personal Medical Ceiling

The $5,000 ceiling is the proposal's public center: no individual owes more than that amount in one calendar year for nationally covered medical care.

It is not presented as an ideal insurance product. Many workers will prefer a plan with a lower deductible or out-of-pocket maximum when the premium tradeoff makes sense. Private insurers, employers, unions, municipalities, charities, and supplemental plans remain free to improve on the national floor.

The ceiling performs a different function: it prevents an ordinary person from facing an unbounded medical loss.

Five thousand dollars is still meaningful and can strain a household. But it is finite. If spread across a year, the full ceiling is approximately $417 per month or $96 per week. It can be saved against, insured against, subsidized, financed, collectively bargained, or reduced through a better plan.

Those equivalents illustrate the size of the annual risk; they do not require providers to offer twelve-month financing. Payment timing and affordable installment rules remain necessary below the ceiling. A federal limit on total liability should not permit a provider to demand the entire amount at an impossible moment as the price of necessary care.

No one must set aside $5,000 or spend $5,000 before care begins. Current plan rules continue below the ceiling. Preventive services can remain free. A low-deductible employer plan can continue paying early. A union can negotiate first-dollar coverage. A town can contribute to an account. An insurer can sell a plan with a $500, $1,000, or $2,500 maximum.

Recognized patient liability includes deductibles, copayments, coinsurance, and permitted direct charges for nationally covered care. It is calculated from the allowed or legally recognized amount—not an unadjusted provider sticker price. Emergency care and other services protected by the National Covered Care Standard cannot be moved outside the ceiling through a network technicality.

Insurance premiums do not count toward the ceiling. They purchase the plan's protection below the federal layer and any benefits exceeding the national standard. Nonmedical amenities and genuinely excluded services also do not count, but a provider or insurer cannot evade the ceiling by relabeling medically necessary covered care. The precise promise is therefore a cap on covered point-of-service medical liability—not on premiums or every household expenditure connected to health.

No qualifying arrangement can expose a person to more than the national maximum for covered care.

The ceiling operates through a continuously updated Individual Medical Accumulator. Claims, copayments, and other recognized charges are credited as they are adjudicated. At $5,000, the patient receives a ceiling-reached notice and providers may collect no further covered liability for the remainder of the calendar year.

Delayed claims cannot require the patient to advance costs above the ceiling. The system provides provisional credit when available documentation establishes that the threshold has been reached, followed by reconciliation among institutions. If later review changes the allowed amount, government, insurer, and provider settle the difference without reopening the patient's exposure except in cases of the patient's proven fraud.

The ceiling resets on January 1. Standardized service-date and episode rules prevent providers from accelerating, delaying, or dividing claims merely to move costs across calendar years. A plan change, job change, move, or change in filing status does not reset the accumulator.

That creates a common safety net without flattening every insurance product into one design.

The number is intentionally universal rather than income-scaled. Universality makes the protection easy to state, easy to recognize, and difficult to turn into another eligibility maze. Ability-to-pay concerns remain important below the ceiling and can be addressed through public programs, insurance products, employer contributions, local assistance, negotiated benefits, and future policy additions. Those mechanisms may reduce what someone actually pays without altering the national maximum.

The ceiling does not require government to pay every bill from the first dollar. Existing plans and institutions continue operating below and above the patient's limit, while federal commercial participation begins only at the separate $10,000 attachment. Contract prices, claims validation, audits, and the insurer's retained share protect the taxpayer; the $5,000 ceiling protects the individual.

The promise is not that sickness becomes cheap.

The promise is that sickness stops becoming financially endless.

This draft treats $5,000 as a fixed statutory promise. It should not drift upward through an obscure administrative index. Any future change should require explicit legislation, public modeling, and a clear statement of its effect on household exposure. The commercial attachment and government-insurer percentage may change contractually without weakening the patient maximum.

5. The $10,000 Federal Attachment

The $5,000 patient ceiling and the $10,000 federal attachment are different rules measured by different accumulators.

The **patient-liability accumulator** measures recognized deductibles, copayments, coinsurance, and permitted direct charges. At $5,000, the patient's covered liability ends.

The **commercial-claims accumulator** measures the person's total recognized allowed spending, regardless of whether the patient, insurer, employer arrangement, or another coordinating payer paid it. Federal commercial reinsurance does not attach until this separate accumulator exceeds $10,000.

The thresholds can therefore be reached at different times—or only one may be reached. Someone with generous insurance may exceed $10,000 in total claims while remaining far below $5,000 in personal liability. Someone with high cost sharing may approach the patient ceiling along a different claims path. The design never treats $5,000 of patient liability and $5,000 of additional claims as one sequential band.

The two rules operate independently:

Until total recognized claims exceed $10,000, the commercial insurer receives no federal reinsurance payment under the new policy. If the patient has already reached the personal ceiling, the insurer also absorbs the covered cost sharing the patient would otherwise have owed. This retained risk preserves the insurer's reason to negotiate provider prices, manage networks, coordinate care, identify unnecessary services, and audit questionable claims.

Above $10,000 in total recognized allowed claims, the leading design divides the upper layer evenly between the insurer and federal government. The federal payment applies only to spending above the attachment—not to the first $10,000. In simplified form:

> Federal reimbursement = contracted federal share × recognized allowed claims above $10,000.

Payments and recoveries from other liable parties, rebates, claim reversals, and later price corrections are reconciled before the federal amount becomes final. The split is established through annual or multiyear contracts rather than negotiated patient by patient.

Government remains the ultimate guarantor if an insurer fails, but that guarantee protects continuity of covered care and the patient's exit from liability. It does not make an insolvent insurer's unverified submissions automatically valid. Government may pay providers under the national contract and pursue recovery through regulation, receivership, or litigation.

The dual threshold improves the trade.

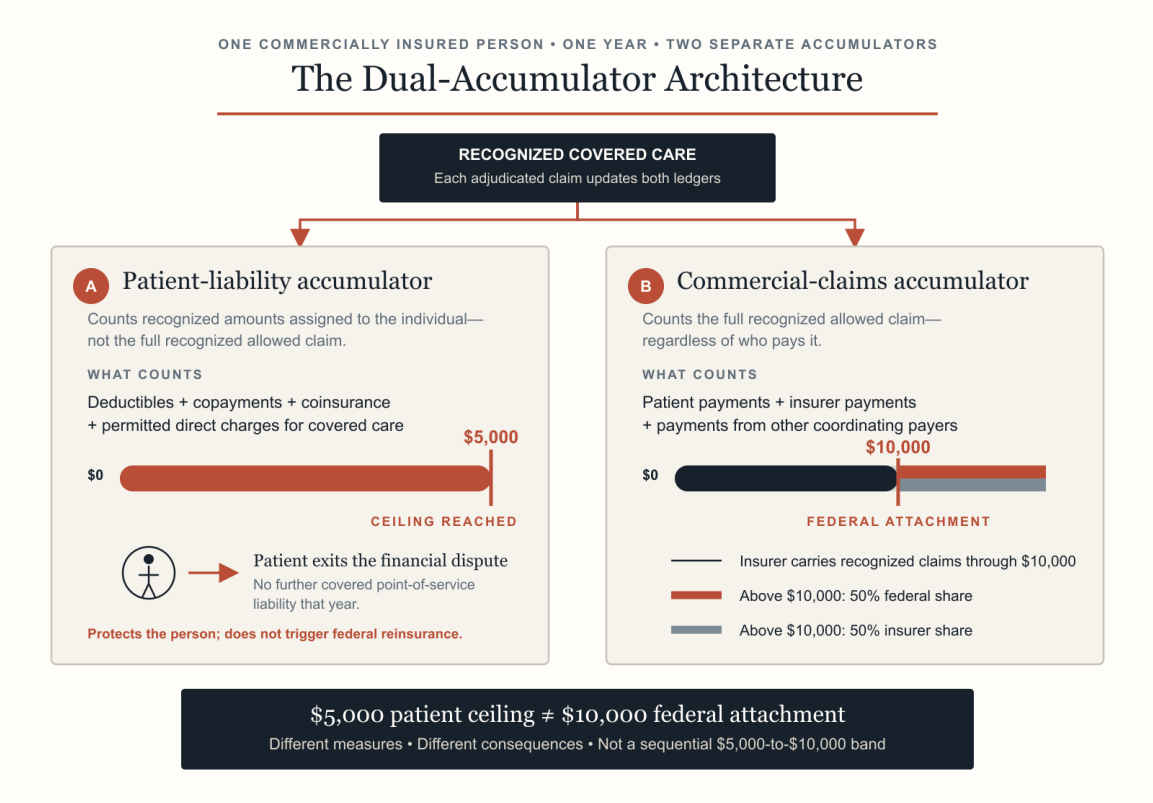

Figure 1: The dual-accumulator architecture for a commercially insured person. The $5,000 patient ceiling and $10,000 federal attachment use different measures and produce different consequences; they are not a sequential $5,000-to-$10,000 band.

An earlier model placed the federal commercial attachment at $5,000 in total recognized claims. The leading model moves that attachment to $10,000 while leaving the separate $5,000 patient-liability ceiling unchanged. Under otherwise similar assumptions, the change reduces estimated annual federal cost by approximately $106.4 billion.

The phrase *insurer-retained $5,000-to-$10,000 band* refers only to the model comparison between two possible commercial-claims attachment points. It does not describe a band of patient spending, and it does not combine the two accumulators.

The federal percentage remains negotiable. A 25 percent, 40 percent, 50 percent, 60 percent, or 75 percent public share produces a different allocation of cost and bargaining power. The current model uses 50 percent as the leading case because it creates a visible partnership while preserving the insurer's reason to control the upper layer. Neither the contractual percentage nor the institutional attachment changes the statutory $5,000 patient maximum.

The model is not a federal takeover of ordinary medical payment. It is a federal purchase of a defined upper layer of commercial medical risk.

6. Coverage-Specific Treatment

The same patient promise can operate across different existing coverage systems.

For commercial private-only coverage, the insurer remains primary. Current plan rules determine payment until recognized patient liability reaches $5,000. The insurer then absorbs further covered cost sharing. On the separate commercial-claims accumulator, the federal government purchases its contracted share only of total recognized allowed claims above $10,000.

For Medicare, Medicaid, CHIP, Veterans Health Administration coverage, TRICARE, and other public coverage, ordinary coordination-of-benefits rules identify the primary program. The new policy fills only covered patient liability above $5,000; it does not create a second federal reinsurance payment on spending already financed publicly. A dual-eligible person receives one patient-liability accumulator and one ceiling, not overlapping federal reimbursements for the same dollar.

For a person uninsured throughout the year, the federal backstop pays nationally covered care after recognized patient liability reaches $5,000. This is direct catastrophic protection, not commercial reinsurance. Charges are converted to a national or regional allowed amount before entering the accumulator; an uninsured person cannot be forced to reach the ceiling using inflated chargemaster prices.

The backstop applies even when a person misses the annual enrollment opportunity; otherwise, the guarantee would disappear precisely when needed. The Household Account nevertheless presents private and public coverage options each year because insurance remains valuable below $5,000 through negotiated prices, routine care, networks, care management, prescription benefits, and protection exceeding the national standard. The ceiling makes being uninsured less catastrophic. It does not make remaining uninsured the better product.

When a person moves between coverage categories, the patient-liability accumulator follows the person. Claims are assigned to the coverage in force on the service date, subject to standardized episode and retroactive-eligibility rules. Institutions reconcile coverage periods, primary and secondary payer status, and attachment calculations without involving the patient. A transition cannot create a gap in protection or a second accumulator.

Across every category, federal payment is net of valid payments, rebates, recoveries, and obligations from other payers. The same covered dollar cannot generate a public-program payment, a patient-ceiling fill, and a commercial reinsurance payment. The federal government guarantees the patient's boundary and serves as payer of last resort for the contracted institutional layer; it is not an additional payer on every claim.

Coverage Group	Patient Rule	Primary System	New Federal Treatment
Commercial private only	Liability ends at $5,000	Commercial plan	Contracted share of total allowed claims above $10,000
Public-program coverage	Liability ends at $5,000	Existing public program	Covered patient-ceiling fill only
Uninsured	Liability ends at $5,000	Federal allowed-price schedule	Direct covered-care backstop above patient ceiling
Coverage transition	One annual ceiling	Coverage on service date	Institutions reconcile; accumulator follows person

Table: Coverage-Specific Treatment

The architecture is plural on the back end and universal on the front end. That allows the reform to use existing infrastructure without making the public promise depend on which system a person happens to enter.

7. The Patient-Exit Rule

The proposal's most humane rule is also one of its most operationally important:

> Once the individual reaches $5,000 in recognized covered liability, the individual exits the financial dispute for the remainder of the year.

Patient exit is a legal and administrative status, not merely an accounting result. When the Individual Medical Accumulator reaches the ceiling, the responsible administrator issues a **Ceiling-Reached Notice** identifying the person, calendar year, effective date, credited amount, and process for correcting an omitted charge. The notice contains no diagnosis, procedure, or unnecessary clinical detail.

The status is visible through the person's Household Account, insurer portal, and ordinary eligibility systems used by participating providers. A patient should not carry bills from office to office to prove that the ceiling has been reached. Providers verify the status through the same kind of routine eligibility transaction already used to confirm coverage.

From that point forward, participating providers may not collect another deductible, copayment, coinsurance amount, or permitted direct charge for nationally covered care assigned to that calendar year. If crossed or delayed claims cause an overpayment, the responsible institution must identify and return it automatically. The patient does not have to discover the error and begin another dispute.

Patient exit does not mean every claim is paid as submitted. Providers can make mistakes. Insurers can deny claims incorrectly. Government can contest reimbursement. Upcoding, duplicate claims, unnecessary services, coordination-of-benefits errors, and documentation failures still require review.

The rule changes who bears the uncertainty during that review.

After patient exit:

- providers cannot balance-bill the patient for amounts assigned to an insurer, public program, or federal contract;
- a reimbursement dispute cannot be converted into a new point-of-service charge or used to condition access to otherwise covered care;
- insurers, providers, public programs, and government determine which institution owes the recognized amount;
- fraud and coding findings trigger institutional recovery, clawback, contract adjustment, or sanction;
- an innocent patient's liability cannot be recreated because an institution loses a later payment dispute;
- the patient retains an appeal if covered spending was omitted, undervalued, or improperly excluded from the accumulator.

The rule is intentionally asymmetric. Institutions may continue appealing one another's calculations after patient exit, and the patient may appeal to add qualifying liability or correct the record. Institutions may not use delayed adjudication or disagreement to reopen the patient's exposure. After the Ceiling-Reached Notice is issued, later claim reversals are reconciled among institutions unless government proves that the patient obtained protection through intentional fraud or knowing material misrepresentation. Coding changes, provider error, insurer delay, and administrative confusion are not patient fraud.

Patient exit applies only to nationally covered care. Premiums, nonmedical amenities, and genuinely excluded elective services remain outside the ceiling. Any exclusion must rest on the National Covered Care Standard and terms disclosed before service; it cannot be invented after treatment because the patient has reached the maximum. Emergency protections remain intact regardless of network status.

The calendar-year rule follows the date of service rather than the date on which institutions finish adjudicating the claim. A December claim cannot become new January liability merely because it was processed late. Changing insurer, employer, residence, or filing status cannot cancel a Ceiling-Reached Notice or create a second accumulator for the same person and year.

