Universal Health Coverage and Equal Access Act

Discussion bill with hospital, academic and state financing provisions • 22 November 2026

Ten things this bill would change

One public health plan would pay for covered care for eligible residents. Patients would choose their clinicians, and employers and households would help pay through taxes.

1. **Take your coverage with you.** You could leave a job, start a business or cut your hours to care for a parent and keep your coverage.
2. **Get care before a problem gets worse.** The plan would charge no premium. You would owe no deductible or copay for covered visits, tests, prescriptions or treatment, including dental, vision, hearing and mental health care.
3. **Choose your clinician.** Independent practices could join the national plan. You could keep seeing a participating doctor with room in the practice. Veterans could stay with their VA team.
4. **See the cost on your pay stub.** You could compare your current medical deduction with the proposed household contribution and see what your employer pays separately. The examples on the next page show who takes home more and who takes home less.
5. **Have a deadline for an appointment.** The plan would have to offer routine primary care within 15 business days and a routine specialist visit within 30. If the deadline were at risk, a regional office would arrange another appointment or buy more clinic time. Paying extra could never buy an earlier place in line.
6. **Get an answer from a clinician.** A medical denial would name the clinician responsible and explain how to appeal for free. An independent clinician would decide an urgent appeal within 24 hours.
7. **Fund both ends of a rural ambulance ride. The 2034 planning allowance is $18 billion for rural hospitals and $95 billion for receiving hospitals. Regions must contract for staffed shifts and accepting beds and pay verified gaps once.**
8. **Use national buying power on prescriptions. Negotiate launch prices against added clinical benefit, collect rebates on excess net branded spending, buy from competing suppliers where possible, and preserve access to medically necessary drugs.**
9. **Know who qualifies.** Full benefits would cover U.S. residents who are citizens or nationals, green-card holders, admitted refugees, people granted asylum, and authorized temporary workers and their authorized resident dependents. Other residents would receive specified emergency and public health care.
10. **See the numbers before Congress votes.** With hospital support within its allowance, 2034 national spending is $107 billion below current law in planning or $253 billion above it under stress, including the new $20 billion academic budget. Additional verified bridge claims raise spending. Congress must show the cost, who pays and whether care is available.

Your paycheck and the plan's funding

What would come out each month?

These are full-year examples for employees paid monthly. Schedule B charges 6% above the household allowance and 12% of employer payroll. The tables also show Schedule A for comparison. The pay stubs use 2026 federal tax rules and current average premiums.

Monthly paycheck line	Today	6% household 12% employer	4% household 14% employer
Family earning $150,000			
Employee health deduction	$622.58	$400.00	$266.67
Direct deposit	$10,194.10	$10,232.08	$10,365.41
Change in take-home pay	**—**	**+$37.98**	**+$171.31**
Single worker earning $100,000			
Employee health deduction	$139.33	$350.00	$233.33
Direct deposit	$6,500.31	$6,248.33	$6,365.00
Change in take-home pay	**—**	**-$251.98**	**-$135.31**

The family has one earner and two qualifying children. Today's premium is pre-tax. The model treats the new contribution as after-tax, which raises ordinary withholding. Covered copays and deductibles would also disappear. Those savings occur when someone uses care. Family pay stub and single pay stub.

How would it stay funded?

Medicare already taxes every dollar of covered wages. Removing a Medicare wage cap would raise $0. Both financing options instead combine uncapped employer contributions, household contributions, higher taxes on qualifying high incomes, and existing public funds for benefits the plan takes over. IRS payroll tax rules.

At 12% for employers and 6% for households, with 4% medical cost growth, the $113B hospital allowance and $20B academic budget, startup borrowing clears in 2037. The Trust sends $1.05T toward debt by 2041 and $4.52T by 2051. Funding the full tested hospital shortfall leaves zero by 2041. CBO and JCT have yet to score the bill.

At 5.5% medical growth the fixed 12% rate yields zero debt payments through 2051. Under §803 the operating supplement begins in 2038. In 2051 the employer rate reaches 17.06% with planning delivery or 19.89% with weaker delivery, assuming spending fits the respective hospital allowances. Higher employer costs may affect raises. Aging and the funding rule

Long-term funding test Employer costs Prescription drug prices Cost curves

What changes for me?

When does my coverage change? Enrollment takes four program years. Eligible uninsured residents may join early in year one. Remaining eligible residents under 19 or 55 and older enter in year two, ages 35–54 in year three, and the rest in year four. Existing coverage continues until replacement is confirmed. Scheduled procedures and prescriptions carry over. §801.

What happens to Medicare, the VA and home care? Premiums for transferred Medicare benefits end. Dental, vision and hearing are covered. Veterans may keep their VA team. People eligible for Medicaid home care under existing rules keep that benefit. An expansion to everyone needs separate funding. §§102, 701 and 809.

I run my own business. What would I pay? Schedule B starts with 10% of positive net active business earnings, adds the household contribution and applies the business credit and household refund. At $100,000 of net profit, the draft's single-filer example pays $8,000 a year after the refund. §§202–204.

Can I pay cash to jump the line? Clinical need determines priority for shared appointments. A membership fee, private policy or cash payment cannot buy an earlier slot for covered care. If a clinically appropriate deadline is at risk, the region must arrange a reachable alternative. §§601–604.

Who qualifies in a mixed-status family? Each person qualifies on their own status and residence. Eligible children receive full benefits even if their parents do not. Residents outside full coverage may receive emergency screening, stabilization and transfer, vaccinations, and communicable-disease testing and treatment. §§101, 106 and 108.

Who would pay more or lose income? A business that provides no coverage takes on a payroll cost. Some individual workers take home less. Hospitals with high commercial prices face lower payments. Drug manufacturers face lower negotiated prices, and displaced insurance and billing workers may receive up to two years of wage replacement and retraining. §§202, 818–819 and 827.

What still needs independent verification? A congressional office must seek CBO and JCT input. Legislative counsel must review state collection, and a rural ER and its actual receiving hospital must test staffing against proposed payments. The pre-vote appendix specifies the records, pass conditions and budget consequences.

Coverage and patient rights

Congress establishes a public purchaser, full coverage for qualifying residents, and emergency and public health benefits under §108. Patients choose their clinicians. Independent practices and hospitals may compete to deliver covered services. The program shall measure household affordability, total health spending, access and clinical outcomes together.

§ 101 Eligibility and continuity

Full benefits are available to residents of the United States or its territories who are U.S. citizens or nationals, lawful permanent residents, admitted refugees, people granted asylum, or lawfully admitted temporary workers and their authorized resident dependents during their authorized stay. Undocumented residents receive only the federal benefits in §108 under this Act unless they acquire a qualifying status. Section 107 governs future provisional status. Determine eligibility individually, including for children, regardless of a parent's status. CMS shall enroll qualifying residents automatically where possible. Employment, income, housing status and tax delinquency do not otherwise determine eligibility.

§ 102 Covered benefits

For residents eligible for full benefits, the program shall cover medically necessary primary, specialty, emergency, maternity, dental, hearing, vision, behavioral health, addiction, prescription and rehabilitation care. Covered care has zero premiums, deductibles and copays. The Trust also pays for home and community based long-term care for residents who qualify under the Medicaid rules in force at enactment. Home care for all residents waits until Congress funds it. Medicaid institutional long-term care and its financing continue until Congress funds an equivalent or better benefit and residents can obtain it. Section 902 protects other Medicaid and CHIP services during transfer. Workers' compensation and liability carriers remain responsible for recoverable injury costs after the patient receives care.

§ 103 Clinical decisions and appeals

An independent clinical board publishes general rules, evidence, conflicts and reasons. Individual cases follow §§812–814. Patients and clinicians may appeal without charge. An independent reviewer shall decide urgent appeals within 24 hours and routine appeals within 15 business days. Treating clinicians may provide immediately necessary care pending review. CMS shall pay undisputed claims while resolving liability. After independent review, patients may seek an administrative hearing and judicial review on terms at least as favorable as those in §1869 of the Social Security Act for a comparable Medicare claim. Each denial shall explain the next appeal, its deadline and the right to representation.

§ 104 What success requires

By the fifth full year, target at least 3% lower risk- and inflation-adjusted per-resident national health spending than the pre-enactment current-law projection. Publish both adjusted and unadjusted totals. Count every payer, public administration and capital cost. Congress shall review savings alongside wait times, quality, staffing and closures. This target is a proposed performance standard. The fiscal examples in this bill are illustrations.

Residency and access to care

§ 105 Establishing residence

A resident makes their home in a state, the District of Columbia, or a U.S. territory. Visiting, including for medical treatment, does not establish residence. CMS shall accept a lease, school record, shelter or community attestation, or other reliable evidence of residence. No minimum period of residence or fixed address is required. This Act preserves eligibility arising independently under other federal laws, treaties and compacts.

§ 106 Verification and newborns

CMS shall use a Social Security number, when available, to match records. Verify the applicant's qualifying status through the relevant agency or accept alternative official records. Recheck time-limited status at its recorded expiration, including lawful extensions. An SSN or a pending immigration application alone cannot establish eligibility. Allow temporary enrollment when credible evidence shows an existing qualifying status and record verification is pending. Cover an eligible newborn from birth, including while records are pending. Give written notice, an opportunity to correct a mismatch and an independent appeal under §103. Continue urgent or ongoing treatment during review.