The system still contains conflict. It places the conflict where capacity exists.

Government and insurers can employ auditors, actuaries, investigators, data scientists, clinicians, lawyers, and contract managers. They can compare millions of claims, identify provider outliers, test coding patterns, and recover improper payments. A sick person cannot do that work while trying to recover.

The patient remains responsible for supplying accurate identity and coverage information, choosing among available plans, paying valid liability below the ceiling, and responding to a specific allegation of personal fraud. Patient exit is not immunity from every rule. It is protection against being used as the collection mechanism in a dispute among institutions.

The reform therefore changes more than who ultimately pays.

It changes who must fight.

8. Tax Day Becomes Check-In Day

Tax Day remains. Its meaning changes.

For most wage-based households, the annual event no longer begins with a blank form. It begins with a prefilled record and a small number of decisions.

Employers already report wages and withholding. Insurers and employers already produce coverage documents. Financial institutions already report many forms of income. The IRS has demonstrated that wage information can be imported into a filing flow, and current withholding tools already calculate adjustments for dependents, multiple jobs, credits, and other income.[8][10]

The Household Account turns those capabilities into an annual confirmation process. It coordinates authoritative records rather than creating a new clinical or financial master file. It displays known information, records corrections and elections, and sends each participating institution only the instructions it needs.

Between January 1 and Tax Day, the filer receives a prompt to review:

- legal identity and filing status;
- spouse;
- dependents;
- primary residence;
- known wage and income records;
- months of health coverage for each person;
- insurer and plan identifiers;
- eligibility or benefit changes;
- desired payroll-deducted supplemental coverage;
- facts missing or disputed in the government record.

Each item identifies its source. A wage record may come from an employer, a coverage record from an insurer or public program, and a dependent relationship from the previous return and current civil records. The taxpayer can confirm, correct, or dispute each item. An unexplained database mismatch cannot become an automatic finding against the household.

The check-in separates two periods that ordinary tax administration often places in the same interaction:

1. **Closed-year confirmation** verifies the prior calendar year's income, withholding, household relationships, and months of coverage for tax and program purposes.
2. **Current-year instruction** records the household as it exists now and updates prospective withholding, benefits, coverage status, and voluntary payroll deductions.

That distinction matters. A marriage in February does not rewrite the previous year's filing status, but it can change the next paycheck. A child born after December 31 may not belong on the closed-year return but immediately enters the current-year household and receives an Individual Medical Accumulator.

If the prefilled record is correct and the taxpayer qualifies for the simplified path, confirmation constitutes filing. The person does not reproduce the same information on a second form. If the record is incomplete, the taxpayer updates it. If income or household circumstances require fuller accounting, the system carries all known information into the complete filing process rather than forcing the person to start again.

At completion, the Household Account produces a plain-language **Annual Confirmation Receipt** showing:

- the people included in the tax household;
- the separate medical accumulator attached to each individual;
- the prior-year tax result, including any remaining refund or balance;
- each person's current coverage status;
- any voluntary plan selection or payroll deduction;
- the prospective withholding instruction and its effective date;
- unresolved items, next steps, and appeal rights.

The receipt makes the transaction inspectable. It explains what changed, which source supplied each fact, and when an instruction will reach payroll or coverage systems. Automation is useful when the individual can see the result and leave quickly—not when a hidden system makes a decision that takes weeks to understand.

Massachusetts provides a narrow precedent for connecting health-coverage facts to a tax return. Its Schedule HC requires residents to indicate whether they had qualifying coverage each month and uses insurer-supplied Form MA 1099-HC information.[9] *Something for Something* expands the administrative purpose without requiring clinical information.

The annual prompt also solves an onboarding problem.

Today, people can remain outside coverage until a crisis, job change, or missed enrollment period forces attention. Under the proposal, every tax household reviews coverage status at least once a year. No one is forced to buy a private product. Everyone receives a recurring, visible opportunity to obtain coverage, including an option to pay premiums through payroll deduction.

Every year, the system asks.

That recurring prompt can increase enrollment without turning the check-in into an insurance mandate. It reaches people who are eligible but unaware, people who lost coverage during a transition, and people who would enroll if selection and payment were placed inside a familiar annual process.

The annual check-in becomes the simplest route into the system. The complete tax return remains the full-featured alternative.

9. A Default, Not a Trap

Automation creates the easiest path, not the only path.

A taxpayer who completes the check-in on time receives immediate confirmation of household status, coverage records, withholding updates, and any selected payroll deduction. The intended interaction is short: confirm what is right, correct what is wrong, and leave.

The system must also define what happens when a person does nothing. Silence is not agreement with every inferred fact, consent to a new paid product, or surrender of the medical ceiling.

The leading default rules are:

- **Medical protection continues.** Missing the check-in does not eliminate the $5,000 individual ceiling.
- **Existing withholding continues.** An employer keeps the last valid withholding instruction until it receives a lawful replacement. A new job without an instruction uses the ordinary statutory default.
- **Existing coverage follows existing rules.** A plan may continue or renew when the person previously authorized renewal and the governing plan permits it.
- **No new premium without consent.** The system may display coverage options and reminders, but it cannot create a new paid insurance obligation merely because the taxpayer did not respond.
- **The last confirmed household is provisional.** Third-party records may flag a possible change, but an unresolved mismatch cannot silently transfer a dependent, terminate protection, or create two medical accumulators.

Defaults are conservative, reversible, and visible. The Household Account shows which rule was applied, what information produced it, and how to correct it.

If a person misses Tax Day, protection does not permanently disappear.

The consequence of missing the deadline is loss of the streamlined route—not loss of the underlying right. The individual can establish the correct household, tax, withholding, and coverage record through the full paperwork and appeal process. Like the current tax system, that route can require forms, documentation, manual review, correction, and legally required reconciliation. It is slower and less convenient, but fully available.

Once the late record is accepted, prospective withholding and coverage instructions update in the next administratively practical cycle. Prior-year tax amounts and benefits are corrected under ordinary law. Covered medical liability incurred during the delay still counts toward the annual accumulator; administrative lateness cannot convert covered care into unbounded personal debt.

This creates two paths:

1. **Automated Check-In** — the normal route for most taxpayers, using known records and a short confirmation.
2. **Full Filing and Appeal** — the complete route for complex cases, disputed records, missed deadlines, irregular income, or anyone who prefers manual filing.

The full path requires the same basic due-process guarantees whether the dispute concerns tax, household status, coverage, or the medical accumulator:

- notice of the proposed determination;
- the data source and rule used;
- an opportunity to submit evidence;
- access to human review;
- a written decision with reasons;
- further administrative and judicial appeal where applicable;
- protection against being billed above the medical ceiling while institutions resolve a timely dispute.

Identity theft, disability, hospitalization, language barriers, lack of internet service, domestic abuse, military deployment, disaster, and other good-cause circumstances require accessible assistance and deadline relief. A system built around a short digital interaction still needs telephone, in-person, authorized-representative, and paper channels.

The automated route can expand without removing due process or pretending every taxpayer can use the same interface.

Administrative simplification fails when it assumes every household is simple. A real system must handle self-employment, tips, contract income, investments, multiple jobs, foreign income, trusts, business ownership, and unusual family structures. Those cases should not prevent a better default for wage-based households, and automation cannot erase anyone's right to a full accounting.

The governing principle is:

> Easy when the record is ordinary. Complete when the record is not.

10. Continuous Withholding

Annual confirmation matters only if it can change the next paycheck.

Once the Household Account is confirmed, the system calculates a prospective withholding instruction. Employers receive only the amount or rate, effective date, and administrative code needed to withhold correctly. They do not receive the household's complete financial record, another employer's identity or wages, the reason for a dependent change, or any clinical information.

This extends existing practice rather than inventing a new tax mechanism. Form W-4 already uses filing status, dependents, multiple-job adjustments, credits, deductions, other income, and additional withholding to determine payroll deductions. The IRS already advises taxpayers to update withholding after major life or income changes.[8]

The proposal changes the cadence, integration, and default source of the instruction.

Instead of waiting for a taxpayer to discover a large refund or balance, the Household Account recalculates when a verified event changes the expected annual result. A raise, new job, second job, marriage, divorce, birth, death, dependent change, reported irregular income, tax-law change, or coverage election can generate a new instruction. The individual receives notice of the previous instruction, its replacement, the effective date, and a plain-language reason for the change.

Continuous does not mean withholding changes every day. Minor fluctuations should not produce payroll noise. Materiality thresholds and regular update windows can absorb small changes while major household or employment events receive prompt treatment. The goal is a current account, not a twitching one.

The calculation works toward an annual target using tax already withheld, expected remaining income, known credits and deductions, and the pay periods left in the year. If the household is ahead, later withholding falls and more money remains in the next paychecks. If it is behind, the remaining obligation is spread across future pay periods rather than hidden until Tax Day.

A **Withholding Stability Rule** prevents an ordinary data correction from consuming an unexpectedly large share of one paycheck. The Household Account displays the required catch-up amount and a default schedule across the remaining pay periods. The taxpayer may choose a faster lawful schedule or request review when the default creates hardship. This does not forgive the underlying tax; it prevents better information from becoming a new form of paycheck shock.

The objective is not literal perfection. No withholding system can know every future capital gain, business loss, deduction, or irregular payment. The objective is to make large routine overpayment and underpayment uncommon while maximizing accurate take-home pay.

For multiple jobs, the central system calculates one household target and distributes privacy-preserving withholding instructions across employers. The default allocation follows expected wages and remaining pay periods, while the taxpayer may place more withholding at a preferred job. No employer needs to know another employer's identity or compensation. The current IRS estimator already addresses multiple-job households and recognizes the tradeoff between accuracy and privacy.[8]

For self-employed and irregular-income taxpayers, the Household Account generates an estimated-payment schedule and updates it after reported receipts, platform statements, or quarterly confirmation. A taxpayer may authorize payment from a bank account or participating payment platform, but the system cannot create an undisclosed debit. The full reconciliation path remains available for business expenses, capital gains, losses, and other items that cannot be known prospectively.

Tax withholding and voluntary insurance deductions remain separate lines. Payroll may transmit both, but a premium change cannot be disguised as a tax increase, and an employer does not need to know why a household selected a particular health product.

The taxpayer may also select a modest refund buffer. Some people prefer a small year-end refund as protection against estimation error; others prefer the largest lawful paycheck now. The system displays that trade instead of creating a large refund by accident. Its default objective is to finish the year within a narrow reconciliation range—not to maximize government possession of the household's money.

Refunds and balances do not become impossible.

They become exceptions rather than the organizing feature of the system.

11. Coverage at Tax Day

Tax Day should include a coverage marketplace without becoming a compulsory sales event.

The Household Account shows each person's current coverage, its expected end date, and whether the plan reports to the Individual Medical Accumulator. If coverage exists through work, Medicare, Medicaid, CHIP, the Marketplace, a spouse, or another qualifying source, the taxpayer confirms it. If coverage is absent, incomplete, or scheduled to expire, the system generates a **Tax Day Coverage Offer**.

Those options may include:

- continuing an employer plan at the next eligible enrollment or renewal;
- joining a spouse or family plan where permitted;
- selecting a Marketplace plan;
- enrolling in an eligible public program;
- purchasing supplemental protection below the $5,000 ceiling;
- electing payroll deduction for a qualified individual plan;
- declining optional private coverage while retaining the universal backstop.

The offer should feel closer to renewing a registration than navigating an emergency benefits office. Before showing commercial products, the system checks eligibility for Medicare, Medicaid, CHIP, Marketplace assistance, and other public support. It then presents qualifying private options through a standardized comparison—not a stack of advertisements.

Each offer should display at least:

- the gross monthly premium and the household's net payment;
- any employer contribution or public assistance;
- the plan deductible and plan-level out-of-pocket maximum;
- confirmation that covered personal liability cannot exceed the national $5,000 ceiling;
- the provider network and a searchable directory;
- prescription-drug treatment;
- major supplemental benefits;
- an independent quality and complaint measure;
- the coverage effective date, renewal rule, and cancellation terms;
- the amount that would appear on each paycheck if payroll deduction is selected.

Only plans that meet the National Covered Care Standard, transmit standardized accumulator information, honor patient exit, and participate in required premium reconciliation may use the integrated enrollment and payroll channel. The tax interface cannot sell ranking position or disguise sponsored placement as a government recommendation.

Enrollment requires affirmative consent. Silence is not purchase. The household receives a durable plan-selection receipt showing the premium, benefits, payroll deduction, effective date, and cancellation rights. Declining private coverage does not eliminate the universal ceiling.

For individual and supplemental products, the proposal creates a regular **Tax Day Coverage Window**. Coverage begins on a clear prospective date after selection, while special-enrollment and midyear-update rules continue for qualifying life events. Enrollment rules prevent strategic movement into and out of richer protection after a diagnosis while permitting legitimate household and employment transitions.

Premiums can be deducted from pay when employment and plan rules permit. The employer receives a deduction-and-remittance instruction—not the employee's health information or reason for choosing the plan. If employment ends, the individual can move payment to a new payroll source or authorized direct-payment method without rebuilding the enrollment record.

Employer plans remain subject to ordinary plan-year locks, qualifying-life-event rules, and renewal cycles during the transition. The federal backstop changes the economics at renewal; it does not rewrite every employer contract immediately.

That distinction prevents the tax check-in from colliding with existing plan administration. A worker may keep an employer plan because it is easier, cheaper, or better. Another taxpayer may select an individual product because portability matters more. The policy does not choose the winner in advance.

It creates potential customers and lets insurers compete for them on price, network, quality, service, and how far their products improve on the federal floor.

Affordability remains the most commonly reported factor among uninsured adults, while knowledge gaps and enrollment complexity also matter.[19] The $5,000 backstop does not eliminate the premium problem. It creates an annual prompt, a simpler comparison point, and a payroll route that can convert some people from passive nonparticipation into active selection.

The desired cycle is:

> More people are prompted. More people enroll. Risk pools broaden. Administrative churn falls. Insurers gain room to compete on price, network, quality, and service.

The enrollment effect must be modeled rather than assumed. A later model should estimate take-up by coverage status, premium, subsidy eligibility, payroll access, and prior insurance history. Increased participation and broader risk pools are plausible growth channels built directly into the administrative design, but neither is counted as a guaranteed saving.

12. The Three-Way Trade

The policy works best as a three-team trade—not a victory by one side over the other two.

The three sides are the individual, the commercial coverage system, and government. Employers and insurers occupy different positions on the commercial side, so their obligations remain distinct even though premiums and wages connect them.

The individual accepts annual confirmation, standardized reporting, more current withholding, and responsibility for valid medical costs below the ceiling. Large tax refunds become less common because more accurate withholding leaves the money in each paycheck. In return, covered medical exposure becomes bounded, coverage choices become easier to reach, and the person exits the institutional payment dispute at $5,000.

The employer accepts transparent premium reconciliation and temporarily shares certified savings with workers through the Employer Health Dividend. In return, it retains part of the savings, faces lower and more predictable benefit pressure, and carries less responsibility for supplying catastrophic financial security through work.

The insurer accepts the $5,000 patient ceiling, absorbs displaced covered patient liability, retains meaningful claims risk, submits standardized data, and passes verified relief into premiums. In return, it receives federal participation above the commercial attachment, a recurring national customer funnel, lower upper-layer volatility, and room to sell products that improve on the federal floor.

Government accepts a large, visible, and enforceable financial obligation. In return, it purchases a defined national safety net, greater visibility into allowed claims, a recurring enrollment opportunity, more precise withholding, and the ability to negotiate and audit upper-layer risk at scale.

No side receives everything. No side gives up everything.

The individual does not receive first-dollar free care. The employer does not retain all certified savings. The insurer does not shed all high-cost risk. Government neither takes over ordinary claims administration nor becomes the only insurer.

That restraint is not rhetorical compromise. It preserves useful incentives. Individuals still have reason to select coverage below the ceiling. Employers still have reason to offer plans people value. Insurers still have reason to negotiate prices and manage care. Government gains enough financial exposure to require standardized data and bargain over the upper layer.

Participant	Gives	Receives	Retains
Individual	Accurate participation and valid liability below $5,000	Bounded exposure and more current paychecks	Coverage and plan choice
Employer	Reporting and temporary worker dividend	Lower, more predictable benefit cost	Part of certified savings
Insurer	Patient ceiling, data, retained risk, and pass-through	Customers and federal upper-layer participation	Networks, pricing role, and product competition
Government	Contracted payments and ultimate guarantee	Tax precision, claims visibility, and bargaining leverage	Contracting rather than ordinary claims administration

Table: The Three-Way Trade

The trade makes the cost struggle explicit. Government will seek lower allowed prices and fewer improper claims. Insurers will seek favorable contracts and workable retained risk. Employers will seek lower premiums. Individuals will seek lower contributions, better plans, and reliable protection. The proposal does not pretend those interests merge.

It standardizes the contest and gives each side something worth protecting. Most importantly, it removes the patient once the statutory ceiling is reached.

13. Employer Relief and the Health Dividend

Employer-sponsored insurance remains the dominant source of coverage for working-age Americans. The proposal does not ask employers to abandon it.

The amounts involved are already large. KFF reported average annual employer-sponsored premiums of $9,325 for single coverage and $26,993 for family coverage in 2025, with workers contributing an average of $6,850 toward family premiums.[5]

It changes the risk embedded in that coverage.

When government assumes part of recognized spending above $10,000, a commercial plan should cost less than the same plan without federal protection. The magnitude will vary by workforce, plan design, geography, provider prices, and contract. The reduction cannot be assumed; it must be measured.

Measurement begins with a counterfactual: what would substantially the same employer plan have cost without the federal layer? **Certified employer savings** equal the difference between that counterfactual and the employer's actual plan cost, adjusted for enrollment, workforce composition, medical trend, benefit and network changes, administrative fees, and the insurer's new responsibility for covered patient liability above $5,000.

The calculation differs by funding arrangement:

- a fully insured employer uses the carrier's certified premium reconciliation;
- a self-funded employer uses recognized claims, administrative costs, stop-loss premiums, and federal reimbursements reported through its plan administrator;
- a collectively bargained plan uses the same economic calculation while preserving bargaining rights;
- a public or nonprofit employer receives the same plan-cost treatment even though its tax consequences may differ.

The **Employer Health Dividend** governs what happens after savings are certified.

For the first five years after certified savings appear, the leading design directs half of the employer portion into taxable cash compensation and leaves the other half with the employer before applicable payroll taxes. Workers separately benefit from lower employee premium contributions. The dividend applies only to measured savings that have reached the employer; a firm does not distribute a forecast that never materializes.

The worker pool is distributed through a simple, nondiscriminatory rule tied to months of plan enrollment and coverage tier—not salary, diagnosis, claim history, or job title. A worker cannot receive less because the worker or a dependent became sick. Part-year employment and coverage changes are prorated. Collective bargaining agreements may improve the worker allocation but cannot direct less than the statutory pool to eligible workers.

The dividend appears as a separate pay-statement line during the transition so workers can see the bargain. It is taxable compensation—not a replacement health premium or restricted account. The five-year expiration ends the federal allocation mandate; it neither claws back wages already paid nor authorizes an offsetting wage reduction.

The current Base paycheck model allocates each $100 of employer-plan premium relief approximately as follows:

- $20.41 reduces worker premium contributions;
- $39.80 becomes the required wage dividend;
- $39.80 remains with the employer;
- ordinary tax effects apply when tax-exempt health compensation becomes taxable cash compensation.

Displayed components may differ by a cent because of rounding.

After modeled taxes, each $100 of premium relief produces approximately $45.92 in additional worker take-home pay and $36.75 in after-tax employer retained value. Approximately $17.33 returns through tax effects in the illustrative case.

The federal commercial payment is not treated as pure insurer savings. Commercial insurers also absorb the calibrated private patient liability displaced by the $5,000 ceiling. In the Base case, the model subtracts approximately $68.5 billion of that new obligation from $391.3 billion in gross commercial reinsurance, leaving approximately $322.8 billion in net commercial insurer relief before estimating the amount flowing through employer plans. HC-256 therefore raises both sides of the trade: insurers assume more measured patient-ceiling cost, but the federal upper-layer payment and remaining insurer relief also increase.

Under the Base assumptions, the workbook estimates approximately $120.1 billion in annual net worker take-home gain, $96.1 billion in employer retained savings, and $45.3 billion in candidate wage and payroll-tax recovery. These results depend on premium pass-through, the share flowing through employer plans, the taxable-wage conversion rate, and the model's tax rates. They are not guarantees.

The wage dividend addresses a central transition problem.

Employer health contributions are generally excluded from employee taxable income and payroll taxes.[7] If federal protection reduces plan costs but the difference remains inside the firm or insurer, the worker may see no improvement. If all savings must immediately become wages, employers lose flexibility to manage transition costs and may resist the reform.

A temporary split creates a bargain.

Workers receive visible value in the paycheck. Employers receive visible relief. Government recovers some revenue as tax-exempt compensation becomes taxable cash compensation.

Anti-avoidance rules are necessary. An employer cannot erase the dividend by cutting base wages, reducing hours, shifting the same health cost into another mandatory fee, moving workers into a nominally different but economically equivalent plan, or changing the comparison baseline without justification. Insurers and employers provide workers with the calculation, and regulators reconcile it against plan and payroll records.

The objective is not to punish employer coverage.

It is to reduce what employers must spend merely to provide a catastrophic guarantee that the national system can supply more broadly.

14. Insurers Get Customers and a Cap

Private insurers retain a large role because the $5,000 ceiling is a protection floor—not a complete insurance product.

They can sell:

- lower deductibles and lower out-of-pocket maximums;
- broader or more selective networks;
- prescription coverage;
- care coordination;
- dental, vision, and supplemental benefits;
- family products;
- employer and union plans;
- premium service and navigation;
- portable plans for workers moving between jobs;
- products designed to help households save for or insure the first $5,000.

The tax check-in creates a national annual customer-acquisition moment. People who now go years without reviewing coverage receive a prompt. Those with work plans may keep them because they are easier or better. Those without work coverage can enter an individual market without having to discover it alone.

This is a customer funnel, not a captive market. Insurers still have to win enrollment. Plans must present comparable prices and benefits, maintain usable networks, honor the National Covered Care Standard, connect to the accumulator, and satisfy patient-exit and pass-through rules. The annual prompt lowers the cost of reaching potential customers; it does not guarantee that any carrier wins or keeps them.

The federal attachment also changes product economics. Government purchases a contracted share of the upper risk layer. Insurers can price the remaining layers with greater certainty while retaining enough exposure to care about provider prices, utilization, coding, and care management.

The word *cap* requires precision. Under the leading 50/50 design, insurer liability does not end at a fixed dollar amount. The insurer continues paying half of recognized allowed claims above $10,000. The policy limits the insurer's share of the marginal upper layer and the volatility it carries alone. The insurer receives a federal risk partner—not immunity from high-cost claims.

This resembles reinsurance, a familiar insurance mechanism. Existing state programs under Affordable Care Act section 1332 have used public reinsurance to reduce individual-market premiums. CMS reported estimated statewide benchmark-premium reductions ranging from 3.75 percent to 41.17 percent across program years and states relative to premiums without the waivers.[6] Those programs are not identical to this proposal, but they demonstrate that public upper-layer protection can translate into lower premiums.

The federal share can also support a standardized contract market.

Annual or multiyear contracts can specify:

- the commercial-claims attachment;
- the federal and insurer percentages;
- covered claims and allowed-price rules;
- geographic and population adjustments;
- risk adjustment across plans;
- reporting and payment timing;
- reserves and solvency treatment;
- quality and network conditions;
- audit, appeal, recovery, and clawback rules;
- premium pass-through and contract-renewal standards.

The percentages are negotiated for a contract period—not beside every hospital bed. That resembles pricing a mortgage or reinsurance tranche: the parties can evaluate a defined stream of risk, compare terms, and lock a rate for a stated period.

Standardized contracts may be pooled for administration or financing, but the government is not creating patient-specific securities or trading individual lives as assets. Clinical identities remain protected, secondary transfers cannot increase the federal obligation, and the original insurer remains responsible for patient protection, claims accuracy, and contract performance unless government approves a successor.

Participation requires more than submitting claims. An insurer must remain solvent, maintain a compliant network, transmit timely accumulator data, accept independent audits, reconcile recoveries from other payers, and demonstrate that federal relief reached premiums or benefits. Standardized claims also give government and insurers a shared basis for detecting anomalous billing and fraud. Chronic failure can produce repayment, reduced future participation, or removal from the Tax Day channel.

Insurers therefore receive two growth opportunities:

1. More people are placed in front of a coverage choice every year.
2. Existing products can become cheaper or richer because part of catastrophic risk is transferred.

A third opportunity may follow if broader, more continuous enrollment reduces churn and spreads administrative costs across more customers. That effect is plausible but not guaranteed, and the current model does not count it as a federal offset.

The insurer gains access to customers and a contractual limit on how much upper-layer risk it carries alone.

In return, the insurer must prove what happened to the savings.

15. Premium Pass-Through Is a Contract Term

Federal protection must purchase lower premiums—not merely higher insurer margins.

The proposal cannot rely on competition alone to pass savings through. Competition may help, but the public is purchasing a specific reduction in insurer risk and must receive a measurable price response.

The pass-through base is **net actuarial relief**, not gross federal reimbursement. The calculation begins with the federal upper-layer payment and subtracts the insurer's new cost of absorbing covered patient liability above $5,000, incremental contract-administration costs, required recoveries owed to other payers, and other approved adjustments. It then compares expected insurer cost with and without the program.

In simplified form:

> Net actuarial relief = federal reinsurance received − new patient-ceiling cost − approved incremental costs and recoveries.

The insurer must pass through the contractually required share of that net amount. This prevents government from demanding nonexistent savings and prevents the insurer from treating a gross public payment as unrelated revenue.

Each participating insurer should file:

- the expected claims and premium baseline without the federal layer;
- the gross federal payment and recognized risk transferred;
- the insurer's patient-ceiling obligation and other permitted deductions;
- the resulting net actuarial relief;
- the contractual pass-through percentage and dollar amount;
- the allocation across individual, small-group, large-group, and self-funded arrangements;
- administrative cost and margin treatment;
- an actuarial certification;
- a year-end reconciliation against actual experience.

The counterfactual holds plan generosity, covered population, geography, provider network, and other material characteristics as constant as practicable. Ordinary medical inflation cannot hide the public credit. The filing shows both numbers: the approved premium with the program and the estimated premium for substantially the same coverage without it.

Pass-through occurs in two stages. First, a prospective credit enters premiums, employer renewals, or self-funded plan budgets using the best available estimate. After the contract year, actual claims, patient-ceiling costs, federal payments, recoveries, and enrollment are reconciled. If too little relief reached customers, the difference becomes a rebate, employer-plan credit, or next-period rate reduction. If the initial credit was too large, correction occurs through prospective approved rates or the institutional contract; consumers never receive a surprise retroactive bill.

Relief follows the claims pool that generated it. An insurer cannot use federal payments produced by one market segment to subsidize an unrelated favored product while leaving the originating customers' premiums unchanged. Risk adjustment and shared administrative costs remain permissible, but their allocation must be disclosed and consistently applied.

Lower premiums are the leading form of pass-through because the proposal is intended to improve household paychecks and employer costs. A richer benefit may count only when it provides measurable value, does not replace a required premium reduction without disclosure, and is approved under the contract. Marketing expenses and cosmetic benefits do not count.

Employers receive a renewal statement separating ordinary medical trend from the effect of federal protection. Workers receive a plain-language statement showing the premium before and after the public layer, their contribution, and any Employer Health Dividend.

For a fully insured plan, relief appears through rates, rebates, or renewal credits. For a self-funded plan, it appears through claims reconciliation, administrative and stop-loss pricing, or a direct plan credit. The economic rule remains the same even when no conventional premium exists.

If pass-through falls below the certified amount, enforcement escalates through correction, interest-bearing customer or plan rebates, recovery of federal payments, civil assessment, reduced future participation, and exclusion from federal contracts or the Tax Day Coverage Offer. Executives and actuaries who knowingly certify false allocations remain subject to ordinary false-statement and claims remedies.

This uses familiar regulatory architecture. The Affordable Care Act already requires covered health insurance issuers to report medical loss ratios, spend minimum shares of premium revenue on medical care and quality improvement, and rebate excess premiums when applicable.[13] *Something for Something* adds a schedule specific to the value of federal reinsurance.

Employer pass-through also requires enforcement.

An employer cannot relabel the same plan, reduce other benefits, increase a mandatory fee, or alter worker contributions and then claim no savings occurred. The baseline is adjusted for enrollment, workforce, plan generosity, provider network, and medical trend. The first-five-year wage dividend applies only to certified net employer savings, and those savings are disclosed and reconciled against payroll records.

The policy is not built on a hope that everyone voluntarily shares the gain.

Sharing the gain is part of the bargain.

16. The National Covered Care Standard

"Good-quality care" is the right public language. Legislation still needs a legal definition.

The **National Covered Care Standard** determines which services count toward the $5,000 patient-liability accumulator and which institutional claims qualify for federal reimbursement. If the standard is too narrow, the ceiling becomes a promise with holes. If it is undefined, providers and insurers can move costs outside the protected category.

The goal is the breadth and reliability associated with a strong employer plan—not the literal copying of one senator's, agency's, or technology company's benefit package. The national standard defines a protected floor without requiring every plan to use the same network, deductible, formulary, care-management system, or supplemental benefits.

The standard begins with comprehensive major medical care familiar to federal and commercial regulation:

- emergency services;
- inpatient and outpatient hospital care;
- physician and clinical services;
- diagnostic testing and imaging;
- prescription drugs;
- maternity and newborn care;
- mental health and substance-use treatment;
- rehabilitation and habilitation;
- medically necessary devices and durable medical equipment;
- preventive and chronic-disease care;
- pediatric care;
- medically necessary transportation where defined;
- other medically necessary treatment meeting national clinical standards.