§ 107 Provisional immigration status

Congress supports a separate, one-time reform law providing a path to permanent residence. Eligibility begins when immigration authorities grant provisional status under that law. Filing alone confers no eligibility. During rollout, §801 applies on the same terms as for citizens. After rollout, coverage begins on the effective date of the grant.

§ 108 Emergency and public health benefits

From program year one, the Trust shall pay for emergency screening, stabilization and medically appropriate transfer, vaccinations, and testing and treatment for communicable diseases for residents outside full coverage. Providers shall accept program payment in full. Emergency departments shall screen and stabilize or appropriately transfer any person without delaying care for an eligibility check. The Trust shall reimburse otherwise unpaid required emergency services once, after payments from other sources. These benefits are expressly authorized regardless of immigration status. Section 811 carries these protections into national-plan hospital agreements.

§ 109 Other care and shared appointments

For services outside a person's federal benefits, residents may self-pay, buy private coverage or receive care through a state-funded program as state law permits. Determine each family member's benefits separately. Providers offering shared appointment slots shall apply §602 to all patients regardless of payer.

§ 110 Cost of eligibility changes

For each tax schedule, price the limited package under current immigration law. Separately model a reform scenario showing annual grants of provisional status, timing of full enrollment, added appointments, staffing, and net federal cost after contributions and displaced payments. Publish the assumptions and show who pays for care outside the federal package.

Contributions and household affordability

§ 201 Federal and state funding

Establish a Universal Health Trust Fund in Treasury, administered by CMS. Credit the trust for existing federal benefits it assumes and for the state contribution in §817. States shall pay monthly under the national per-resident formula and transition in §§817 and 832. Preserve VA mission funding, tribal obligations and remaining Medicaid benefits. Reconcile payments by payer and benefit, including §108 claims, to prevent duplicate reimbursement. Score the federal cost of any state shortfall. Fund start-up under §803. Record employer tax effects, changes in federal compensation and the net fiscal results required by §807.

§ 202 Employer and household rates

Schedule B governs collections under this Act. Employers pay an initial 12% of uncapped covered payroll. Households pay 6% of adjusted gross income above an indexed allowance of $30,000 single or $60,000 joint, plus $5,000 per dependent. Apply an additional 2% to income above $150,000 single or $300,000 joint and a further 4% above $500,000 single or $1 million joint, and apply the high-income measures in the financing appendix. Apply rates marginally. Include realized taxable gains and aggregate controlled entities. For married separate returns use single thresholds and split dependents without duplication. Use joint thresholds for surviving spouses and single thresholds plus dependent allowances for other filers.

§ 203 People who work for themselves

Apply 10% under Schedule B to positive net active business earnings after ordinary expenses. Exclude wages already assessed on payroll, aggregate commonly controlled businesses and attribute reasonable labor earnings to active owners. Credit the smaller of the levy or $3,000 single/$6,000 joint, multiplied by a factor of one up to $30,000/$60,000 of household income that declines linearly to zero at twice that income. Index these thresholds. Allow annualized quarterly payments, loss years and a year-end reconciliation. Retain existing federal income and payroll taxes. Adjust Medicare premium collections in the score as the federal program assumes those benefits.

§ 204 Direct contribution limit

For households up to $150,000 single/$300,000 joint, refund the excess of the household and net self-employment contributions above 8% of positive household adjusted gross income. For the next $100,000 single/$200,000 joint, taper the refund linearly to zero. Index the bands. Use income before deductions for the new contributions. Count this refundable credit in the fiscal score. The limit excludes an employer's payroll levy and its possible wage effects.

§ 205 Employers in transition

For firms with annual covered payroll below $1 million, credit 50% of the employer levy in their first two covered years and 25% in their third and fourth. Phase this relief linearly to zero between $1 million and $2 million payroll. Aggregate affiliates and exclude owner earnings eligible for §203 relief from this calculation. Treasury shall publish the cost, enforce worker classification and reconcile employee withholding, self-employment and mixed-coverage months.

What the financing would buy

Illustration in a full operating year. Single filers, no dependents, no other income. The examples assume household income equals wages or net business profit and apply Schedule B before any congressional revision.

Income and work	Business levy after §203 credit	Household levy	§204 refund	Direct annual bill
$20,000 self-employed	$0	$0	$0	$0
$45,000 self-employed	$3,000	$900	$300	$3,600
$100,000 self-employed	$10,000	$4,200	$6,200	$8,000
$100,000 employee	$12,000 employer[1]	$4,200	$0	$4,200

[1] Employer amount assumes the ordinary rate. The worker does not remit it. Wages may adjust over time. At $100,000 net profit the freelancer pays $2,000 more than someone previously spending $6,000 directly, or $10,000 less than someone spending $18,000. Both gain protection against additional covered bills.

§ 301 National financing test

CBO and the Joint Committee on Taxation should score the same text before passage. Show each year's covered services, local rate supplements, legacy debt, capital, transition, administration, loan awards and reserves. Show transfers, taxes, credits and behavioral responses separately. Include both eligibility scenarios in §110 and both provider payment designs in §805. Reconcile federal outlays and receipts with separate estimates of national health spending and household burden. Treasury shall compare these figures annually with actual receipts and outlays. Dedicate a reserve equal to 60 days of projected benefits, phased in over five years and separately financed.

§ 302 Affordability and shortfall

Publish the median and 90th-percentile change in premiums, taxes and out-of-pocket spending by income, family size, disability, employment type and region. Count employer wage incidence in the burden test. Require funding for the scored transition and ten full operating years. Seek adoption only if the projected median burden does not rise in any of the lowest three income quintiles. Publish the share paying more in each quintile. The Secretary has no authority to fill the gap by lowering access standards or imposing a patient fee.

§ 303 Scale and stress test

CMS recorded $5.3 trillion in US health spending in 2024. At 12%, the $12.41 trillion BEA wage base that year yields $1,489 billion gross. Actual payroll collections depend on exemptions, credits, phase-in and behavior. For example, a $100 billion annual gap on a $10 trillion effective tax base would require one additional percentage point before behavioral effects. Run downside cases with zero net administrative savings for two years, 10% higher use of newly covered services, lower payroll receipts and accessible capacity sufficient to deliver requested medically necessary care.

Recommended rates and the scoring comparison

§ 304 Schedules for the same benefits

The sponsor recommends Schedule B under §§202–203. Score Schedule A only as a comparison using 14% of employer payroll, 4% of household income above the same allowances and 8% of net active business earnings. For A, use a maximum §203 credit of $2,400 single or $4,800 joint and the same phaseout. Hold benefits, access standards, surcharges, small-firm credits and the §204 limit constant. Treasury may collect only Schedule B, subject to §803. Switching to A requires a statutory amendment. The former 8% and 10% employer rates are withdrawn.

Full operating year, single filer	Schedule A	Schedule B
$45,000 net self-employment income	$3,000 direct	$3,600 direct
$100,000 net self-employment income	$8,000 direct	$8,000 direct
$100,000 wages, worker contribution	$2,800 direct	$4,200 direct
$100,000 wages, ordinary employer levy	$14,000 employer	$12,000 employer

§ 305 Size of the financing decision

In 2024 private health insurance spending totaled $1.645 trillion and households spent $557 billion out of pocket. Some of that spending remains outside the new program. Each percentage point of employer rate on the 2024 BEA wage base is about $124 billion a year before credits, wage changes and tax interactions. Calculate separately what the changed household rate and credits collect. These figures establish scale; they do not predict the trust's balance.

§ 306 Rule for a final vote

Before recommending a vote, determine whether Schedule B finances the full period, maintains the reserve and satisfies §302. Compare the burden in the lowest three income quintiles under A and B. Count the §816 debt payment as a use of surplus, never as a source of funds. Display yearly deficits, borrowing and year-ten operating balance to expose reliance on temporary receipts. If B fails, publish the gap and revise and rescore the proposal before seeking a vote. Include the cost of achieving the access standards and rerun the finance and capacity tests together. Apply the 2034 downside test in the fiscal schedule to each tax schedule.

§ 307 What counts as savings

Count each saving once and deduct added care, staffing, capital and transition costs. Report transfers and resource savings separately under §807. Publish the itemized 2034 estimates and actual results. Before a vote, verify insurer exits, replacement costs, provider payments, use, access and the cash reaching the Trust. Commit only verified savings.

Hospitals and independent practices

§ 401 Annual hospital budgets

Regional purchasers shall pay monthly budgets using three audited years, projected case mix and the local traditional Medicare method, including cost-based rates where applicable. Reconcile other payers. Fund teaching, trauma, maternity and emergency standby separately after existing receipts. Section 819 sets the four-year path; §829 pays a bridge while each reduction takes effect. Appropriate $113 billion in 2034 for rural and transfer capacity, initially $18 billion for rural facilities and $95 billion for receivers. Pay verified gaps, reconcile actual payments and reestimate annually under §§402 and 829. Section 831 funds the academic missions separately.