To enter the national system, a service generally satisfies five conditions:

1. It prevents, diagnoses, treats, manages, or rehabilitates a recognized health condition.
2. It is medically necessary under published, evidence-based criteria appropriate to the patient's circumstances.
3. It is furnished or ordered by a qualified provider or facility acting within lawful scope.
4. It is documented through standardized service, provider, and claims information sufficient for audit.
5. It is priced at a recognized allowed amount rather than an unadjusted provider charge.

The standard includes professional and facility claims. It protects emergency care regardless of network status, applies mental-health and substance-use treatment on equal terms, and prevents separate billing entities from multiplying liability by fragmenting one episode.

The allowed-price rule is essential. For in-network care, the recognized amount ordinarily follows the negotiated contract. For emergency and other legally protected out-of-network care, it follows the applicable statutory or independently determined rate. For an uninsured person using the federal backstop, it follows the national or regional allowed-price schedule. A provider's sticker price determines neither the patient's accumulator nor federal reimbursement.

The two accumulators treat a covered service differently. Only the recognized amount assigned to the patient enters the $5,000 patient-liability accumulator. The full recognized allowed claim—including amounts paid by the plan—enters the commercial-claims accumulator. A no-cost preventive visit may therefore add nothing to patient liability while still appearing in the institutional claims record.

Coverage on paper is not enough. Participating plans must maintain reasonable network access, timely appointments, emergency access, accurate directories, continuity during active treatment, and a clinically independent appeal process. Prior authorization and utilization review may continue, but they cannot relabel covered care after service, stall an accumulator indefinitely, or make the patient finance an institutional dispute.

Several categories require explicit legislative treatment:

- routine adult dental care;
- routine vision care;
- long-term custodial care;
- fertility treatment;
- experimental or investigational treatment;
- cosmetic procedures;
- nonmedical amenities;
- services received outside the United States.

Exclusion from the national standard does not prohibit private insurance from covering a service. It means the federal ceiling and reinsurance payment do not automatically apply to that service.

Plans and states may exceed the national floor by covering routine dental or vision care, broader fertility services, international care, premium amenities, or other benefits. An added benefit does not automatically create a federal obligation. Its treatment, patient cost sharing, and relationship to the national accumulator must be disclosed before enrollment and, where practicable, before service.

The initial statute establishes the core categories and anti-evasion rules. A national standards body then maintains detailed clinical and billing rules through a public process with clinical, actuarial, patient, disability, insurer, provider, employer, and taxpayer representation. Each update publishes the medical evidence, access effects, fiscal effects, implementation date, and risk that a new classification creates a loophole around the ceiling.

Every denial requires a reason tied to a published provision of the standard. The individual receives an expedited clinical appeal when delay may harm health and an ordinary appeal for other classifications. While institutions dispute payment for care already recognized as covered, the Patient-Exit Rule continues to control the person's liability.

The patient's question must remain simple:

> Is this medically necessary care inside the national promise?

The institutional answer must be legally auditable.

17. Claims Data as an Integrity System

The $10,000 attachment creates a predictable point around which institutions may try to game payment.

Providers or insurers may try to accelerate claims, intensify coding, shift services between years, split episodes, or move recognized spending toward the federal layer. Upcoding—billing a more severe diagnosis or more expensive service than was provided—is already a known enforcement problem.[15]

The answer is not to return the burden to the patient. It is to make claims integrity part of the federal contract.

Every participating claim carries a standardized transaction record containing at least:

- a unique claim and revision identifier;
- the person-specific accumulator token;
- service and submission dates;
- provider, facility, and ordering identifiers;
- service, diagnosis, and episode codes where required;
- the billed and recognized allowed amounts;
- the amount assigned to the patient and each institutional payer;
- the effect on both accumulators;
- the amount eligible for federal reimbursement;
- reversals, corrections, rebates, and other-payer recoveries.

Corrections append to the record rather than erase its history. Government and insurers need to know not only the final number but how a claim changed, who changed it, and whether the change occurred before or after an attachment was crossed.

Claims move through a common integrity sequence:

1. **Normalize.** Confirm identity tokens, codes, service dates, provider status, and allowed-price rules.
2. **Coordinate.** Identify duplicates, other liable payers, prior payments, and episode relationships.
3. **Accumulate.** Credit the correct amounts to the patient-liability and commercial-claims ledgers.
4. **Adjudicate.** Apply insurer, public-program, and federal contract rules.
5. **Pay or hold.** Pay validated amounts and place specifically questionable institutional amounts into review.
6. **Reconcile.** Process corrections, recoveries, appeals, and postpayment findings without recreating innocent-patient liability.

The system monitors:

- unusual clustering near $5,000 and $10,000;
- abrupt coding changes after attachment;
- providers with anomalous intensity or volume;
- duplicate and overlapping claims;
- claim acceleration near year-end;
- reversals and resubmissions;
- patient accumulators rising without corresponding encounters;
- geographic and specialty outliers;
- insurer-specific patterns inconsistent with comparable populations.

The federal government and insurer reconcile against a common logical ledger while maintaining separate audit authority. No agency must store every clinical record in one database. Standard transaction records can remain distributed across authorized claims systems while producing a consistent payment history.

Insurers remain the first-line claims reviewers because they retain financial exposure on every commercial claim. Federal integrity teams review the public share, compare activity across carriers, and audit insurers and providers. An independent channel adjudicates disputes over misclassification, documentation, or delay.

Random audits prevent the system from examining only known outliers. Prepayment review can stop obvious anomalies. Postpayment review, clawbacks, interest, civil penalties, contract exclusion, professional referral, and criminal referral address conduct discovered later. A statistical flag begins an inquiry; it is neither proof of fraud nor sufficient by itself to deny necessary care.

The patient can inspect a plain-language list of encounters and accumulator entries. Someone who sees an unfamiliar provider, a service never received, or an amount that appears wrong can flag it without understanding billing codes. The report protects the insurer and taxpayer while giving the individual a direct way to correct a phantom claim.

When a suspicious institutional claim is held or reversed, the insurer, provider, and government resolve payment. Covered care continues under ordinary clinical rules, and the Patient-Exit Rule remains intact. Only proven intentional patient fraud or knowing material misrepresentation can reopen the patient's protection; a provider's false claim cannot become the patient's debt.

This creates a recurring fraud detector for insurers. Government sees cross-plan patterns that one carrier may miss. Insurers see local provider and member behavior in greater detail. Each side has reason to challenge the other rather than pass every dollar forward.

The taxpayer receives a bounded payment formula, not a fixed national cost. Under the Base contract, government pays nothing on an invalid claim and only half of each validated allowed dollar above the $10,000 commercial attachment. The attachment, retained insurer share, allowed prices, audits, and recoveries constrain exposure, but aggregate federal spending can still rise with legitimate high-cost claims. The $10,000 attachment is not an absolute federal spending cap.

Improper-payment figures require care. CMS reported substantial improper payments across Medicare and Medicaid in fiscal year 2025, but CMS and GAO emphasize that an improper payment is not synonymous with fraud. Documentation failures, technical violations, errors, underpayments, and overpayments can all be classified as improper.[14]

For that reason, the fiscal model assigns only a modest candidate payment-integrity recovery. It does not treat every reported improper dollar as recoverable.

The larger benefit is repeated, actionable data.

The attachment point gives government and insurers a shared reason to detect suspicious high-volume patterns before they compound.

18. Privacy by Separation

The tax system must not become a medical-record system.

The Household Account needs only a narrow set of health-administration facts:

- who the individual is;
- which tax household administers the record;
- whether qualifying coverage existed during each month;
- the insurer and plan identifier;
- whether the individual ceiling has been reached;
- whether a payroll-deduction election exists.

It does not need diagnoses, procedure codes, medications, provider notes, laboratory results, imaging, treatment plans, or claim details.

Those records remain inside healthcare and claims environments subject to health-privacy law and role-based access. The tax environment receives only the confirmation needed to administer household status, withholding, enrollment, and protection.

The separation is statutory, technical, and visible to the individual.

1. The Household Account stores identity, household, income, coverage, and election data.
2. The Individual Medical Accumulator stores recognized financial totals and a ceiling-status indicator.
3. The Claims Integrity System stores claims detail for payment, audit, and appeal.
4. Clinical systems remain with providers and health plans.

The systems exchange tokens and limited status messages rather than copying complete records. An ordinary exchange answers a narrow question—*Is this the correct person? Was qualifying coverage active? What is the recognized accumulator status? What deduction instruction was authorized?*—without exposing the underlying tax return or medical history.

The ordinary information flow is therefore limited:

- the Household Account sends an identity token, coverage election, and permitted household relationship;
- the coverage system returns plan identity, effective months, and enrollment status;
- the accumulator returns a recognized dollar total or ceiling-reached status;
- payroll receives only the withholding and authorized deduction instructions;
- detailed claims remain within authorized payment, audit, and appeal systems.

Even the household view is segmented. An adult spouse does not automatically receive another adult's claim details. A filer administering a dependent receives enough information to confirm coverage and resolve an action item—not a diagnosis. Guardians receive access appropriate to law and care responsibility, with special protection for sensitive adolescent services. Shared custody, domestic abuse, protected addresses, and legal separation require confidential-contact and delegated-access rules.

Current law provides useful precedent. Internal Revenue Code section 6103 generally treats tax returns and return information as confidential. Existing ACA rules allow the IRS to disclose only specified filing, household, and income information to health marketplaces and agencies for eligibility purposes under strict safeguards.[11] HIPAA's minimum-necessary principle similarly requires covered entities to limit many uses and disclosures to information needed for the stated purpose.[12]

Something for Something should add:

- explicit prohibition on clinical data in the Household Account;
- tokenized identifiers rather than routine circulation of Social Security numbers;
- encryption in transit and at rest;
- role-based, least-privilege, and time-limited access;
- immutable access logs visible to the individual;
- independent security audits;
- short retention and automatic deletion for transient exchange data;
- breach notification, containment, and individual remediation duties;
- civil and criminal penalties for unauthorized use;
- no sale or advertising use;
- no employer access beyond the payroll instruction and coverage administration it requires;
- no use for employment decisions, credit scoring, unrelated underwriting, or routine immigration or law-enforcement screening;
- a correction and appeal right for every person.

Purpose limitation follows the data after an authorized exchange. An agency or contractor cannot obtain a coverage token for enrollment and reuse it to build an unrelated behavioral profile. Exceptional disclosure required by other law remains subject to controlling legal process, minimization, logging, and later review; participation in the guarantee creates no new general-purpose government search authority.

Automated matching can identify a conflict but cannot silently decide a contested identity, household relationship, coverage termination, or fraud allegation. The person receives the conflicting sources, the rule applied, and access to human review. A system that is difficult to correct is not safe merely because access is restricted.

Retention follows function. Tax records remain under tax rules. Claims remain under health-payment and audit rules. Clinical records remain under clinical and health-privacy rules. Exchange tokens and temporary copies disappear when their administrative purpose ends. The architecture does not accumulate duplicate records merely because storage is inexpensive.

The tax-health connection is narrow by design.

For the ordinary taxpayer, the connection remains a few checkboxes, identifiers, status messages, and instructions—not a national chart note.

19. Prevention, Use, and the Middle

A known ceiling may change how people think about seeking care.

The Federal Reserve reported that 28 percent of adults skipped some form of medical treatment because of cost in 2024, including dental care, physician or specialist visits, prescription medicine, follow-up care, and mental-health treatment. Even among insured adults, 26 percent reported going without some treatment because they could not afford it.[1]

The $5,000 ceiling does not make every visit free. Current plan rules continue below it. But the ceiling removes the fear that beginning a medical investigation could open an unknowable financial chain.

That psychological change may matter most to people in the middle.

Low-income households may already interact with Medicaid, subsidies, safety-net systems, or charity care. High-income households may be able to absorb large bills. Middle-income workers often have insurance but still face enough cost sharing and uncertainty to postpone care, accept a lower-quality option, or avoid learning what a problem will cost.

The proposal may also change plan choice for this group. Once catastrophic personal exposure is fixed, a worker can compare premiums, networks, service, and protection below $5,000 without wondering whether one diagnosis could create an unlimited bill. Some people may buy less expensive supplemental coverage. Others may pay for a lower plan maximum, stronger network, or better navigation. The federal floor does not dictate the choice; it makes the choice more legible.

A visible ceiling can encourage a different calculation:

> I may have a difficult medical year, but I know the maximum covered consequence of entering the system.

The objective is not to make people spend $5,000 for its own sake. The ceiling is a boundary, not a utilization target. The objective is to make appropriate care usable without catastrophic fear. An annual Tax Day prompt reinforces that goal by asking whether each person has coverage, a usual source of care, an overdue refill or follow-up, and access to recommended preventive services.

The annual prompt does not deliver diagnoses or make clinical decisions. It routes the person to the plan, provider, or public program responsible for appropriate reminders. Preventive participation remains voluntary, and the Household Account receives only completion or coverage status when administratively necessary—not clinical results.

Additional use falls into at least four categories:

1. **Recovered necessary care** that had been delayed or skipped because of cost or uncertainty.
2. **Earlier preventive and chronic care** that may improve health even when it does not save money.
3. **Timing shifts** in which people schedule legitimate services before the annual accumulator resets.
4. **Low-value or supplier-induced care** encouraged by reduced marginal patient cost after the ceiling.

The fourth category is a real design concern. The ceiling may create a year-end pattern similar to people using remaining dental or vision benefits before expiration. Some activity is beneficial because it brings overdue care forward. Some may merely shift spending between months or encourage marginal services. Plans retain ordinary cost sharing below $5,000, insurers retain claims exposure above it, and the National Covered Care Standard still requires medical necessity. Those features reduce—but do not eliminate—the incentive.

Service-date and episode rules prevent providers from splitting or accelerating claims merely to exploit the calendar boundary. Plans should offer scheduling support so necessary follow-up is not crowded into December, while patients remain free to complete legitimate care during the protected year. The annual reset remains simple and visible; utilization management occurs through clinical and claims rules rather than by making the patient's ceiling uncertain.

A known maximum may also make patients more willing to seek a higher-quality provider rather than choosing solely from fear of price. Because price is not a reliable proxy for quality, the Tax Day Coverage Offer and plan-navigation systems should present validated quality, access, and outcome information alongside cost.

Greater use can increase near-term spending. Rather than counting prevention as immediate savings, the Base fiscal model applies a 2 percent induced-utilization assumption to modeled program payments, with zero in the Low case and 5 percent in the High case. These are scenarios, not behavioral estimates. Prevention may improve health and lower some long-run costs, but it cannot finance the headline promise until evidence establishes timing, attribution, and budget effects.

Evaluation tracks skipped care, primary and preventive visits, medication adherence, avoidable emergency use, hospital admissions, outcomes, patient-reported access, spending by service category, and clustering near the annual reset. Higher use is not automatically success, and lower use is not automatically savings.

The honest formulation is:

> The ceiling is designed to improve access and certainty. Any long-run savings are a possible dividend, not a prerequisite.

20. The Fiscal Case

The proposal has a large federal cost: approximately $483.7 billion annually in the Base gross model.

The workbook is a transparent planning model—not a Congressional Budget Office score, an actuarial certification, or a claim that the proposal is self-financing. Its purpose is to expose the scale of the commitment, show which assumptions drive it, and prevent the public promise from being discussed as though it were free.

The model uses the 2024 Medical Expenditure Panel Survey Full-Year Consolidated File, HC-256, as its person-level spine. MEPS provides nationally representative information for the civilian noninstitutionalized population, including annual medical spending, payment source, insurance coverage, and out-of-pocket spending.[4]

The weighted pass produces these estimates:

- approximately 339.8 million represented people;
- approximately $2.836 trillion in measured annual personal medical expenditures;
- approximately 102.1 million people with total spending above $5,000;
- approximately 63.1 million people with total spending above $10,000;
- approximately $2.040 trillion in spending above $5,000;
- approximately $1.640 trillion in spending above $10,000;
- approximately $626.0 billion in spending above $10,000 for the model's private-only commercial cohort.

MEPS does not equal the National Health Expenditure Accounts. It excludes the institutionalized population and omits or treats differently categories included in the broader national accounts. CMS reports $5.3 trillion in 2024 national health expenditures.[2] The model therefore presents a direct-data Low case and calibrated scenarios rather than treating the MEPS pass as a federal score.

The Base case applies four principal assumptions to the measured data:

- 1.25 calibration factors for the private-only commercial upper layer and uninsured upper layer;
- a 50 percent federal share of validated commercial claims above $10,000;
- a 1.30 calibration to observed patient liability above $5,000 in public programs;
- a 2 percent induced-utilization assumption and 1 percent federal administration assumption on the applicable payment base.

Commercial claims, patient liability, and public-program cost sharing remain separate quantities. Version 2.0 does not treat federal commercial payments as pure insurer savings. It subtracts the insurer's calibrated cost of absorbing private covered patient liability above $5,000 before calculating premium, paycheck, and tax effects. The policy assumptions are unchanged from Version 1.5; the movement in the core estimate comes from replacing HC-251 with HC-256.

The leading Base gross annual federal estimate is documented in Appendix A and the supplementary fiscal workbook:[22]

Base Gross Component	Annual Amount
Commercial reinsurance	$391.3 billion
Uninsured backstop	$12.4 billion
Public-program patient-ceiling fill	$65.9 billion
Induced utilization	$9.4 billion
Federal administration	$4.8 billion
Base gross federal cost	**$483.7 billion**

Table: Base Gross Federal Cost

Note: Displayed components may not sum exactly to the total because each amount is rounded independently.

The modeled gross range is approximately $377.3 billion to $620.0 billion annually. It reflects calibration, utilization, and other policy assumptions—not conventional statistical confidence intervals.

Because the core model contains no independently verified offset, its formal internal net remains equal to gross cost: $483.7 billion in the Base case. The lower $402.3 billion figure appears only after applying a separate stack of candidate offsets. The two numbers must not be collapsed into one headline.

The corrected commercial bridge is also important. The Base model begins with approximately $391.3 billion in gross federal commercial reinsurance, subtracts approximately $68.5 billion in calibrated private patient-ceiling cost, and estimates approximately $322.8 billion in net commercial insurer relief. After applying assumptions about the employer-plan share and premium pass-through, the model produces approximately $261.5 billion in employer-plan premium relief, equivalent to a 21.3 percent reduction across its modeled employer-sponsored premium pool. That is a scenario result—not a forecast.

The Base candidate offset stack is:

Candidate Offset	Annual Amount	Confidence
Wage and payroll-tax recovery	$45.3 billion	Moderate
Premium-tax-credit savings	$20.3 billion	Moderate
Uncompensated-care substitution	$6.2 billion	Low–moderate
Corporate-income-tax recovery	$7.2 billion	Low
Payment-integrity recovery	$2.4 billion	Low
Total candidate offsets	**$81.4 billion**	**Illustrative**
Illustrative provisional net cost	**$402.3 billion**	**Not formally scored**

Table: Base Candidate Offset Stack

None of these offsets has been independently verified.

The strongest candidates are wage and payroll-tax recovery and lower premium-tax-credit outlays if reinsurance reduces benchmark premiums. Existing section 1332 policy already uses federal premium-tax-credit savings as pass-through funding for state reinsurance programs.[6]

Uncompensated-care substitution depends on identifying public spending already financing care that would move into the backstop. Corporate-income-tax recovery depends on how much employer retained savings becomes taxable profit rather than wages, prices, investment, or public-employer relief. Payment integrity should remain modest because improper payments are not synonymous with recoverable fraud.

The model assigns zero savings to prevention, lower medical debt, long-term labor mobility, simpler administration, insurer onboarding, and additional economic consumption. Those effects may strengthen the policy case, but they cannot finance the promise until separately modeled.

The offset schedule avoids obvious double counting. Wage-tax recovery uses compensation shifted from tax-excluded health benefits into taxable cash. Corporate-tax recovery applies only to modeled employer-retained value, not the worker portion. Premium-tax-credit savings use a separate federal subsidy baseline. Uncompensated-care substitution cannot exceed the new uninsured backstop. Payment-integrity recovery applies only to the modeled program-payment base.

The proposal does not yet select a complete financing package. Continuous withholding improves timing and accuracy; it does not create $483.7 billion of revenue. Unless Congress enacts new revenue, reallocates existing spending or tax preferences, or adopts another financing source, the gross cost increases federal outlays and borrowing. A legislative version must disclose the incidence of any payroll contribution, income-tax change, spending substitution, borrowing, or mixed approach rather than hiding financing inside the administrative redesign.

At mature annual scale, the $483.7 billion Base gross estimate equals approximately 6.5 percent of CBO's projected $7.4 trillion in federal outlays for 2026. The $402.3 billion provisional estimate equals approximately 5.4 percent.[17] These are static scale comparisons against an FY2026 baseline, not claims that the program would begin at full cost in 2026 or remain the same share of future budgets.

The proposal is therefore financeable only in the broad sense that the federal government operates programs of this scale—not in the sense that it is small, painless, or available without tradeoffs.

It should also be placed beside the existing federal role. CBO and the Joint Committee on Taxation project approximately $2.4 trillion in net federal health-insurance subsidies in 2026, including Medicare, Medicaid and CHIP, employment-based coverage tax preferences, premium tax credits, and other support.[16]

The gross and provisional estimates can be located within the current federal budget as follows:

FY2026 Comparison	Annual Scale	Gross Share	Provisional Share
Total federal outlays	$7.4 trillion	6.5%	5.4%
Federal health-insurance subsidies	$2.4 trillion	20.2%	16.8%
Major federal health-program outlays	$1.9 trillion	25.5%	21.2%
Federal Medicaid outlays	$708 billion	68.3%	56.8%
Defense funding	$898 billion	53.9%	44.8%
Department of Veterans Affairs request	$441.3 billion	109.6%	91.2%

Table: Approximate Federal Scale Comparisons. The categories mix outlays, subsidies, funding, and a departmental request and are presented as scale comparisons rather than interchangeable budget accounts.[16][17][23]

The most intuitive institutional comparison is the Department of Veterans Affairs: the gross proposal is now modestly larger than the cited VA request, while the provisional estimate is slightly smaller. The more relevant system comparison is federal health support. The gross estimate equals approximately one-fifth of the federal government's existing annual health-insurance subsidy commitment, and the provisional estimate equals approximately one-sixth.

The $483.7 billion gross estimate also equals approximately 9.1 percent of the $5.3 trillion the United States spent on healthcare in 2024.[2] The proposal is better understood as a national risk-allocation layer applied to a vast existing system than as an attempt to construct a new healthcare economy.

The proposal is therefore not introducing government into a previously private system.

It is asking whether a portion of the government's existing and additional health commitment can purchase one universal, legible guarantee.

The economic return is not a budget offset

Public spending does not vanish. It becomes provider revenue, insurer payment, wages, and household liquidity. The modeled worker take-home gain of approximately $120.1 billion is the clearest direct consumption channel. Reduced fear of medical debt may also lower precautionary saving, improve job mobility, and release household spending elsewhere in the economy.

But the flows are not all the same kind of economic activity. Much of the commercial reinsurance payment changes who finances an existing medical claim. The induced-utilization component represents additional modeled healthcare use. Premium and wage effects redistribute resources from health-plan financing toward employers and workers. Later consumer spending may support output and tax receipts, but it is a second-round response rather than repayment of the original federal claim.

Those effects matter, but they belong in three different categories.

Candidate federal offsets could directly reduce the program's net budgetary cost: wage and payroll-tax recovery, lower premium-tax-credit outlays, substitution for uncompensated-care spending, corporate-income-tax recovery, and payment-integrity recoveries. The current model provisionally counts only these channels.

Additional fiscal feedback may arise when greater take-home pay supports consumption, expanded insurance participation generates taxable business activity, or reduced financial distress improves employment and earnings. Those channels could return revenue to federal, state, and local governments, but they require a dynamic model and are excluded from the headline offset stack.

Economic and public value includes bounded household risk, lower fear of medical debt, improved access to care, stronger labor mobility, more predictable employer costs, broader insurer enrollment, and a patient who can leave the financial dispute after reaching the ceiling. Those are reasons to enact the policy even when they do not appear as federal receipts.

A dollar circulating through consumption can support income and tax receipts without erasing the original appropriation. A change in payer also does not automatically create new output: when government assumes a bill that an insurer would otherwise have paid, the financing source changes but the underlying medical service does not become new economic activity.

The honest fiscal question is not whether all $483.7 billion returns to the Treasury. It will not. The question is how much returns through identifiable budget channels and whether the remaining public cost purchases enough economic security, institutional leverage, and universal protection to justify the commitment.

What changed in the 2024 data

AHRQ released HC-256, the 2024 Full-Year Consolidated person-level file, in August 2026.[21] Version 2.0 reruns the same coverage hierarchy and threshold method used for HC-251. It does not apply a uniform national spending-growth factor. Fixed $5,000 and $10,000 thresholds respond to the distribution of person-level spending, coverage categories, and payer mix, so the underlying microdata must be processed again.

The 2023 control rerun reproduces the Version 1.5 weighted inputs within rounding tolerance, and both years assign zero weighted population to the unclassified residual. The principal changes are:

Measured Item	2023	2024	Change
Total MEPS spending	$2.505 trillion	$2.836 trillion	+13.2%
Private-only claims above $10,000	$509.7 billion	$626.0 billion	+22.8%
Private-only OOP above $5,000	$37.7 billion	$52.7 billion	+39.7%
Public-program OOP above $5,000	$42.4 billion	$50.7 billion	+19.5%
All OOP above $5,000	$84.0 billion	$106.4 billion	+26.6%
Base gross federal estimate	$397.4 billion	$483.7 billion	+21.7%

Table: Controlled 2023–2024 MEPS Bridge. Policy assumptions are held constant; dollar figures are weighted point estimates documented in Appendix A.8 and the supplementary fiscal workbook.[22]

The new data make the proposal more expensive, but they also show more measured exposure above the limits the proposal is designed to contain. That is not a contradiction. A backstop becomes more expensive when the underlying risk grows—and more valuable for the same reason.

The one-year movement should not be interpreted as proof that every individual became 39.7 percent worse off. Inflation, utilization, treatment intensity, population change, coverage composition, and survey variation may all contribute. The defensible conclusion is narrower: under the same model rules, HC-256 measures substantially more private claims and patient liability above the proposal's fixed thresholds than HC-251 did.

The next model version should add replicate-weight uncertainty estimates, clearer reconciliation to the National Health Expenditure Accounts, distributional results by income and coverage, and independent actuarial review. The current Low, Base, and High cases are policy scenarios—not substitutes for sampling uncertainty, behavioral estimation, or formal legislative scoring.

21. Move the Levers Together

The policy can be implemented faster than a complete replacement of American healthcare because most infrastructure remains. Faster does not mean immediate.

The tax system, payroll withholding, employer plans, insurers, claims processing, public programs, and provider networks remain. The reform changes their coordination, liability endpoints, and information flows.

That does not make implementation small. It makes implementation a matter of connecting, governing, and changing several existing systems at once. Those connections must be ready before the financial promise becomes active.

Four sets of institutions require defined leadership:

- Treasury and the IRS administer the Household Account, simplified filing, and withholding instructions;
- HHS and CMS administer the National Covered Care Standard, accumulator rules, federal contracts, and public-program coordination;
- the Department of Labor governs employer-plan reporting and the Employer Health Dividend where applicable;
- state insurance regulators continue supervising licensed plans, networks, rates, and consumer protection while using national contract and data standards.

A joint program office manages deadlines and interoperability without receiving unrestricted access to every participating system. An independent privacy and fiscal board publishes readiness findings, security audits, implementation spending, and unresolved risks.

Phase	Timing	Primary Work
Design	Prelaunch	Enact financing and authority; define covered care, privacy boundaries, allowed prices, contracts, data standards, appeals, and implementation governance
Launch	Year 1	Tax Day offer, Household Account confirmation, protected pilot cohorts, insurer contracts, patient-exit rule, manual fallback
Expand	Year 2	Automated check-in for most routine taxpayers, two claims accumulators, withholding updates, employer renewals, contract reporting
National scale	Year 3	Near-national household availability, migration and custody routines, provider verification, insurer and public-program reconciliation
Full operation	Years 4–5	Universal ceiling, automated updates, premium pass-through, Employer Health Dividend enforcement, independent evaluation
Stabilize	Years 6–10	Contract repricing, public outcomes, refined fraud controls, independent review, reauthorization or permanence

Table: Implementation Roadmap

The model assumes activation of 25 percent in Year 1, 60 percent in Year 2, 85 percent in Year 3, and 100 percent in Year 4. Prelaunch design sits outside that fiscal clock. Wherever the program is active, the ceiling remains $5,000. Activation measures how much of the population and contract system is operating—not a smaller promise for early participants.

Pilot and expansion populations must include commercial coverage, public programs, uninsured participants, small and large employers, rural and urban providers, multiple states, and complex households. A pilot limited to healthy workers or administratively easy taxpayers would understate cost and difficulty. Selection rules, comparison groups, and exit dates are published before enrollment.

National expansion depends on readiness gates rather than the calendar alone:

1. **Legal readiness.** Covered care, patient exit, appeals, financing, and institutional authority are in force.
2. **Claims readiness.** Both accumulators reconcile accurately across plans, providers, and coverage changes.
3. **Consumer readiness.** Providers can verify ceiling status, overpayments can be returned, and manual assistance is available.
4. **Contract readiness.** Insurer payment, pass-through, solvency, and clawback rules have been tested through a full reconciliation cycle.
5. **Privacy readiness.** Independent testing confirms separation, logging, access control, breach response, and correction rights.
6. **Fiscal readiness.** Updated data and appropriations support the next activation step without relying on unverified offsets.

Failure at a gate delays expansion; it does not reduce the $5,000 protection for people already activated. Contingency operations preserve accumulator balances and patient-exit status while institutions repair a failed interface or reconcile payments manually.

The provisional ten-year Base case, beginning in 2028, estimates:

- approximately $4.312 trillion in nominal provisional federal cost;
- approximately $3.603 trillion in present-value provisional federal cost under the model's discount assumption;
- approximately $1.270 trillion in cumulative worker take-home gain.

These are illustrative planning values, not a formal legislative score.

The workbook also contains a $10 billion one-time implementation placeholder distributed across the first three years. It is not an engineering estimate or evidence that the systems can be built for $10 billion. A legislative version needs independent estimates for tax modernization, identity resolution, claims exchange, cybersecurity, call centers, provider integration, state grants, and transition administration.