§ 402 Solvency and capital

Before conversion, publish each essential facility's monthly liquidity and coverage of debt principal and interest for 36 months under base and downside demand. A forecast below 45 days' operating cash or 1.2 times scheduled debt service triggers review and an interim payment or refinancing plan within 30 days. Test standalone and affiliated cash flows. Cover essential legacy bonds and leases once, assign future capital through open regional appropriations, and exclude acquisition premiums and excessive related-party charges. Maintain payroll and patient transfers while any operator is restructured. Provide for each incurred §829 obligation before a §816 debt transfer. Procure the service from a successor when an operator cannot deliver it.

§ 403 Worked hospital test

Suppose a hospital collects $100 million and incurs $93.5 million in annual operating expense. Assume for this example that those expenses are cash costs including interest. A proposed $90 million budget and $2 million in verified savings leave a $1.5 million operating cash shortfall. If $2 million of principal also comes due, the cash gap is $3.5 million. Fund it, refinance it or demonstrate equivalent reachable capacity before conversion. In an actual review, reconcile depreciation, working capital and capital costs to cash.

§ 404 Primary care and clinicians

Set professional fees at 100% of the traditional Medicare allowed amount for the service, locality, setting and year. The Trust pays both Medicare's share and the beneficiary's share. If Medicare allows $100 for a specialist visit, the clinician receives $100 and the patient owes zero. Apply §808 to independent and employed clinicians. For primary care, convert 40% of projected practice revenue to a risk-adjusted monthly patient payment and retain 60% as visit and procedure fees. Calibrate both components before launch and retain high-cost exceptions. Pay clean claims within 14 days with automatic interest for delay.

§ 405 Training debt and capacity

Pay up to $30,000 annually for five years against qualifying outstanding training debt for clinicians serving in verified shortage areas. Appropriate residency and team training in the same regions. Test whether representative independent practices can cover staff, premises, supplies and competitive clinician pay. Persistent vacancies trigger local rate adjustments or funded training places. Include the full costs under §301.

Competition and purchasing

§ 501 Same service and same payment

For routine services safe in either setting, pay the same risk-adjusted amount in an independent office and a hospital-owned outpatient department. Ownership alone creates no facility fee. Pay separately for documented standby costs under §401. Subtract services purchased from the hospital operating budget where necessary to avoid duplicate payment.

§ 502 Open entry and patient choice

Any qualified independent provider may enter the national network on published safety and payment terms. Use one credentialing application, claim format and electronic remittance. CMS shall decide a complete application within 60 days, state reasons for denial and provide independent appeal. A patient may redirect the monthly primary care payment when changing practice. The regional purchaser shall release the volume-related share of incumbent budgets when patients move. Preserve fixed readiness payments where the region still requires the service.

§ 503 Purchase extra capacity openly

Where waits exceed standards, offer publicly funded episodes to qualified providers, including new entrants. Score bids on total episode cost, completed care, outcomes, accessibility and time to treatment, with risk adjustment and mandatory acceptance on common clinical terms. Publish bids, awards, volumes and follow-up outcomes. Include complications and transfers in comparisons. Contracts shall never confer an earlier place based on what a patient, donor or employer pays.

§ 504 Reward verified efficiency

For three years a provider may retain half of audited recurring savings below its risk-adjusted benchmark for staff or patient services. The remaining half returns to the trust. Reduce the benchmark after the sharing period. Eligibility requires stable or improved outcomes and access, adjusted for case mix. Audit referrals, service reductions, coding and cost shifts. Claw back unsupported awards. A rural sole provider receives a readiness contract and independent cost review.

§ 505 Merger review and medicines

Require notice of serial practice acquisitions and beneficial ownership. Refer suspected anticompetitive acquisitions to federal and state enforcers, bar exclusive referral conditions and require portable clinical records. The Secretary shall secure payment rates for every covered prescription drug under the drug payment schedule appended to this Act. The Secretary may also negotiate covered device prices and shall publish the agreed terms. The Part D noninterference provision (42 U.S.C. §1395w–111(i)) does not apply to Trust purchases. Existing Part D rules, including negotiated prices for selected drugs, govern purchases still payable by Part D. Assign discounts and rebates once to the responsible payer. Use multisupplier bids for interchangeable products where feasible, with quality and supply commitments, shortage contingencies and expedited patient-specific formulary appeals.

Equal access and patient remedies

§ 601 Duty to accept public payment

A provider furnishing a service that the program covers for an individual shall accept public payment in full. Once a person's benefit takes effect, a Medicare opt-out affidavit or private contract under 42 U.S.C. §1395a(b) cannot authorize billing that individual for a service the Trust covers, including under an agreement signed before transfer. Private insurance or contracts may pay for services outside that individual's benefits under §109. Duplicate payment and the sale of priority are prohibited, including through affiliates, self-pay practices, membership clubs and employer clinics. State licenses continue under state law. A provider may limit its scope or close an objectively full practice on uniform terms.

§ 602 One clinical priority rule

In shared appointment slots, schedule patients with comparable needs by the original request or referral date, including patients paying privately or through a state program. Clinical urgency, necessary expertise, continuity and patient preference permit documented exceptions. Amenities may be sold only when clinically equivalent appointments remain equally accessible. Ban paid callbacks, cancellation priority, donor overrides and paid tests or referrals sold to advance a patient. Accept clinically valid findings obtained elsewhere. Reassess urgently whenever symptoms change.

§ 603 Time to treatment

Proposed maximum times to an offered appropriate appointment are 15 business days for routine primary care and 30 for routine specialist consultation. Clinicians assign shorter deadlines based on need. Emergency assessment is immediate when clinically indicated. Clinicians shall set and document a deadline for definitive treatment at assessment. The same booking remedy applies. Record request, first appropriate offer, attendance and treatment. Retain original dates after provider cancellations. Patient preference for a later date is documented without losing priority. Publish the median, 90th percentile and share missing each deadline. Apply §§606–607 to staffing, completed care and booking.

§ 604 Individual remedy

When the deadline is at risk, the regional access office shall secure a reachable alternative, including travel and disability accommodation at program expense, or buy extra sessions. Patients may remain on the original list. Urgent clinical escalations receive same-day review. An independent ombudsman may order booking and payment. Audit paired booking calls and schedules. Intentional paid priority requires refunds and civil penalties up to three times consideration or $25,000 per incident, whichever is greater, after notice and hearing. Protect reporting patients and workers.

§ 605 Emergency and behavioral care

Fund walk-in addiction and crisis care, mobile teams, medical respite and staffed inpatient beds where boarding blocks emergency access. Cover evidence-based stimulant treatment and medications for opioid use disorder. Apply the same clinical urgency standard across income, housing and diagnosis. Track repeat visits, time to clinical assessment, hours awaiting an inpatient bed and departures before assessment.

Veterans and the four year transition

§ 701 VA care and earned benefits

Veterans may keep their VA team under existing VA eligibility rules. Veterans eligible for national coverage may also book community care directly through the national program. Ordinary covered care requires no separate VA referral authorization. Preserve veteran-specific rehabilitation, prosthetics, spinal cord and polytrauma teams, training, research and service-connected benefits through a distinct VA appropriation. Disability compensation and eligibility remain separate from this program.

§ 702 One accountable payer per service

The Trust pays for routine community care it assumes for veterans. VA shall end the associated duplicate authorization, network fees and claims processing at transfer. VA pays for care in its own facilities and for VA-specific benefits. Reconcile payments annually. Use consent-based record exchange, one referral identifier and one wait clock. Continue ongoing treatment. Before transferring a local VA service, consult veterans and demonstrate staffed replacement capacity, comparable outcomes and timely access at lower total cost, including travel, transition and fixed costs that VA will still incur.

§ 703 Tribal and regional governance

Honor federal trust and treaty responsibilities and preserve Indian Health Service and tribal delivery systems. Offer shared claims processing or purchasing only by agreement with tribal governments. Preserve direct appropriations and tribal control of facilities. HHS regional offices shall publish needs, staffing, prices, purchases and appeal outcomes, with privacy protection. Patients, clinicians, rural communities, tribes and veterans shall hold seats on regional advisory boards. The Inspector General audits conflicts and related-party payments.

§ 801 Phased enrollment

Count program years from the first January 1 at least 12 months after enactment. Use year one to finance start-up, test claims, start §108 and enroll uninsured residents eligible for full benefits who elect early coverage, contract clinicians and test hospital budgets. For remaining eligible residents under §§101 and 107, enroll those under 19 or 55 and older in year two, ages 35–54 in year three, and all remaining eligible residents in year four. Apply the transfer dates in §§806 and 901–906. Maintain current coverage until replacement coverage is confirmed. Honor existing prescriptions, scheduled procedures and treatment authorizations. Require uninterrupted care in pregnancy, dialysis, oncology and addiction treatment.

§ 802 Collection during conversion

During conversion, prorate employer and self-employment levies by worker-months of full coverage. Prorate household contributions and credits by the fraction of all household member-months with full coverage. Limited benefits alone do not count as full coverage. Require coordinated individual releases from mixed-family employer plans, adjust premiums to the remaining covered lives, and provide refundable transition credits for unavoidable overlapping premiums. Protect collectively bargained compensation through bargaining over released benefit contributions. Neither the law nor its distributional score assumes automatic dollar-for-dollar wage increases.