Eight guardrails apply throughout implementation:

1. **Same ceiling.** The individual promise remains $5,000 wherever the program is active.
2. **Tax Day is a default.** Missing the automated path never permanently eliminates protection or appeal.
3. **Midyear updates.** Household, work, residence, income, and coverage changes can be reported throughout the year.
4. **Patient exit.** Institutional disputes cannot recreate covered liability after the ceiling.
5. **Plan-year continuity.** Existing employer contracts transition at lawful renewal points.
6. **Contracted split.** Government-insurer percentages are set prospectively, not negotiated per patient.
7. **No calendar override.** Expansion occurs only after published readiness findings.
8. **No data shortcut.** Operational pressure cannot collapse the privacy separation among tax, accumulator, claims, and clinical systems.

The implementation strategy is to move several existing levers together.

That is an overhaul of the bargain without destroying the machinery that already works.

22. What Is New and What Is Borrowed

The components of this proposal have clear precedents.

High-deductible insurance and health savings accounts have long treated catastrophic coverage as a distinct layer. In 2000, Milton Friedman advocated catastrophic insurance with a $4,000-to-$5,000 annual deductible and described a government-financed voucher role. Martin Feldstein and Jonathan Gruber's 1994 major-risk analysis examined high coinsurance paired with a limit on personal out-of-pocket spending, including government provision of major-risk insurance.[18] Modern ACA plans use annual out-of-pocket limits. Employers use stop-loss coverage. States use public reinsurance. The tax system already collects household and health-coverage information, and Marketplaces use limited tax data for eligibility.

The novelty is not catastrophic insurance itself.

Nor is every administrative tool new. The proposal borrows mechanisms institutions already understand:

Existing Mechanism	What It Already Does	Proposed Adaptation
Plan out-of-pocket maximum	Limits cost sharing inside a particular plan	One national individual ceiling across qualifying coverage changes
Public reinsurance	Pays part of a defined private claims layer	National contracts above a separate commercial-claims attachment
Employer stop-loss	Protects a plan sponsor against high claims	Coordinates with, but does not replace, the federal upper layer
Tax health reporting	Confirms household, income, or coverage facts	Annual check-in, coverage offer, and current withholding instruction
Prefilled filing tools	Reuse information government already receives	Confirmation becomes filing for eligible routine cases
Claims-integrity analytics	Detects coding, duplication, and payment anomalies	Shared government-insurer scrutiny tied to the public payment layer

Table: Borrowed Mechanisms and Their New Assignment

What is new is the combination and assignment of responsibility:

- a universal individual ceiling attached through the tax household;
- a separate $10,000 federal commercial attachment;
- insurer absorption of covered patient liability after patient exit while the separate commercial-claims ledger continues;
- a contracted government-insurer split above attachment;
- an annual Tax Day enrollment and household-confirmation moment;
- prospective withholding updates after confirmation;
- an employer savings dividend shared with workers;
- a patient-exit rule that relocates disputes;
- a claims-integrity system built around the public attachment;
- strict separation between household tax data and clinical claims.

The architecture lies in the sequence. The tax household establishes identity and presents the annual choice. The patient-liability accumulator creates the $5,000 exit. The separate commercial-claims accumulator determines when the federal contract begins. Insurers retain risk and receive customers. Employers receive relief but share certified savings. Government pays a defined upper-layer share and gains claims visibility. The patient leaves the payment fight without government replacing every plan below it.

Many reform families address one part of the system: national coverage, premium subsidies, savings accounts, individual mandates, catastrophic insurance, simplified filing, or automated benefits. *Something for Something* joins medical-risk and tax-administration reform in one reciprocal bargain, then uses the employer and insurer transition to distribute the gain.

The strongest originality claim is therefore architectural rather than elemental:

> The proposal combines a universal personal medical ceiling, a separate federal claims attachment, annual tax-household confirmation, prospective withholding, voluntary coverage onboarding, patient exit, and a worker share of employer relief in one operating system.

That claim remains appropriately bounded. This paper identifies important antecedents, but it is not a complete legal, academic, patent, or legislative priority search. Before publication, the related-work review should test the combined design against additional catastrophic-insurance proposals, automatic-filing systems, state reinsurance programs, employer pass-through rules, and international tax-health integrations.

Subject to that review, the combined sequence and assignment of responsibility are the paper's distinctive contribution.

23. What Success Looks Like

Enrollment and federal spending alone cannot determine whether the proposal succeeds.

The primary test is whether ordinary people experience a different kind of security.

The north-star metric is the rate and dollar value of nationally covered medical liability billed to or collected from individuals after the $5,000 ceiling. The statutory target is zero, with rapid automatic refunds and enforcement when a violation occurs.

That metric is necessary but insufficient. A national dashboard organizes measures into seven domains.

Patient protection

- percentage of eligible individuals with a functioning accumulator;
- number and share reaching the ceiling;
- time from the qualifying claim to the Ceiling-Reached Notice;
- covered amounts billed or collected after exit;
- time required to return overpayments;
- balance-billing complaints, appeals, and resolutions.

Tax and household administration

- annual check-in completion and average completion time;
- use of the full filing and appeal path;
- correction time for household, coverage, and withholding errors;
- frequency and size of routine refunds and balances;
- timing and accuracy of prospective payroll changes;
- user comprehension, satisfaction, and trust.

Coverage and access

- uninsured rate, coverage continuity, and plan churn;
- Tax Day offers presented, selected, declined, and later cancelled;
- premium, network, appointment, and claims-denial measures;
- care delayed or skipped because of cost;
- preventive, chronic, emergency, and hospital use;
- medical debt, collections, and financial distress.

Worker and employer value

- premium reductions attributable to federal protection;
- lower worker contributions and verified wage dividends;
- employer retained savings and administrative cost;
- distribution across firms, industries, wage levels, and plan types;
- evidence of offsetting wage, hour, benefit, or fee changes.

Federal fiscal performance

- gross payments by component and coverage group;
- verified offsets separately from candidate offsets;
- implementation and administration spending;
- net cost per protected person and per person reaching the ceiling;
- variance from appropriations, contracts, and actuarial projections;
- long-term growth in claims, allowed prices, and public exposure.

Integrity and due process

- clustering and coding shifts around both thresholds;
- prepayment holds, confirmed overpayments, underpayments, and recoveries;
- false-positive and appeal-overturn rates;
- provider, insurer, and patient findings reported separately;
- time that legitimate claims remain unresolved;
- instances in which an integrity review interrupted covered care or violated patient exit.

Privacy, security, and equity

- unauthorized access, breaches, and remediation time;
- individual use of access logs and correction rights;
- outcomes by income, age, disability, race and ethnicity, geography, coverage source, and household type where lawful and statistically sound;
- differences in accumulator accuracy, patient exit, appeals, access, premiums, and medical debt across those groups;
- suppression and privacy controls for small or identifiable populations.

No single metric can establish success.

Lower federal cost achieved by denying covered care is failure. Higher enrollment without meaningful coverage is failure. Lower premiums without worker pass-through represent an incomplete success. More care without better access or outcomes may indicate low-value use. Large fraud recoveries paired with high false-positive or appeal-overturn rates may indicate an abusive integrity system.

Baselines, target ranges, and failure thresholds are published before each implementation phase. Agencies and contractors cannot define success after seeing the results. Operational measures appear monthly, a consolidated dashboard quarterly, and an independent evaluation annually. Five-year reauthorization depends on the complete record rather than a single budget or enrollment figure.

Evaluation is independent of the agencies and vendors operating the program. Pilot designs, comparison methods, and material model changes are registered in advance. Researchers receive privacy-protected data sufficient to reproduce national estimates, and every public model retains versioned assumptions and corrections.

Failure triggers a proportionate response. A broken interface requires repair. A carrier that withholds pass-through requires recovery or exclusion. A privacy failure may require suspension of a particular data exchange. Unexpected federal cost requires contract and financing review. None of those responses can casually reopen liability for a patient who has reached the ceiling.

Success is a balanced result:

> More people protected, fewer people financially afraid to seek care, reliable patient exit, more accurate paychecks, visible worker and employer value, functioning private coverage, defensible privacy, and auditable public cost.

24. Costs and Objections

The proposal must survive its hardest objections—not only the questions its architecture already answers.

The first objection is gross cost.

The Base model produces $483.7 billion in annual gross federal cost, equal to approximately 6.5 percent of projected FY2026 federal outlays. The $402.3 billion provisional figure depends on $81.4 billion of candidate offsets that are not formally scored. Economic circulation is not an answer to this objection. Universal bounded medical risk must be evaluated against other federal health commitments, tax preferences, household costs, and competing uses of federal money.

The controlled HC-256 refresh raises the Base gross estimate by approximately $86.3 billion, or 21.7 percent, relative to the 2023 pass. That is a genuine deterioration in the fiscal case. It is also accompanied by a 22.8 percent increase in measured private-only claims above the $10,000 attachment and a 39.7 percent increase in measured private-only out-of-pocket liability above $5,000. The higher estimate therefore does not show that the mechanism failed; it shows that the risk being transferred was larger in the new data. The proposal becomes more expensive and more protective at the same time. The one-year change does not establish its cause and should not be treated as a forecast of continuing growth.

The $10,000 commercial attachment is a major reason the cost is large. Raising it would reduce federal spending but also reduce premium relief, employer savings, and bargaining leverage. The current threshold is a modeled policy choice—not an immutable definition of catastrophic risk—and the fiscal tradeoff should remain visible in every contract review.

The second objection is financing.

The paper does not yet identify a complete revenue package. More accurate withholding changes timing, not tax liability. Premium relief and economic activity may produce receipts, but they do not finance the appropriation automatically. A legislative version must choose and distribute the burden of taxes, payroll contributions, spending or tax-expenditure reallocations, borrowing, or a mixed approach. Until then, the proposal is an architecture with a cost estimate—not a financed bill.

The third objection is that $5,000 remains unaffordable.

For many households, it does. The ceiling is not, however, an amount everyone must pay before care begins. Existing insurance and public programs continue below it, and supplemental products can reduce it. The reform addresses catastrophic exposure first; it does not solve every affordability problem below the ceiling in one move.

Keeping one universal number preserves clarity without forbidding assistance below it. Employers, unions, states, towns, charities, insurers, and future federal policy can subsidize or insure the first $5,000 without changing the national maximum. Evaluation must measure how many people still delay care or incur debt below the ceiling rather than treating bounded risk as complete affordability.

The fourth objection is adverse selection.

An uninsured person retains the federal backstop above $5,000. Some healthy people may decide premiums are not worth paying, leaving private plans with a sicker pool and increasing federal uninsured costs. The Tax Day prompt, payroll payment, lower premiums, annual enrollment windows, and valuable protection below $5,000 may move behavior in the other direction, but that is not guaranteed. The enrollment model must test both outcomes. If voluntary enrollment falls materially, the proposal will need stronger incentives, redesigned subsidies, or different uninsured financing.

The fifth objection is that the threshold could increase utilization.

It may. Some additional use will be appropriate care previously delayed by fear; some may be low value. Ordinary cost sharing below the ceiling and insurer responsibility through $10,000 preserve incentives to manage use. The model includes utilization sensitivity and assigns no preventive savings.

The sixth objection is provider-price inflation.

A public payer entering the upper layer can weaken price resistance if providers expect government to absorb part of every additional dollar. The insurer's retained share preserves discipline but may not be sufficient in concentrated markets. Recognized allowed prices, contract benchmarks, geographic adjustment, provider competition, rate review, and federal negotiating authority are therefore essential fiscal controls. The proposal does not by itself solve provider consolidation or national medical-price growth.

The seventh objection is insurer and provider gaming.

Attachment points create incentives. Standardized claims, episode rules, random audits, clustering detection, clawbacks, and independent enforcement are therefore core design features—not later additions.

Those controls can also become abusive if statistical suspicion replaces evidence. False-positive rates, appeal outcomes, delayed legitimate claims, and effects on care must be reported alongside recoveries.

The eighth objection is that employers or insurers will keep the savings.

They may unless pass-through is enforced. Net-relief calculation, actuarial certification, prospective premium credits, year-end reconciliation, rate correction, rebates, and the temporary Employer Health Dividend are therefore contractual requirements. Even then, counterfactual pricing is difficult. Independent review and worker-visible statements remain necessary because no formula can eliminate the baseline dispute.

The ninth objection is that the National Covered Care Standard could become rationing by definition.

Any protected-care boundary can be narrowed to save money or expanded without financing. The safeguards are a statutory core, public evidence and fiscal review, published allowed-price rules, expedited clinical appeals, and freedom for plans and states to add benefits. Those procedures reduce the risk but cannot remove the political conflict over medically necessary covered care.

The tenth objection is privacy and administrative concentration.

Connecting health administration to tax identity creates risk. Data minimization and separation are essential: the Household Account receives coverage facts and status indicators—not diagnoses or clinical records. Existing tax confidentiality and health-privacy protections provide a starting point, but the program requires explicit new safeguards.

Separation also creates operational dependencies. A failed identity service, accumulator exchange, or payroll instruction channel could affect millions of people. Independent security testing, distributed claims storage, manual continuity, access logs, breach duties, and staged readiness gates are essential. The tax system should coordinate the record without becoming a single medical database or single point of irreversible failure.

The eleventh objection is tax complexity.

The annual check-in does not eliminate complex taxation. It creates a simple default for routine cases and preserves the complete filing path. More agentic administration should shorten the individual's interaction without producing opaque automatic decisions. Every automated result requires an explanation, correction channel, and human appeal.

Continuous withholding will not eliminate all refunds and balances. Irregular income, capital gains, deductions, and late information still require reconciliation. The defensible promise is fewer routine surprises and more current paychecks, not perfect prediction.

The twelfth objection is that people should not be tied to tax filing to receive healthcare protection.

The tax household is the administrative anchor—not a condition of human worth. People outside ordinary filing, including children, dependents, people with no taxable income, and those who miss a deadline, retain protection through dependent records, public programs, automatic defaults, and appeal. Tax Day is the onboarding route, not the moral basis of coverage.

The thirteenth objection is federal and state legal authority.

The design crosses federal taxation, federal health spending, state insurance regulation, employer plans, public programs, and provider payment. ERISA, tax confidentiality, appropriations, administrative procedure, state licensing, and federalism questions cannot be solved through architecture alone. The legislative stack needs a dedicated authority-and-preemption memorandum identifying national rules, remaining state functions, treatment of self-funded plans, and required waivers or cooperative administration.

The fourteenth objection is that the proposal is not radical enough.

It preserves private insurance, employer plans, cost sharing, public programs, provider markets, and the tax system. That is intentional. The proposal changes the endpoint of personal risk without requiring every institution to be rebuilt first.

Preservation has a cost: the back end remains complex. The argument is not that institutional complexity disappears. It is that the individual receives one understandable boundary while institutions continue managing the plural system behind it.

The final objection is that moving multiple levers at once is administratively dangerous.

Coordination creates execution risk. It also creates the value. A patient ceiling without insurer pricing reform can become a hidden premium increase. Reinsurance without pass-through can become an insurer windfall. Tax enrollment without privacy separation can become surveillance. Employer relief without a worker dividend can become invisible.