Implementation and fiscal accountability

§ 803 Treasury cash and reserve

Appropriate covered payments when due. Treasury shall finance approved startup and temporary cash shortfalls, record each advance as federal borrowing, and publish cash, liabilities and reserves quarterly. Repay startup advances with interest from operating surpluses at the starting rates. Apply the automatic employer contribution in the permanent financing schedule only when the Chief Actuary certifies an operating gap that remains after the §815 corrections. Apply §815 before raising the employer rate, and make the §816 debt payment only from a surplus. A replacement revenue measure must take effect before Congress reduces the adjustment. See the financing formula.

§ 804 Independent review and conversion

Before each cohort moves, CMS shall publish independent test results on payment accuracy, continuity, regional capacity and beneficiary access under §607. Retain the existing payer as bridge administrator with federal payment if a region fails. Enrollees keep covered benefits and zero cost sharing on schedule, including if the administration transition slips. Specify the cost and end date of each bridge. GAO audits implementation, household distribution, competition and facility liquidity annually.

§ 805 Decision before a final vote

Congress must assess each schedule and variant against the access and affordability standards. An official score has yet to be obtained. Sponsors shall seek CBO technical assistance through a congressional office, including JCT revenue estimates for §§202–205 and a comparison under §§304 and 810, and obtain an independent actuarial stress test. If financing is insufficient or regional access deteriorates, publish the gap, revise the tax or payment schedule, and rescore before requesting a final vote under §306. Before a final vote, legislative counsel shall prepare conforming amendments to Title XVIII of the Social Security Act, the Internal Revenue Code and other affected laws. Identify the governing law and effective date for each transfer and residual benefit. Reconcile ERISA, Medicaid, veterans and immigration laws and assess the private-contract and mandatory-payment provisions and the state contribution in §817.

§ 806 Effective dates and outstanding claims

At least 180 days before each scheduled enrollment group moves, CMS and the agencies named in §§901–906 shall publish a binding schedule by program and benefit. Name the successor payer, effective date, discontinued contract or deduction, retained benefits and funding source. Give each household its coverage dates, instructions and appeal contact. Make scheduled transfers on the first day of a month. Maintain existing coverage for anyone receiving only §108 benefits. If §804 requires a bridge, the Trust pays the former administrator for the replacement benefit. The former payer settles services furnished before transfer, including appeals and recoveries. For treatment spanning the date, the payers shall assign charges once and resolve disputes without billing the patient.

§ 807 Public accounting for consolidation

Before passage and annually after launch, publish a financial statement for each program against current law. Report funds transferred to the Trust, net federal savings or cost, and the change in total U.S. health spending as separate figures. Identify who bears any change in state or household costs. Deduct replacement benefits, lost premium receipts, residual contracts, transition costs and continued facility costs. Reconcile payments for the same service once. GAO shall audit the annual results.

Medicare rules for the national plan

§ 808 Annual Medicare payment updates

CMS shall maintain and publish the traditional Medicare schedules and local dollar amounts needed for §§401 and 404 after beneficiaries transfer. Apply each annual Medicare update once. Use the same professional benchmark regardless of who employs the clinician, and deduct any professional payment already in a hospital budget before paying it separately. For covered services without a comparable Medicare price, including pediatric services, publish interim rates based on comparable clinical work, audited costs and regional wages. Review those rates annually. Section 102 governs coverage. Publish any access supplements under §§401, 402 and 405 separately.

§ 809 Financing transferred Medicare benefits

Each month, Treasury shall allocate existing hospital insurance tax receipts to the new Trust in proportion to the share of projected current-law Part A spending the Trust has assumed. Reconcile that share annually. First retain in each Medicare account enough to pay retained benefits, outstanding claims, appeals and required reserves. Publish balances and liabilities before any transfer. Direct existing general-revenue contributions to the Trust only for the benefits it assumes. Replace lost premiums from the revenues enacted for the Trust. Report any shortfall and Treasury advance under §§301, 803 and 807. Social Security retirement and disability benefit funds remain separate.

§ 810 Comparing the two payment designs

For each tax schedule, score the proposed Medicare-based payments alongside the earlier design. In the comparison, independent clinician fees start at 110% of Medicare. Hospital budgets start from three audited cost years and move in equal steps over five years toward benchmarks for comparable efficient hospitals. The earlier design is for scoring only. Hold benefits, eligibility, enrollment dates and access standards constant. For each year, report national spending, the federal budget effect, changes in use of care and the cost of meeting access guarantees. Show rural and teaching hospital results separately. Identify the initial change in prices and the subsequent annual growth rate under each design.

§ 811 Emergency care agreements

Every hospital participating in the national plan remains subject to the applicable screening, stabilization and transfer duties, enforcement provisions and patient remedies of the Emergency Medical Treatment and Labor Act (42 U.S.C. §1395dd). These duties apply regardless of a patient's coverage and continue when a hospital's Medicare agreement ends. Preserve the hearing and review rights in §103 when coverage transfers.

Who decides coverage and care

§ 812 Routine care and medical coverage decisions

The board has no authority to decide individual cases. Routine covered care may proceed on the treating clinician's order with patient consent. CMS may require advance approval only for services on a public list adopted after public comment. For each entry, publish evidence of a specific safety risk or inappropriate use, explain why review after care is insufficient, and reassess annually. Emergency care requires no advance approval.

Only a named, licensed clinician employed by CMS with relevant clinical expertise and no conflict of interest may issue an initial denial on medical grounds, including for a drug exception. The reviewer shall examine the patient's record, offer direct consultation with the treating clinician and consider individual exceptions. Give the patient and clinician the reviewer's name, the rule, the clinical reason, any appropriate covered alternative and appeal instructions in plain language. Contractors and software may flag claims and correct billing errors. A clinical objection always requires clinical review, including under a §804 bridge. A duplicate or coding error creates no patient liability.

§ 813 Care and payment during review

CMS shall decide initial advance requests within 24 hours if urgent and 15 business days otherwise, from receipt. An independent clinician with relevant expertise who took no part in the denial shall decide medical appeals within the §103 deadlines. If delay would risk serious harm, the Trust shall pay for immediately necessary care within the patient's benefit while a decision is pending. Continue previously approved care during a timely appeal when interruption risks harm. A missed deadline provisionally authorizes the requested service within the patient's benefit categories pending decision. Patients owe nothing for care furnished in good faith under these protections.

No reviewer or contractor may be rewarded for denials or dollars withheld. CMS shall publish denial, delay and reversal rates by service. Include reviewer staffing, appeals and care paid during review in the §810 estimates.

§ 814 Patient choice at the end of life

Patients may choose among medically appropriate options with their treating team, including continuing life-sustaining treatment, refusing treatment or electing hospice. If a patient lacks capacity, follow applicable law governing advance directives and authorized surrogates. No coverage official may order that resuscitation be withheld, a patient enter hospice or life support be withdrawn. Eligibility for other covered care cannot depend on accepting a planning conversation, signing a directive or choosing hospice. No individual medical denial may rest on age or disability alone, perceived social worth or a spending target.

Cost growth, debt reduction and transition

§ 815 Spending growth limit

Limit annual Trust payment growth to five-year average collectible payroll growth from the first full operating year, plus the documented demographic adjustment under §828. Publish prices, intensity, use, aging and labor costs by sector each September. Hold price increases for existing drugs and devices to general inflation. Apply §§827–828 before referring a remaining financing gap to §803. Protect benefits, access, primary care, rural readiness and shortage supplements. Report the verified service costs and realized operating savings under §§829–830 before determining a residual gap.

§ 816 Debt reduction payment

Each year, after paying or providing for incurred §§829 and 831 obligations, other covered payments, administration, the reserve deposit and repayment of Treasury advances, the Chief Actuary shall certify the Trust's surplus. Treasury shall apply 90% of that surplus to retire federal debt held by the public and may spend it on nothing else. The Trust keeps 10% as a cushion above the 60-day reserve. Payments start in the first full operating year after startup advances are repaid. No payment is due in a deficit year. Publish each payment, the running total and the interest avoided. Separate tax legislation is outside this bill and its figures.

§ 817 State contribution

States shall pay monthly for the Medicaid and CHIP benefits assumed by the Trust. For the 50 states and D.C., move 20% of the assessment each program year to a common amount per resident, reaching 100% in year five. Section 832 determines the national pool, enrollment adjustment, credits and reconciliation. Territories retain separate assessments. Treasury shall publish estimated bills before implementation. Coverage continues during any dispute. Report and finance any collection shortfall under §§803 and 816.

§ 818 Insurance and billing workers

A worker whose job in health insurance, claims administration or medical billing ends because of this Act qualifies for wage replacement for up to two years, retraining and relocation costs, pension credit when within five years of retirement, and first preference for Trust claims, enrollment and access-office jobs. Fund the program for the first five program years, capped at 1% of Trust outlays a year. Score the cost under §301. Insurers receive no compensation for lost business.

§ 819 Hospital step-down

Through program year two, start from audited revenue for the same care. Apply 25%, 50%, 75% and 100% of the scheduled reduction in program years three through six (2030–33). Section 829 governs each affected service. Provide the bridge or activate a verified alternative before essential coverage is put at risk. Transition money may not fund acquisitions, executive increases or excessive related-party charges.

Better outcomes

§ 820 A primary care team for every resident

Each qualifying resident may register with a named primary care team. Offer evening and weekend access. Move primary care toward 12% of Trust payments over ten years using verified reallocation from hospital or specialty budgets. Publish annual shares and named offsets. Protect §829 facilities and avoid double counting the same reduction. Finance outstanding gaps under §803 before expanding contracts.

§ 821 Mothers and infants

Cover midwife-led maternity care and birth centers on the same terms as physician care. Offer every family nurse home visits after a birth, and sustained visits through age two where risk is high. Publish maternal and infant deaths by region and by race.

§ 822 Chronic disease control

Pay nurse- and pharmacist-led teams to find and control high blood pressure and diabetes, with physician backup. Keep a registry of each practice's patients and publish control rates. Pay practices for reaching uncontrolled patients, never for excluding them.

§ 823 One health record

Build one lifelong record that follows the patient across every provider. The patient owns it, and any treating clinician may read it with consent. Every participating provider shall connect. Log each access and let patients see the log.

§ 824 Treatment evaluation and patient safety

An independent institute shall assess the added benefit of new drugs, devices and procedures, publish its evidence and list low-value services the plan stops paying for. It may not value a life by age or disability. A separate safety board shall collect confidential reports of harm and near misses and publish what it learns, as aviation does. The institute shall administer time-limited coverage with evidence under §831.

§ 825 Prevention

Create a prevention fund for tobacco control, vaccination outreach, screening and community programs with measured results. Cover obesity medication at a negotiated price for patients who meet clinical criteria.

§ 826 Workforce and research

Fund 5,000 new primary care residency positions a year and matching nurse and nurse practitioner training. Recognize the full scope of practice that a clinician's state license permits. Offer a supervised pathway to practice for qualified foreign-trained clinicians. Fund a research and prize account so that lower drug prices do not slow the search for new treatments. Section 831 reconciles these awards with separately funded academic work.

Drug purchasing and clinical value

§ 827 Branded drug rebates and launch pricing

For each calendar year CMS shall establish a net branded-drug spending budget under §815. Before the year begins, publish the covered products, the permitted growth, expected eligible patient volume, shortage exemptions and a common rebate agreement. Each manufacturer shall repay its allocated share of spending above the budget. The default recovery is 100% of the net overrun, allocated in proportion to covered net sales. An agreement may reduce recovery for a documented supply or access need; CMS shall publish and finance the difference.

Calculate quarterly provisional rebates and reconcile within 180 days of year-end against paid units and net manufacturer receipts. Allocate an overrun only once across products and manufacturers. Subtract applicable Medicare, Medicaid, 340B and contractual discounts already realized; exclude amounts already returned and exempt sales from the allocation base. Audit data, collect unpaid amounts with interest, and provide independent review. Preserve dispensing fees, continuity of supply, shortage exceptions and urgent patient access under §§103, 505 and 813.

Before a covered drug launches, the §824 institute shall compare its added clinical benefit with the best available treatment for the same indication and patient population. Publish evidence quality, meaningful outcomes, uncertainty and net comparator cost. CMS shall negotiate a launch price reflecting that assessment. With no demonstrated added benefit, use the verified net comparator cost as the presumptive ceiling. Permit a reasoned exception for unmet need or supply risk. For uncertain benefit, set a provisional price, evidence deadline and repayment or repricing terms. Where comparable high-income countries pay less for the same product, use their median net price as a further ceiling.

Reassess within two years, and sooner if material evidence changes. Maintain coverage for medically necessary exceptions and continuity of care while prices are disputed. Publish reimbursed units, net prices and cash actually recovered. Include obesity medications on the same clinical and pricing terms. This section earns no savings credit above the retail drug line without verified incremental collections.

Payment updates, staffing and aging

§ 828 Implementation of the spending limit

Targeted fee review. Before reducing a fee, CMS shall audit rapid growth in billed units, coding and payment intensity. Adjust for patient need, case mix, newly eligible patients and progress against waiting lists. Give clinicians notice, publish findings and apply justified changes prospectively. Exempt primary care, shortage services and areas missing access standards. Record the net result after changes in volume and quality.

Elective payment pilot. A region may test variable fees for selected elective services for three years. Publish the sector budget, case mix and volume assumptions in advance. Limit reductions to 2% per year, prospectively. Exclude urgent care, primary care, rural and transfer standby, and shortage services. Publish completed treatment, outcomes, waiting times, coding and volume against a comparison region. Suspend reductions when staffing or access deteriorates. Expansion requires independent evaluation and congressional authorization.

Supply. Under §§405, 606–607 and 826, fund evening and weekend sessions, retention, supervision and training consistent with state licensing rules. Purchase filled rosters and completed visits or procedures. Distinguish graduates and open posts from staff already delivering care. Publish rural and urban vacancy, retention, boarding and transfer-acceptance data. Reconcile shared positions across the access and outcomes budgets. Pay new capacity once.

Demographic allowance. Beginning in 2035, the Chief Actuary may add up to 0.50 percentage point to annual payroll-linked growth for measured additional age and clinical-risk costs beyond the existing baseline. Require fixed age-risk weights, published enrollment data and an annual true-up. Exclude price or coding inflation and demographic changes already counted. Carry an overpayment back in the next update. No automatic entitlement to the half point arises. Include any approved amount in the §803 funding requirement.

Protection for emergency and transfer capacity

§ 829 Bridge payments during the hospital step-down

The national §819 benchmark changes on schedule. An uncovered reduction at an essential service is subject to the service test below. Before each step, reconcile payer claims, standalone and affiliated financial statements, cash, debt covenants, leases and capital needs. A hospital projected to fall below 45 days of accessible operating cash or 1.2 times scheduled principal and interest in the 36-month projection receives a bridge payment for the verified gap. The bridge requires an approved plan to lower operating cost and ends when the tests are met. No bridge may rest on a parent subsidy without a binding, funded commitment. Give new or differently classified receiving hospitals the same protections.

Before the first reduction, publish actual sending and receiving partners, transport availability and signed acceptance commitments by acuity and specialty. Verify reachable alternatives using travel times, seasonal conditions, night and weekend rosters and staffed receiving beds. Patients, clinicians and emergency medical services may challenge a designation. Provide prompt written review and expedited action when care is at risk.

At 2034 prices the planning accounts are $18B rural and $95B receiving. Under the 5% facility cost shock, test $21B and $132B respectively. Contract for service hours, transport and accepting capacity. Pay monthly for reasonable costs after plan and retained payer revenue, Medicaid changes, standby, teaching, capital and other grants. Reconcile each site, service and month. Pay verified critical claims above the estimate, publish the shortfall and apply §§803 and 815. Reallocate only while both ends of the route remain available.

Before each rate step and monthly thereafter, measure filled ER hours by credential, staffed bed-hours by specialty, transfer requests and refusals, time to acceptance and arrival, boarding, transport and safety outcomes. Compare baseline and contract minimums by shift, season and severity. If access is at risk, pay the verified bridge or activate a reachable staffed alternative. Suspend only the uncovered reduction at the affected service until the regional officer and an independent auditor verify safe operations. Restore essential coverage immediately upon failure. Protect services elsewhere if a designated hub or route becomes unavailable.

§ 830 Hospital operating savings and essential service contracts

Within 180 days of designation and before claiming savings, each operator shall file an audited expense and staffing baseline, annual targets through 2033, affected accounts, transition costs and an accountable manager. Compare similar facilities by size, wages, case mix and geography. The Secretary shall publish and update essential-service contracts and review designation challenges under §829.

Count recurring payroll removed, terminated billing contracts and lower delivered prices for the same clinical product or service. Deduct severance, transition, replacement and upkeep as incurred. Track released clinician time as capacity until an expense actually falls. Reconcile with insurer wind-down, §818 workforce assistance, drug or device discounts, access purchases and affiliated accounts. Count each saving once.

Assign zero prospective agency savings to designated rural ERs and receiving sites. Later credit requires paid invoices and rosters demonstrating the same qualifications, pay, hours, shifts, surge and on-call availability. Withhold credit for shifts lost, transfers denied or staffed beds closed. Require corrective action within 90 days while essential services continue. Rebid the service or replace management for repeated failure. Activate a successor only when staff, transport and beds are available.

The initial conditional planning estimate is $8.78B annually at 2034 prices. It counts toward the former $124.87B national operating-cost assumption only where a saving lowers an otherwise payable obligation. No uniform facility cut or automatic award arises from the $116.09B residual. Apply actual costs and verified savings before the §816 distribution. The Inspector General shall audit duplicate claims, service delivery and recoveries. Publish quarterly awards, paid bridges, verified savings and uncovered needs. Reforecast debt payments through 2041 and 2051 annually.

Civilian health program transfers

§ 901 Medicare contracts and premium deductions

Medicare provides federal coverage chiefly to people aged 65 or older and certain younger people with disabilities or qualifying conditions. On each beneficiary's transfer date the Trust assumes hospital, outpatient and prescription benefits under Parts A, B and D. CMS shall end corresponding Medicare Advantage (Part C) and drug-plan payments, including the transferred share of monthly plan payments. CMS, Social Security and the Railroad Retirement Board shall stop collecting the premiums and income-related surcharges for replaced coverage. Refund excess deductions within 30 days of identification. Notify beneficiaries and Medigap issuers of the transfer and stop charges for replaced benefits. Preserve separately priced benefits the Trust does not assume. Honor active prescriptions, authorizations and scheduled treatment. Treasury shall transfer and reconcile Medicare financing under §809. CMS shall maintain the payment benchmarks under §808.