The levers must move together because each addresses a weakness in another. But they move through readiness gates—not political optimism. A failed component delays expansion while protection continues for people already inside the guarantee.

Conclusion: The Something for Something Doctrine

Americans should not have to become experts in healthcare finance to know the maximum financial risk of getting sick. They should not have to become payroll specialists to know whether routine withholding is approximately correct.

The country already possesses most of the necessary machinery: tax accounts, payroll systems, insurers, employer plans, public programs, claims processors, provider networks, marketplaces, privacy law, auditing agencies, and reinsurance experience.

The machinery lacks one coordinated bargain.

Something for Something proposes one.

Every taxpayer, spouse, and dependent receives an individual $5,000 annual ceiling on covered medical liability. It is not a deductible everyone must satisfy. It is the point beyond which covered illness can no longer continue damaging the patient's finances.

Two separate accumulators make that promise compatible with the existing plural system. The patient-liability accumulator ends covered personal exposure at $5,000. The commercial-claims accumulator determines when the federal contract begins at $10,000. The thresholds may be reached at different times because they measure different things.

Commercial insurers remain primary. They absorb covered patient cost sharing after patient exit, retain responsibility below the claims attachment, and continue paying their contracted share above it. Public programs remain in place. Uninsured people receive the backstop and a yearly route into optional coverage. Private plans remain valuable because they can reduce exposure below $5,000, organize networks, coordinate care, and offer benefits beyond the national floor.

The patient exits the financial dispute.

Government, insurers, and providers can argue about prices, coding, medical necessity, reimbursement, documentation, and fraud. They have the time and tools. The patient gets to focus on getting better.

Tax Day becomes Check-In Day. Most wage-based households confirm a prefilled closed-year record and establish a current-year instruction rather than reconstructing information government already receives. Coverage status and options appear every year. Withholding updates prospectively, and midyear changes remain possible. Complicated and late cases retain the full filing and appeal system. Missing the easy path removes convenience—not medical protection.

Employers receive relief but temporarily share certified savings with workers. Insurers gain access to customers and a federal upper-layer partner but retain meaningful claims risk and must prove premium pass-through. Government accepts the cost of purchasing a universal safety net, greater claims visibility, a recurring enrollment moment, and more precise household administration.

No participant receives everything. No participant gives up everything.

The bargain is reciprocal without making healthcare protection conditional on perfect paperwork. Individuals provide accurate information, pay valid liability below the ceiling, and decide whether private coverage is worth purchasing. Employers report and share measured relief. Insurers validate claims, retain risk, and pass through the public benefit. Government finances and enforces the boundary.

The federal cost is real. Using the 2024 HC-256 person-level file, the Base gross estimate is approximately $483.7 billion annually, about 6.5 percent of projected FY2026 federal outlays. Because there are no verified offsets yet, the current internal net is also $483.7 billion. Candidate offsets of approximately $81.4 billion produce an illustrative provisional estimate of $402.3 billion, but those offsets remain unverified. The 2024 data refresh is complete; the proposal still needs a financing package, replicate-weight uncertainty estimates, independent actuarial and distributional analysis, reconciliation to the broader National Health Expenditure Accounts, legal-authority work, and formal budget scoring.

Those unfinished requirements are substantial. They do not erase what the architecture establishes: the United States can preserve private coverage and public programs while placing one comprehensible limit on the financial risk assigned to a person.

This is not free healthcare. It is an end to unbounded personal healthcare risk.

Five thousand dollars is not nothing, and for many households it remains difficult. But it is the difference between a hard medical year with a visible endpoint and an unknowable liability capable of following someone for years. It can be insured, saved against, subsidized, bargained, financed, or improved without weakening the universal promise.

The reform moves uncertainty upward.

The individual receives a boundary. Institutions absorb the complexity beyond it. The state guarantees that the dispute ends for the patient even when the institutions continue fighting.

One known medical maximum. One annual confirmation. A full alternative when automation fails. More accurate paychecks and a worker share when savings materialize. A private market with customers and room to compete. A government capable of bargaining over cost without leaving the patient in the middle.

Healthcare can remain expensive.

It can no longer remain financially endless.

At $5,000, the individual leaves the fight and focuses on getting better.

Appendix A. Fiscal Model and Audit Trail

This appendix documents the inputs, calculations, assumptions, and validation checks underlying the paper's fiscal estimates. Its purpose is to make the whitepaper understandable without requiring immediate access to the companion workbook. The workbook remains the complete formula-driven computational artifact.

The estimates presented here are planning estimates rather than a Congressional Budget Office, Joint Committee on Taxation, Centers for Medicare & Medicaid Services, or independent actuarial score. Unless otherwise stated, monetary values are annual amounts expressed in billions of dollars.

The model uses the 2024 Medical Expenditure Panel Survey Full-Year Consolidated File, HC-256, as its person-level empirical spine. It preserves separate patient-liability and commercial-claims accumulators, applies the paper's coverage hierarchy, and models Low, Base, and High policy cases. A controlled rerun of HC-251 provides the 2023 comparison and confirms that the movement in the headline estimate results from the updated data year rather than an unreported change in policy assumptions.

Model at a Glance

The Base-case calculation is summarized below. Dollar amounts are annual and expressed in billions.

Model stage	Base-case calculation	Result
Private commercial claims above the $10,000 attachment	2024 MEPS weighted estimate	$626.0
Federal commercial reinsurance	$626.0 × 50% federal share × 1.25 calibration factor	$391.3
Uninsured backstop	Recognized uninsured claims above $5,000 × 1.25 calibration factor	$12.4
Public-program patient-ceiling fill	Recognized public-program patient liability above $5,000 × 1.30 calibration factor	$65.9
Induced utilization	2% of program payments before utilization	$9.4
Federal administration	1% of payments after utilization	$4.8
Gross annual federal cost	Sum of the five program components	**$483.7**
Candidate offsets	Wage-tax recovery, premium-tax-credit savings, uncompensated-care substitution, corporate-tax recovery, and payment integrity	**–$81.4**
Illustrative provisional federal cost	$483.7 − $81.4	**$402.3**

The $402.3 billion result is provisional rather than formally scored. Candidate offsets remain separately identified because several depend on employer, insurer, and legislative behavior. The formula-driven workbook is included as optional replication material; the methodology, assumptions, sensitivity results, and internal checks are reproduced in this appendix. Displayed components may not sum exactly to the total because each amount is rounded independently.

A.1 Population and Coverage Hierarchy

The model covers the civilian noninstitutionalized population represented by HC-256.[4] Each person is assigned to one mutually exclusive coverage category so that spending, patient liability, and federal obligations are not counted more than once.

The hierarchy is:

1. Medicare, including people who also hold supplemental private coverage;
2. Medicaid or CHIP without Medicare;
3. other public coverage without Medicare, Medicaid, or CHIP;
4. private coverage without any of those public-program flags;
5. uninsured throughout the year.

This ordering matters. A person with Medicare and supplemental employer coverage remains in the Medicare cohort rather than also entering the commercial private-only calculation.

Coverage Category	Weighted Population	Total Spending
Private only	169.5 million	$1,171.4 billion
Medicare	70.1 million	$1,159.8 billion
Medicaid or CHIP	66.0 million	$389.8 billion
Other public	12.1 million	$91.0 billion
Uninsured all year	22.0 million	$24.2 billion
Total	**339.8 million**	**$2,836.1 billion**

Table A1: HC-256 Population and Spending by Coverage Hierarchy

Note: Values are weighted point estimates and may not sum exactly because of rounding.

The $2.836 trillion MEPS spending total is not intended to reproduce the $5.3 trillion National Health Expenditure Accounts total.[2] MEPS is a person-level survey of the civilian noninstitutionalized population; the national accounts include broader institutional, administrative, investment, public-health, and other spending categories. The model uses MEPS to estimate the distribution of person-level exposure across the two thresholds, not as a complete accounting of every national healthcare dollar.

A.2 The Two Accumulators

The model maintains two independent annual ledgers for each individual.

Let L_i represent the total recognized patient liability assigned to person i during the calendar year:

$$L_i = \sum_j \ell_{ij}$$

where ℓ_{ij} is the recognized deductible, copayment, coinsurance, or other covered patient liability associated with claim j.

The amount the individual may be required to pay is:

$$P_i = \min(L_i, 5{,}000)$$

The covered patient liability transferred away from the individual is:

$$X_i = \max(0, L_i - 5{,}000)$$

Once L_i reaches \$5,000, the Patient-Exit Rule applies. The individual owes no additional recognized point-of-service liability for nationally covered care during that calendar year. Insurers, providers, public programs, and government may continue disputing price, coding, documentation, reimbursement, medical necessity, or fraud, but those disputes cannot reopen covered liability for the patient.

The second ledger measures total recognized allowed claims. Let C_i represent the accumulated allowed claims for person i:

$$C_i = \sum_j a_{ij}$$

where a_{ij} is the recognized allowed amount for claim j.

For a commercially insured person, the claims layer eligible for the federal contractual share is:

$$U_i = \max(0, C_i - 10{,}000)$$

The insurer remains responsible for claims through the $10,000 attachment. Above that point, the insurer and federal government divide qualifying claims according to the contracted percentage.

The two thresholds do not measure the same thing. A person can reach $10,000 in total allowed claims without accumulating $5,000 in patient liability. A person with unusually high cost sharing can approach the $5,000 liability ceiling before reaching the commercial attachment. Neither accumulator substitutes for the other.

For commercially insured people, the insurer absorbs X_i, the covered patient liability displaced by the ceiling. The model therefore subtracts this calibrated patient-ceiling obligation from gross federal commercial reimbursement before estimating net insurer relief. This prevents the same public intervention from being counted once as patient protection and again as unrestricted insurer savings.

A.3 HC-256 Threshold Measurements

The fiscal model does not apply the thresholds to national aggregate spending. It applies them person by person within HC-256 and then weights the resulting upper layers to the represented population.[4]

"Dollars above threshold" means only the amount exceeding the specified boundary. It does not mean all spending incurred by people who cross that boundary.

Measured Upper Layer	People	Dollars
Private-only total claims above $10,000	24.7 million	$626.0 billion
Private-only patient liability above $5,000	8.9 million	$52.7 billion
Uninsured total claims above $5,000	1.2 million	$9.9 billion
Public-program patient liability above $5,000	6.3 million	$50.7 billion

Table A2: Leading HC-256 Threshold Measurements

Note: Values are weighted point estimates and may not sum exactly because of rounding.

The $626.0 billion private-only claims layer is the leading empirical input for commercial reinsurance. In the Base case, the federal government purchases 50 percent of that upper layer before calibration and utilization adjustments.

The $52.7 billion private-only patient-liability layer measures the cost commercial insurers would absorb when covered personal liability ends at $5,000. This amount is calibrated before being deducted from gross commercial reinsurance to estimate net insurer relief.

The $9.9 billion uninsured claims layer supplies the direct uninsured backstop input. Because no commercial insurer stands between the uninsured patient and the guarantee, this cohort receives separate fiscal treatment.

The $50.7 billion public-program patient-liability layer combines Medicare, Medicaid or CHIP, and other public coverage. Existing programs remain primary; the model estimates only the additional amount required to enforce the national patient ceiling.

Across all coverage categories, approximately 15.7 million people had measured out-of-pocket liability above $5,000 in HC-256, representing approximately $106.4 billion above the proposed patient ceiling. That national total is an audit measure rather than a single federal payment base because each coverage category is financed differently.

A.4 Gross Federal-Cost Scenarios

The Low, Base, and High cases hold the $5,000 patient ceiling, $10,000 commercial attachment, and 50 percent federal commercial share constant. The range therefore reflects calibration and utilization assumptions rather than different versions of the central policy bargain.

Assumption	Low	Base	High
Federal commercial share	50%	50%	50%
Private-claims calibration	1.00	1.25	1.55
Uninsured calibration	1.00	1.25	1.55
Public-program liability calibration	1.00	1.30	1.66
Induced utilization	0%	2%	5%
Federal administration	1%	1%	1%

Table A3: Gross Federal-Cost Assumptions

The calibration factors are explicit policy-model assumptions rather than measured MEPS values. They recognize that MEPS does not capture every claim or expenditure included in the broader healthcare economy. The Low case uses the direct survey estimates. The Base case applies partial calibration. The High case provides a wider reconciliation boundary. The 1.66 public-program factor approximates the broader national-to-MEPS out-of-pocket relationship used in the model.

Let:

- R equal commercial reinsurance;
- B equal the uninsured backstop;
- F equal public-program patient-ceiling fill;
- u equal the induced-utilization rate;
- a equal the federal administration rate.

The commercial component is:

$$R = 626.032 \times 0.50 \times k_c$$

The uninsured component is:

$$B = 9.891 \times k_u$$

The public-program component is:

$$F = 50.692 \times k_p$$

where k_c, k_u, and k_p are the scenario-specific calibration factors.

Program payments before utilization are:

$$Q = R + B + F$$

Gross federal cost is:

$$G = (Q \times (1 + u)) \times (1 + a)$$

Applying those formulas produces:

Annual Component	Low	Base	High
Commercial reinsurance	$313.0B	$391.3B	$485.2B
Uninsured backstop	$9.9B	$12.4B	$15.3B
Public-program ceiling fill	$50.7B	$65.9B	$84.1B
Induced utilization	$0.0B	$9.4B	$29.2B
Federal administration	$3.7B	$4.8B	$6.1B
Gross federal cost	**$377.3B**	**$483.7B**	**$620.0B**

Table A4: Low, Base, and High Gross Federal-Cost Results

Note: Displayed components may not sum exactly to the total because each amount is rounded independently.

No independently verified offset is included in these gross scenarios. The model's formal internal net therefore remains equal to gross cost until a separate offset receives sufficient evidence and formal scoring.

A.5 Commercial Attachment and Federal-Share Sensitivity

The $5,000 patient ceiling does not require the federal commercial contract to begin at the same amount. The patient-liability and total-claims accumulators remain separate.

Moving the commercial attachment from $5,000 to $10,000 leaves the patient promise unchanged while requiring insurers to carry a larger portion of the claims layer before federal participation begins.

Policy Configuration	Low	Base	High
$5K patient ceiling / $5K claims attachment	$460.8B	$590.1B	$755.8B
$5K patient ceiling / $10K claims attachment	$377.3B	$483.7B	$620.0B
Federal savings from $10K attachment	**$83.4B**	**$106.4B**	**$135.8B**

Table A5: Gross Federal Cost by Commercial Attachment

In the Base case, the $10,000 attachment reduces estimated annual federal cost by approximately $106.4 billion relative to a commercial contract beginning at $5,000. The individual still exits covered patient liability at $5,000 under both configurations.

The commercial contract can also vary the federal percentage without changing the patient ceiling. The following sensitivity table isolates the commercial reinsurance component using the Base private-claims calibration. It excludes the uninsured backstop, public-program ceiling fill, induced utilization, administration, and the insurer's patient-ceiling obligation.