§ 902 Medicaid and children's coverage

Medicaid is the joint federal-state program serving qualifying low-income people and others eligible under state plans. The Trust assumes covered medical, hospital and drug services for transferring Medicaid and Children's Health Insurance Program (CHIP) members. For someone enrolled in both Medicare and Medicaid, pay the covered service once and retire corresponding premium assistance. Preserve federal matching funds and state funding and administration for institutional long-term care, disability supports, transport and children's screening and treatment entitlements wherever the Trust has yet to deliver equivalent services. For mixed-benefit managed-care contracts, adjust the monthly payment to fund only the remaining obligations. Preserve existing entitlements for people outside the new full-benefit program.

§ 903 Marketplace coverage and subsidies

When national coverage begins, the Marketplace and Treasury shall end the transferred member's overlapping premium tax credit, cost-sharing assistance and subsidized coverage. Recalculate the remaining family members' coverage and advance credit, notify the household and insurer, and reconcile the correct months on the tax return. Preserve assistance for anyone still entitled under existing law. Fund assistance with enrollment and appeals during the transition.

§ 904 Federal and postal employees and retirees

The Office of Personnel Management and Postal Service shall transfer overlapping domestic medical coverage under the Federal Employees Health Benefits and Postal Service Health Benefits programs. Stop the corresponding agency and employee premium shares on the transfer date. Preserve earned retiree commitments, overseas benefits and other benefits the Trust does not assume. Price the remaining coverage separately for each contract and family, including dependents who transfer later.

Military care and special purpose programs

§ 905 Military health and TRICARE

The Defense Health Agency shall transfer ordinary domestic civilian claims for enrolled beneficiaries to the Trust. For TRICARE For Life, retire secondary payments for services the Trust pays in full. Preserve funding for military readiness, deployed and overseas care, military treatment facilities and military-specific benefits. The existing payer remains responsible for earned benefits outside the national plan. Inform each beneficiary where to obtain care before the transfer.

§ 906 Veterans tribal care and HIV services

Apply §§701–703 to VA and tribal programs. Name each transferred VA community contract and each function retained by VA. Identify separately any shared purchasing or claims agreement accepted by a tribal government. Under the Ryan White HIV/AIDS Program, the Trust pays first for covered visits and medicines. Preserve grants for case management, support services and patients whose care falls outside the national benefit. Reconcile grants only for amounts attributable to services the Trust actually pays.

§ 907 Medicare Advantage payment comparison

For each year, estimate the cost of continuing Medicare Advantage for the transferring population and the cost of delivering the promised benefits through the Trust. Adjust for health status, coding differences, provider rates, use of care and supplemental benefits. Publish the difference after transition costs. MedPAC's estimate of $76 billion in higher 2026 payments compares Medicare Advantage with traditional Medicare. The score for this Act must use its own benefits and rates.

Evidence used in drafting

Sanders Senate bill S. 1506 • national budgets and payment methods

Jayapal House bill H.R. 3069 • coverage and transition

CMS national health spending • 2024 spending baseline

BEA wages and salaries • payroll scale check

CBO single-payer scenarios • effects on spending, supply and demand

CBO provider prices • site-neutral payments and competition

MedPAC 2026 hospital report • hospital margins and payment adequacy

Veteran ambulance study • outcomes and cost in emergency care

Medicare and Medicaid benefits and coordination

MedPAC 2026 Medicare Advantage payment comparison, chapter 12

CBO review of Veterans Community Care Program costs

Fiscal schedule for 2034

CMS projects $8,970B under current law in 2034. Both scenarios fund medical use, access staff, hospital transfers, dental, hearing, vision, the §§820–826 programs and the §831 academic mission. Existing Medicaid home care continues. The §817 benchmark reallocates the same total state assessment.

Annual amount, $ billions	Planning case	Downside case
Net national savings	+$107	−$253
National health spending	$8,864	$9,224
Rural hospital support	$18	$21
Receiving hospital support	$95	$132
Total hospital access allowance	**$113**	**$153**

What the hospital allowance covers

The broader receiving network and full Medicare pricing produce $113B in planning or $153B under the facility cost shock. The separate $31B for other capacity stays funded. The historical $101B and $140B estimates and their inputs appear in the background tables. Additional bridges require documented facility-level needs.

Fund staffed emergency departments and inpatient beds at rural hospitals, and the staffed beds and specialist teams needed to accept transfers. Before conversion, verify each network's receiving hospitals, staffing, transfer delays and the cash and debt tests in §402. Regional bed counts alone cannot establish that a bed is available when a patient needs it.

Can the enacted schedules finance the downside?

At a fixed 12% employer and 6% household rate, Schedule B runs an operating surplus from 2033 in the planning case and a shortfall in the downside. Startup advances are repaid from those surpluses. Estimated national savings and a debt payment are separate measures.

Gross payment reductions are $726B in planning and $528B in stress. The Trust receives 90% or 75% and pays modeled costs in full. After the academic budget and hospital allowances, the 2034 cash gain is $34B in planning or a $385B cash cost in stress. The $8.78B operating estimate supports delivery of the hospital rate reduction already counted here.

CBO and JCT should publish both annual balances for each schedule. Apply §306 over the transition and ten full operating years. If the recommended Schedule B fails, publish the remaining gap and revise the financing before a final vote. A Treasury advance under §803 covers temporary cash shortfalls and must be repaid.

Sources CMS spending projections • NASHP hospital cost reports • Rural transfer stress test, 22 November 2026

Testing the 2034 financing gap

All figures are annual nominal billions for 2034. The table separates new receipts from changes in the cost of transferred medical bills. The annual ledger also includes the effects of tax credits, collections, interest, transition and reserves.

Which payments move to the Trust?

Gross transferred payments in the main test are $2,958B, including private premiums, an assumed 80% of personal out-of-pocket spending and 75% of Medicare B and D premiums. Subtracting the $34B planning gain or adding the $385B stress cost gives about $2,924B or $3,343B to finance before the other cash adjustments.

What the proposed rates raise before credits and reserves

Financing option	New receipts	Planning balance[1]	Downside balance[1]
8% employer, first draft (withdrawn)	$2,543	−$381	−$800
10% employer, first draft (withdrawn)	$3,289	+$365	−$54
Schedule A: 14% / 4%	$3,760	+$836	+$417
Schedule B: 12% / 6%	$3,761	+$837	+$418
Schedule B, wider transfer	$3,761	+$558	+$139

The main rows precede tax credits, startup, reserve funding and collection losses. The wider case transfers the full $883B of out-of-pocket bills and $408B of Medicare premiums. Reconcile Medicaid-paid premiums with the associated public payments. Use the later §803 cash ledger to assess solvency. [1] The last two columns show receipts less the estimated Trust cost.

How to interpret the figures

The calculation assumes existing public funding follows each benefit the plan takes over. Section 817 allocates the payroll-indexed pool by population under §832. It counts public-employer payroll in new receipts. A federal score must deduct new public-employer costs, test collection of the state contribution, retain funding for residual programs, and measure federal income-tax changes from wages and employer premiums. Only the assumed share of gross payment reductions enters Trust cash. Added services and replacement administration are charged in full.

CMS spending, tables 1 and 16 | Medicare Trustees, tables III.C4 and III.D3 | Treasury revenue estimates

Does the financing last ten years?

The cash test covers rollout in 2028–31 and ten full operating years in 2032–41. It funds the 60-day reserve and charges 4.5% on opening advances. The Trust first repays advances. It holds remaining cash in the repayment year. From the following full year it pays 90% of each year's eligible surplus toward publicly held debt. Cash retained in earlier years covers later deficits before new borrowing.

Annual Trust cash and payments toward publicly held debt

Schedule B, fixed 12% employer rate, planning delivery, $113B hospital allowance and $20B academic budget. Payroll grows 4%. Medical growth is 4% or 5.5% after 2034. Balances include reserves and interest. These figures assume no further bridge awards. See the hospital bridge scenarios for higher outlays. Nominal $ billions.

Year	Balance, limit holds	Debt payment	Balance, limit fails	Debt payment
2028	−36.4	—	−36.4	—
2029	−238.1	—	−238.1	—
2030	−272.1	—	−272.1	—
2031	−289.7	—	−289.7	—
2032	−75.6	—	−75.6	—
2033	+112.2	—	+112.2	—
2034	+198.7	—	+198.7	—
2035	+217.0	—	+155.5	—
2036	+236.6	—	+105.0	—
2037	+257.4	—	+46.3	—
2038	+274.6	247.1	−21.3	—
2039	+285.6	257.0	−98.7	—
2040	+297.0	267.3	−186.8	—
2041	+308.9	278.0	−286.6	—
Total paid	**—**	**1,049.4**	**—**	**0.00**

Borrowing peaks near $0.91T in 2032. At 4% cost growth it clears in 2037 and payments begin in 2038. Transfers total $1.05T by 2041 and $4.52T by 2051. At 5.5% the fixed-rate case pays zero. The separate §803 operating adjustment reaches 13.12% in 2041.

Pricing the 22 November changes

These transition, state-index and benefit costs remain in the cash test. The dental, vision and hearing allowance is included once. The separate better-outcomes schedule prices §§820–826.

Item	2028–33 total	2034, a year	In the cash tables
Insurance and billing worker program (§818)	$184	$0	Yes
Small-employer credit (§205)	$272	$0	Yes
State index below medical cost growth (§817)	$144	$55	Yes
Added dental, vision and hearing use (§102)	$212	$55	Yes
Universal home care, deferred (§102)	$1,368	$360	No

Basis. Worker program: the §818 cap of 1% of Trust outlays binds every year. PERI counts 1.68 million displaced workers. Credit: firms under 20 workers hold 12.1% of private payroll and firms of 20 to 39 hold 5.4% (Census, 2022). State index: CMS projects state Medicaid funding of $600 billion in 2034, growing 5.6% a year against a 4.15% payroll index, with 85% assumed to be care the Trust takes over. Dental, vision and hearing: 10% more use of $300 billion in dental care plus $25 billion of new hearing and vision use, scaled from CBO's 2019 Medicare estimate. Home care: CBO's 2020 estimate of $290 billion in 2030, grown 5.5% a year. The Urban Institute's 2020 estimate implies up to $465 billion.

Choices that change the debt payments

Option	Cost in 2034	Employer rate needed	Debt payments by 2041
Every section as priced, at 12%	—	—	1,049
At the earlier 11.5% rate	—	-0.50 points	0
Without obesity medication (§825)	-$45	—	1,534
Limit at wage growth plus half a point	—	—	391
Universal home care, if enacted now	$360	2.03 points	0

Each row changes one financing or benefit assumption while retaining the $113B hospital allowance and $20B academic budget. No additional bridge spending is assumed. Transfers begin in the full year after startup advances clear. Universal home care requires new financing.

The payroll index saves states an estimated $55B in 2034 relative to medical-cost growth. Applying the new 12% base to the same state and local wage estimate gives about $256B in employer contributions before credits, against $429B of projected premiums. Public payroll and Medicaid payments are distinct. The appendix retains the optional state relief comparisons.

Pricing the better-outcomes sections

Annual amounts are in billions of 2034 dollars. They enter the cash tables scaled to enrollment during rollout and grow with other Trust costs afterward. The health record is built over 2029–33. These are planning estimates built from published program costs and need an official score.

Section	2034, a year	One-time cost	In the cash tables
Primary care shift (§820)	$0	—	Yes
Mothers and infants (§821)	$10	—	Yes
Chronic disease control (§822)	$15	—	Yes
One health record (§823)	$3	$30	Yes
Evaluation institute and safety board (§824)	$2	—	Yes
Prevention fund (§825)	$10	—	Yes
Obesity medication (§825)	$45	—	Yes
Workforce training (§826)	$5	—	Yes
Research and prize account (§826)	$10	—	Yes
Total	$100	$30	Yes

Basis. Primary care: the $0 incremental estimate requires an equal enacted transfer from independently verified unprotected budgets. Unfunded reallocation increases the Trust cost dollar for dollar. Mothers and infants: three home visits for each of 3.6 million births, plus sustained visits for 400,000 higher-risk families. Chronic disease: about $200 a year for each of 75 million patients with uncontrolled blood pressure or diabetes. Prevention fund: five times the $2 billion a year the 2010 health law intended. Obesity medication: 15 million patients at about $3,000 a year. Workforce: 15,000 residents in training at $180,000 each, plus nurse training. Research: $10 billion a year.

Charge $100B for §§820–826 and $20B for §831 at maturity and $30B for building the health record in 2029–33. Assume no later health savings. Book the outcomes programs separately from the $83B–$165B access purchases. Reconcile invoices, staff and visits across programs before payment. The drug and fee rules receive zero additional savings credit.

Keeping the Trust funded after 2041

The existing Medicare tax applies to every dollar of covered wages. The worker and employer each pay 1.45%, and high earners can owe an additional 0.9%. Social Security has the wage cap. Both proposed employer contributions also apply to uncapped covered payroll. Existing Medicare receipts follow transferred benefits under §809 after provision for remaining claims.

What happens after year ten

Schedule B at fixed rates. These figures show each annual balance after reserve deposits and interest but before §816. Payroll grows 4% annually. The facility screen and expanded benefits are included in both rows.

Schedule B at fixed rates	2041	2042	2045	2051
Growth limit holds	+$309	+$321	+$361	+$457
Limit fails, costs grow 5.5%	−$287	−$399	−$826	−$2,215

With 4% medical growth, the academic budget and the hospital allowance, advances clear in 2037 and transfers reach $4.52T by 2051. At 5.5% growth advances remain outstanding at a fixed 12%. The employer schedule shows the separate §803 operating correction.

How the employer contribution adjusts

Before setting starting rates, require a funded 20-year projection. Each year update the ten-year forecast, 75-year actuarial outlook, reserve balance and annual employer adjustment under §803. Congress enacts the formula with the starting rates. Treasury publishes the calculated rate. Congress can replace it with other enacted financing that raises the same amount.

Starting rates are 12% for Schedule B and 14% for the alternative Schedule A. Only B is fully rerun here. Its 2051 employer rate is 12% in the central 4% case and reaches 19.89% in the combined downside. Independent tax-return and wage-response estimates remain outstanding.

IRS Medicare and Social Security rates

Rates and assumptions to score

Decision before a final vote

The sponsor recommends B. Score A for comparison only. Schedule B starts at 12% for employers, 6% for households and 10% for self-employment with the larger §203 credit. Schedule A starts at 14%, 4% and 8% respectively. Score both with identical benefits, supplements and access protections under §306. The following cash scenarios use Schedule B.

For the high-income measures in both schedules, score an extra 1.2 percentage points on applicable earnings above $400,000 and on the lesser of net investment income or modified income above that threshold. Index the rate threshold. Phase in the investment-tax base for qualifying active business income from $400,000 to $500,000 of adjusted gross income, halved for separate married returns. Use the Treasury definitions. Reconcile §203 and preserve Medicare funds for remaining claims under §809. Count only incremental receipts.

How the revenue and cash estimates were made

Apply the household rates to the mean income in each 2023 IRS income and filing-status group. Scale return counts by CMS population growth and mean income by growth in personal income per person. Index starting allowances and brackets from 2026 with CPI. The gross test omits dependent allowances, business credits, refunds and behavior. Its 2034 household estimates are $956 billion for A and $1,305 billion for B. The Medicare Trustees' payroll series gives $19.84 trillion in combined earnings. Estimate $18.64 trillion of employer wages by scaling the bill's 2024 wage base with personal income. Apply the employer-only rate increase to wages.

The cash test assumes 95% collections, the inherited high-income sensitivity and rollout at 5%, 55%, 80% and 100% enrollment. Public operating costs and additional care track enrollment. Clinician fee and drug price reductions track enrollment. Insurer overhead falls as members transfer, with 80% of the reduction counted until 2034. Hospital reductions start in 2030 at 25%, reaching 100% in 2033.

Allow start-up costs of 0.5% of national spending in each of years one and two, then 0.25% in each of years three and four. Build one fifth of the 60-day target per year, using 85% of personal health spending times enrollment as the covered-benefit proxy. After 2034 assume annual growth of 4% in receipts and savings and 5.5% in replacement costs and benefits. Closing the books requires cohort claims, actual tax and credit distributions, revised drug costs, and documented state and federal transfers. Publish results for the lowest three income quintiles under §302.

The cash tables now include the §818 worker program, the §205 credit, the §§817 and 832 state benchmark, added dental, vision and hearing use and §§820–826 and 831. Universal home care is deferred under §102 and priced separately on the pricing page. The §819 step-down follows the savings ramp in the cost curves.

IRS income by filing status | CMS projections | Medicare Trustees, IV.A2 | Treasury high-income provisions

What households would pay

Use adjusted gross income (AGI) and the filing status on the federal return. The table gives the additional annual health contribution for a full year at the bill's starting thresholds. Apply each marginal rate only to income in its band. Schedule A pairs its rates with the 14% employer rate. Schedule B pairs its rates with the 12% employer rate. Existing federal income and payroll taxes continue.

Single AGI	Joint AGI	A rate	B rate
To $30,000	To $60,000	0%	0%
$30,000–$150,000	$60,000–$300,000	4%	6%
$150,000–$500,000	$300,000–$1 million	6%	8%
Over $500,000	Over $1 million	10%	12%

For dependents, add $5,000 each to the starting allowance. The 2- and 4-point surcharges still begin at the upper thresholds shown. Use single thresholds for head of household and married filing separately, and joint thresholds for a surviving spouse. Split dependents once across separate returns. Thresholds are indexed. Under both schedules, add the applicable investment and earnings taxes described on the preceding page. For example, $500,000 of wages for a single filer would add $1,200 at the stated $400,000 threshold.

Before and after for employees

Before the plan, add your share of annual premiums and the bills you actually paid for care the plan would cover. KFF's 2026 employer survey found average worker premiums of $1,672 single and $7,471 family, before out-of-pocket costs. If you have Medicaid, Medicare, a Marketplace plan or no insurance, use your own premium after subsidies. After enrollment, covered care has zero premiums, deductibles and copays. The following sample paychecks show monthly withholding and direct deposits for both financing options.