Federal Share	$5K	$7.5K	$10K	$12.5K	$15K
25%	$247.3B	$217.6B	$195.6B	$178.1B	$163.6B
40%	$395.6B	$348.1B	$313.0B	$285.0B	$261.8B
50%	$494.5B	$435.1B	$391.3B	$356.2B	$327.3B
60%	$593.4B	$522.2B	$469.5B	$427.5B	$392.7B
75%	$741.8B	$652.7B	$586.9B	$534.4B	$490.9B

Table A6: Commercial Federal Component by Attachment and Federal Share

The leading design uses a $10,000 attachment and 50 percent federal share, producing approximately $391.3 billion in gross commercial reinsurance before the other program components. The table also shows that the government-insurer division is contractually adjustable. The public promise is fixed at the patient level; the institutional division above it can be renegotiated through transparent multiyear contracts.

A.6 Net Insurer Relief and Employer-Plan Pass-Through

Gross federal commercial reimbursement is not equivalent to unrestricted insurer savings. Commercial insurers receive the federal upper-layer payment, but they also assume the covered patient liability displaced by the $5,000 ceiling.

In the Base case:

Calibrated private patient-ceiling obligation:

$$52.676 \times 1.30 = 68.479$$

Net commercial insurer relief:

$$391.270 - 68.479 = 322.791$$

All figures are annual billions of dollars.

This correction prevents the model from treating the insurer as receiving federal reinsurance without also recognizing its new responsibility for covered patient cost sharing above $5,000.

The Base employer-plan scenario then applies two explicit assumptions:

- 90 percent of net commercial insurer relief flows through employer-sponsored plans;
- 90 percent of that amount passes through into lower premiums.

The resulting employer-plan premium relief is:

$$322.791 \times 0.90 \times 0.90 = 261.461$$

The modeled employer-sponsored premium pool is approximately $1.228 trillion, producing an illustrative premium reduction of approximately 21.3 percent.

Base Commercial and Employer-Plan Bridge	Annual Amount
Gross federal commercial reinsurance	$391.3 billion
Less calibrated insurer patient-ceiling obligation	$68.5 billion
Net commercial insurer relief	**$322.8 billion**
Relief allocated to employer plans	$290.5 billion
Premium relief after assumed pass-through	$261.5 billion
Modeled employer-sponsored premium pool	$1,227.5 billion
Illustrative premium reduction	21.3%

Table A7: Base Net-Insurer-Relief Calculation

Note: Displayed components may not sum exactly because of rounding.

The $261.5 billion is a scenario result, not a forecast. It depends on the modeled employer-plan share and premium pass-through rate. Actual contracts would require prospective premium credits, actuarial certification, worker-visible statements, year-end reconciliation, rate correction, rebates, and enforcement against withheld savings.

Under the Base worker-distribution assumptions, the premium relief produces:

Base Distribution Result	Annual Amount
Lower worker premium contributions	$53.4 billion
Employer premium savings	$208.1 billion
Required five-year wage dividend	$104.0 billion
Employer retained savings after payroll tax	$96.1 billion
Gross worker compensation gain	$157.4 billion
Candidate federal tax recovery (worker-side taxes plus employer payroll tax)	$45.3 billion
Net worker take-home gain	**$120.1 billion**
Average annual gain per covered worker	$1,776
Average monthly gain per covered worker	$148

Table A8: Base Employer and Worker Distribution

{Note: The $45.3 billion candidate recovery includes employer payroll tax. Net worker take-home subtracts only worker-side tax recovery, so $157.4 billion minus $45.3 billion is not the take-home calculation.}

These values demonstrate a possible transfer mechanism rather than guaranteeing a particular macroeconomic result. The paper's policy claim is that measurable insurer and employer relief should be made visible and partially returned to workers—not that every federal dollar automatically becomes wages.

A.7 Candidate Offsets and the Fiscal Boundary

The core model contains zero verified offsets. The following amounts are maintained in a separate schedule so that plausible fiscal feedback is not presented as already scored financing.

Candidate Offset	Low	Base	High	Confidence
Wage and payroll tax recovery	$23.1B	$45.3B	$78.6B	Moderate
ACA premium-tax-credit savings	$10.6B	$20.3B	$32.8B	Moderate
Uncompensated-care substitution	$3.0B	$6.2B	$10.7B	Low–moderate
Corporate-income-tax recovery	$1.5B	$7.2B	$16.2B	Low
Payment-integrity recovery	$0.4B	$2.4B	$6.1B	Low
Preventive-care savings	$0.0B	$0.0B	$0.0B	Unscored
Total candidate offsets	**$38.6B**	**$81.4B**	**$144.5B**	—

Table A9: Candidate Federal Offset Schedule

The Base candidate calculations are:

- **Wage and payroll tax recovery:** $45.3 billion, linked to the worker-premium reduction, required wage dividend, assumed tax rate, and employer payroll tax.
- **ACA premium-tax-credit savings:** $20.3 billion, using a $112 billion federal baseline, the modeled premium-reduction proxy, and an 85 percent translation factor.
- **Uncompensated-care substitution:** $6.2 billion, equal to 50 percent of the modeled uninsured backstop.
- **Corporate-income-tax recovery:** $7.2 billion, based on the portion of retained employer savings assumed to become taxable profit and an illustrative effective tax rate.
- **Payment-integrity recovery:** $2.4 billion, equal to 0.5 percent of the new program-payment base.
- **Preventive-care savings:** zero, pending longitudinal evidence capable of establishing a federal budget effect.

Each candidate uses a separate payment base. Wage-tax recovery is not counted again as corporate-tax recovery. Marketplace savings cannot exceed the relevant federal premium-tax-credit baseline. Uncompensated-care substitution cannot exceed the uninsured backstop. Payment-integrity recovery applies only to the new program-payment base, and reported improper payments are not treated as equivalent to recoverable fraud.

Applying every candidate produces the following illustrative bridge:

Federal Cost Measure	Low	Base	High
Gross federal cost	$377.3B	$483.7B	$620.0B
Candidate offsets	$38.6B	$81.4B	$144.5B
Illustrative provisional cost	**$338.7B**	**$402.3B**	**$475.6B**

Table A10: Illustrative Cost After Candidate Offsets

The $402.3 billion Base figure is not the paper's verified net cost. Until the offset channels are independently validated and formally scored, the internal Base net remains $483.7 billion.

Broader economic value is also kept outside the offset schedule. Increased consumption from higher take-home pay, reduced medical debt, improved labor mobility, easier insurance onboarding, provider-price negotiation, prevention, and administrative simplification may be socially or economically valuable without reducing federal outlays dollar for dollar. The model does not count those effects as financing.

A.8 Controlled 2023–2024 Data-Year Bridge

Version 2.0 replaces the 2023 HC-251 person-level file with the 2024 HC-256 file while holding the policy mechanics and scenario assumptions constant.

The controlled rerun preserves:

- the coverage hierarchy;
- the $5,000 patient-liability ceiling;
- the $10,000 commercial claims attachment;
- the 50 percent Base federal commercial share;
- the calibration factors;
- the induced-utilization assumption;
- the federal administration rate.

The 2023 control reproduces the Version 1.5 weighted inputs within rounding tolerance, and both years assign zero weighted population to the unclassified residual. This establishes that the bridge measures a data-year change rather than an unreported redesign of the model.

Measured Item	2023	2024	Change
Weighted population	334.5M	339.8M	+1.6%
Total MEPS spending	$2,504.7B	$2,836.1B	+13.2%
Private-only claims above $10K	$509.7B	$626.0B	+22.8%
Private-only patient liability above $5K	$37.7B	$52.7B	+39.7%
Uninsured claims above $5K	$9.6B	$9.9B	+2.8%
Public-program liability above $5K	$42.4B	$50.7B	+19.5%
Base gross federal estimate	**$397.4B**	**$483.7B**	**+21.7%**

Table A11: Controlled HC-251 to HC-256 Bridge

Note: Values are weighted point estimates and may not sum exactly because of rounding.

The Base gross estimate rises by approximately $86.3 billion. Most of that increase comes from the larger measured commercial claims layer.

Source of Base Estimate Change	Annual Change
Commercial reinsurance	+$72.7 billion
Uninsured backstop	+$0.3 billion
Public-program ceiling fill	+$10.7 billion
Induced-utilization amount	+$1.7 billion
Federal administration	+$0.8 billion
Total Base gross change	**+$86.3 billion**

Table A12: Decomposition of the Base Gross Increase

{Note: Displayed components may not sum exactly to the total because each amount is rounded independently.}

The updated data make the proposal more expensive and more protective at the same time. Under unchanged rules, HC-256 measures substantially more private claims and patient liability above the fixed thresholds than HC-251 did.

The one-year movement does not establish its cause. Inflation, utilization, treatment intensity, population growth, coverage composition, survey variation, and other factors may contribute. It should not be treated as proof of a continuing annual growth rate or as evidence that every individual's costs rose by the same percentage.

A.9 Ten-Year Implementation and Fiscal Ramp

The full-run annual estimate does not begin immediately. The companion model uses a four-year operational phase-in beginning in fiscal year 2028.

The Base planning assumptions are:

- program activation: 25 percent in 2028, 60 percent in 2029, 85 percent in 2030, and 100 percent beginning in 2031;
- employer-plan renewal: 20 percent, 55 percent, 85 percent, and 100 percent over the same period;
- automated Tax Day check-in: 35 percent, 70 percent, 90 percent, and 100 percent;
- annual medical and fiscal growth: 4 percent;
- nominal federal discount rate: 3.5 percent;
- one-time implementation fund: $10 billion, allocated as $5 billion, $3 billion, and $2 billion during the first three years.

The 4 percent growth rate is an editable planning assumption rather than a forecast. The implementation fund is also an unscored placeholder for claims exchange, tax-account integration, appeals, contracting, security, and administrative construction.

FY	Active	Gross Cost	Offsets	Provisional	Worker Gain
2028	25%	$125.9B	$17.7B	$108.2B	$24.0B
2029	60%	$304.8B	$48.0B	$256.8B	$68.7B
2030	85%	$446.7B	$74.8B	$371.9B	$110.4B
2031	100%	$544.1B	$91.5B	$452.6B	$135.1B
2032	100%	$565.9B	$95.2B	$470.7B	$140.5B
2033	100%	$588.5B	$99.0B	$489.5B	$146.1B
2034	100%	$612.1B	$103.0B	$509.1B	$151.9B
2035	100%	$636.5B	$107.1B	$529.5B	$158.0B
2036	100%	$662.0B	$111.4B	$550.6B	$164.3B
2037	100%	$688.5B	$115.8B	$572.7B	$170.9B
Total	—	**$5,175.0B**	**$863.5B**	**$4,311.5B**	**$1,269.7B**

Table A13: Base Ten-Year Ramp

Note: Gross cost includes the $10 billion implementation placeholder. Offsets remain candidates rather than verified savings. Values may not sum exactly because of rounding.

The discounted present value of the Base provisional ten-year cost is approximately $3.603 trillion under the 3.5 percent nominal discount assumption. The modeled ten-year provisional range is approximately $3.629 trillion in the Low case, $4.311 trillion in the Base case, and $5.098 trillion in the High case before discounting.

The automated check-in becomes the routine route as implementation matures, but the complete filing and appeal system remains legally available. A zero steady-state share for the manual path means the model does not assume it remains the normal route; it does not mean the alternative is abolished. People with irregular income, disputed records, late information, missed deadlines, or other complicated circumstances retain the full process.

A.10 Internal Checks, Exclusions, and Unfinished Work

The companion workbook contains formula-driven reconciliation checks across the MEPS inputs, fiscal model, paycheck model, candidate-offset schedule, and ten-year ramp.

Internal Check	Status
Coverage-hierarchy population ties to the HC-256 weighted population	Pass
Total spending ties to the HC-256 input	Pass
National upper layers above $5,000 and $10,000 tie	Pass
Base net equals gross when verified offsets equal zero	Pass
$10,000 attachment costs less than $5,000 attachment	Pass
Patient-liability ceiling remains $5,000	Pass
Commercial claims attachment remains $10,000	Pass
Net insurer relief subtracts the private patient-ceiling obligation	Pass
Worker and employer allocations reconcile to premium relief	Pass
Candidate offsets do not exceed their relevant payment bases	Pass
Candidate offsets do not exceed gross federal cost	Pass
Ten-year activation, implementation fund, and fiscal totals reconcile	Pass
Formula-error scan	No errors found

Table A14: Version 2.0 Internal Model Checks

These checks establish internal consistency. They do not constitute independent actuarial validation, causal evidence, a federal budget score, or proof that the behavioral assumptions will occur.

The model deliberately excludes or leaves unresolved:

- replicate-weight uncertainty estimates and conventional confidence intervals;
- formal reconciliation to the complete National Health Expenditure Accounts;
- institutionalized populations and other spending outside the MEPS person-level survey;
- an independent actuarial estimate of insurer premiums and plan behavior;
- enrollment response, adverse selection, and default-plan pricing;
- provider-price response and market-concentration effects;
- a full behavioral model of induced utilization;
- long-run preventive-care savings;
- state and local fiscal effects;
- a distributional analysis by income, age, disability, region, race, family structure, and health status;
- the exact statutory National Covered Care Standard;
- provider reimbursement, billing, and appeal regulations;
- federal and state legal authority, including ERISA and preemption;
- a complete financing package;
- formal privacy, security, and data-access specifications;
- independent red-team review and formal federal scoring.

The model also does not claim that $5,000 is easy for every household to pay. It measures the cost of ending unbounded personal liability at that amount. Insurance products, employer assistance, unions, states, towns, charities, payment plans, and future policy can reduce exposure below the ceiling without changing the national maximum.

Similarly, the model does not assume that insurer or employer relief automatically reaches workers. Pass-through, premium credits, wage dividends, reporting, reconciliation, rebates, and enforcement are policy requirements whose effectiveness must be evaluated during implementation.

The current evidence supports an architectural and provisional fiscal claim:

> Under explicitly stated assumptions and the 2024 HC-256 person-level data, the United States can model a universal $5,000 patient-liability ceiling while preserving the existing plural insurance system and assigning a defined upper claims layer to federal contracts.

It does not yet support the stronger claim that the proposal is fully financed, independently scored, or ready for immediate national enactment without additional technical and legislative work.

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About the Author

Scott Jellen is an independent researcher and protocol designer focused on system design, institutional structure, cultural systems, and long-range public frameworks. His work explores how infrastructure, incentives, governance, memory, and symbolic form shape complex systems across digital, civic, economic, and cultural domains.

About Jellen Protocol Lab

Jellen Protocol Lab is an independent research initiative focused on designing and articulating system-level frameworks across public infrastructure, economic coordination, institutional design, media systems, protocol architecture, and symbolic infrastructure.

Version Notes

v1.0 — Initial public release.
This version establishes the central public bargain, $5,000 individual ceiling, $10,000 federal commercial attachment, coverage-specific treatment, patient-exit rule, Tax Day Household Account, enrollment and withholding architecture, Employer Health Dividend, insurer contract model, National Covered Care Standard, integrity and privacy framework, fiscal case, implementation roadmap, objections, citation layer, and self-contained fiscal-model appendix. Fiscal values are reconciled to Version 2.0 of the companion model, which uses the 2024 HC-256 person-level file, separates patient-liability and commercial-claims accumulators, and nets the insurer's private patient-ceiling obligation from gross reinsurance before estimating downstream benefits. Appendix A reproduces the principal inputs, formulas, scenario assumptions, sensitivity results, fiscal bridge, implementation ramp, internal checks, and limitations. All values remain illustrative rather than formally scored.

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