Filing status and annual wages	Prior premium only[1]	After A	After B
Single, $50,000	$1,672	$800	$1,200
Single, $100,000	$1,672	$2,800	$4,200
Joint, 2 dependents, $100,000	$7,471	$1,200	$1,800
Joint, 2 dependents, $150,000	$7,471	$3,200	$4,800
Joint, 2 dependents, $250,000	$7,471	$7,200	$10,800

[1] Survey averages per enrolled worker. Family rows assume one family policy. Examples use wages equal to AGI and compare direct dollars. For a single worker at $100,000 on B, $4,200 exceeds the average premium by $2,528. Their direct spending falls if covered out-of-pocket bills exceed that difference. A family at $150,000 on B pays $2,671 less than the average family premium alone. Pre-tax deductions, subsidies, wage changes and uncovered services affect take-home results.

KFF 2026 Employer Health Benefits Survey, sections 1 and 6

Monthly paycheck with family coverage

Married filing jointly, one wage earner, two qualifying children under 17 and $150,000 annual salary. The employee has family coverage today. Each column is one monthly paycheck, using the same salary and 2026 federal withholding rules. The proposed options use the bill's starting allowances and a full year of coverage.

Monthly earnings and deductions	Today	6% household	4% household
Gross pay	$12,500.00	$12,500.00	$12,500.00
Employee medical premium (pre-tax)	$622.58	$0.00	$0.00
Wages subject to federal tax and FICA[1]	$11,877.42	$12,500.00	$12,500.00
Federal income tax withheld	$774.70	$911.67	$911.67
Social Security withheld	$736.40	$775.00	$775.00
Medicare withheld	$172.22	$181.25	$181.25
New household health contribution	$0.00	$400.00	$266.67
Total employee deductions	$2,305.90	$2,267.92	$2,134.59
Take-home pay / direct deposit	**$10,194.10**	**$10,232.08**	**$10,365.41**
Employer-paid health benefit[2]	$1,736.00	$1,500.00	$1,750.00

The monthly medical deduction falls from $622.58 to $400.00 or $266.67. Federal income and payroll tax withholding rises $184.60 when the old pre-tax premium ends. The monthly deposit rises $37.98 with the 6% contribution or $171.31 with the 4% contribution. Covered deductibles and copays also disappear. Those savings occur when a family uses care.

Where the new deduction comes from

The starting joint allowance is $60,000 plus $5,000 for each dependent. That leaves $80,000 of income subject to the base rate. At 6% the annual household contribution is $4,800, or $400 a month. At 4% it is $3,200, or about $266.67 a month.

[1] The taxable-wage line is informational. The illustration assumes a Section 125 pre-tax premium today, an after-tax household contribution, unchanged wages, no state or local income tax, no retirement or other deductions, and a federal W-4 with Step 2 unchecked, $4,400 in Step 3 and no Step 4 adjustments. Actual withholding and year-end tax can differ.

[2] Employer-paid medical premium today, or the employer's new 12% / 14% contribution after transition credits expire. Employer dollars are outside the employee's deposit. Current premiums use 2026 survey averages.

KFF premium survey IRS withholding tables IRS pre-tax benefits

Monthly paycheck with single coverage

Single filer with no dependents, $100,000 annual salary and employee-only coverage today. Each column is one monthly paycheck. The two proposed options have the same covered benefits and different divisions of the cost between employers and households.

Monthly earnings and deductions	Today	6% household	4% household
Gross pay	$8,333.33	$8,333.33	$8,333.33
Employee medical premium (pre-tax)	$139.33	$0.00	$0.00
Wages subject to federal tax and FICA[1]	$8,194.00	$8,333.33	$8,333.33
Federal income tax withheld	$1,066.85	$1,097.50	$1,097.50
Social Security withheld	$508.03	$516.67	$516.67
Medicare withheld	$118.81	$120.83	$120.83
New household health contribution	$0.00	$350.00	$233.33
Total employee deductions	$1,833.02	$2,085.00	$1,968.33
Take-home pay / direct deposit	**$6,500.31**	**$6,248.33**	**$6,365.00**
Employer-paid health benefit[2]	$677.67	$1,000.00	$1,166.67

The monthly medical deduction rises from $139.33 to $350.00 or $233.33. Once federal income and payroll tax changes are included, take-home pay falls by $251.98 or $135.31 a month. With the 6% option, avoided covered medical bills averaging more than $251.98 a month would offset the drop in take-home pay.

Find the comparable amount on a pay stub

Find the employee medical deduction under benefits. To get a monthly average from a biweekly check, multiply it by 26 and divide by 12 in a 26-check year. For twice-monthly pay, multiply by two. Use a full year of deductions if the employer collects premiums on only some checks. Employer contributions are shown separately. Subtract covered expenses you would stop paying when comparing total household spending.

[1] The taxable-wage line is informational. The illustration assumes a Section 125 pre-tax premium today, an after-tax household contribution, unchanged wages, no state or local income tax, no retirement or other deductions, and a federal W-4 with Step 2 unchecked, $0 in Step 3 and no Step 4 adjustments. Actual withholding and year-end tax can differ.

[2] Employer-paid medical premium today, or the employer's new 12% / 14% contribution after transition credits expire. Employer dollars are outside the employee's deposit. Current premiums use 2026 survey averages.

KFF premium survey IRS withholding tables IRS pre-tax benefits

What employers and business owners would pay

Before the plan, count the firm's own annual premium contributions. A self-insured firm should use net claims, stop-loss premiums and plan administration, less worker contributions. Keep costs for any benefits the firm continues. KFF's 2026 figures imply average employer payments of $8,132 for single coverage and $20,832 for family coverage. A firm offering no plan starts at $0. Use the whole firm's actual covered payroll, including workers who previously declined insurance.

Payroll bands and the small-employer credit

Total covered payroll	Years 1–2 share due	Years 3–4	Year 5 onward
Up to $1 million	50%	75%	100%
$1.5 million	75%	87.5%	100%
$2 million and above	100%	100%	100%

Multiply payroll by the selected employer rate, then by the share due. Between $1 million and $2 million, phase out the credit linearly. At a quarter of the way through that band, a firm gets three quarters of the maximum credit. Aggregate affiliates, exclude owner earnings already assessed under §203, and prorate by covered worker-months during enrollment.

Annual charge after credits expire	Schedule A, 14%	Schedule B, 12%	8%, withdrawn	10%, withdrawn
Per $100,000 of payroll	$14,000	$12,000	$8,000	$10,000
At $1 million payroll	$140,000	$120,000	$80,000	$100,000

For example, a $1 million payroll firm on Schedule B pays $60,000 in each of years one and two, $90,000 in each of years three and four and $120,000 thereafter, assuming full-year coverage. If it pays $120,000 today for displaced benefits, its ongoing direct cost is unchanged. If it pays $60,000 today, its ongoing direct cost rises $60,000. Schedule A costs this firm $140,000 once credits expire. Apply the same payroll credit bands to both. Compare future wage and tax effects separately.

Sole proprietors and other self-employed filers

Use positive net active profit after ordinary expenses. Apply 8% under Schedule A or 10% under Schedule B. Subtract the §203 credit, capped at the levy. It is up to $2,400 single/$4,800 joint under A or $3,000/$6,000 under B. The credit is full up to $30,000/$60,000 household income and tapers to zero at twice those thresholds. Add the household contribution. Under §204 the direct total is capped at 8% of positive AGI up to $150,000 single/$300,000 joint, then the refund tapers over the next $100,000/$200,000. A single filer with $45,000 net profit owes $3,000 under A or $3,600 under B. At $100,000 both total $8,000 after the refund. Compare with actual net premiums and bills paid for covered care.

Drug payment schedule under §505

One published payment rate for each covered product

Before each enrollment cohort transfers, CMS shall publish a price file for covered prescription drugs. Identify the ingredient, strength, form, package, unit price, effective date and pharmacy dispensing fee. Charge the patient $0 for a covered prescription. The Trust shall pay the pharmacy promptly for verified acquisition cost up to the applicable supply price plus a separate dispensing fee reflecting the cost of dispensing, including rural access. Reconcile supplier discounts so pharmacies can obtain the drug at the published rate and so intermediaries pass them through once.

How CMS shall set the price

Seek competitive bids from qualified manufacturers for interchangeable products. Use multiple suppliers where practical and require delivery commitments. For sole-source drugs, CMS shall negotiate directly with the manufacturer. Price a new drug by its proven added benefit over existing treatment, as assessed under §824. Give priority to products with high total spending, few alternatives or rapid net price growth. Compare current U.S. net acquisition prices, treatment alternatives, comparative benefit, reliable supply and comparable foreign prices. Match strength, form and quantity and identify taxes, pharmacy fees, rebates and currency date. Where a Medicare maximum fair price already applies, use it as the ceiling for an equivalent Trust purchase unless a documented supply exception applies.

If negotiations miss the transfer date, CMS shall publish an interim maximum payment using the best verified net comparator and give the manufacturer a reasoned decision and 30 days to contest the data. An independent reviewer shall decide within 60 days. If a medically necessary drug cannot be obtained at that price, authorize immediate patient-specific supply, pay the verified cost and review the exception within 90 days. Continue existing prescriptions, clinical exceptions and urgent appeals under §§103 and 813. Publish exceptions and audit shortages and pharmacy closures.

How to measure savings

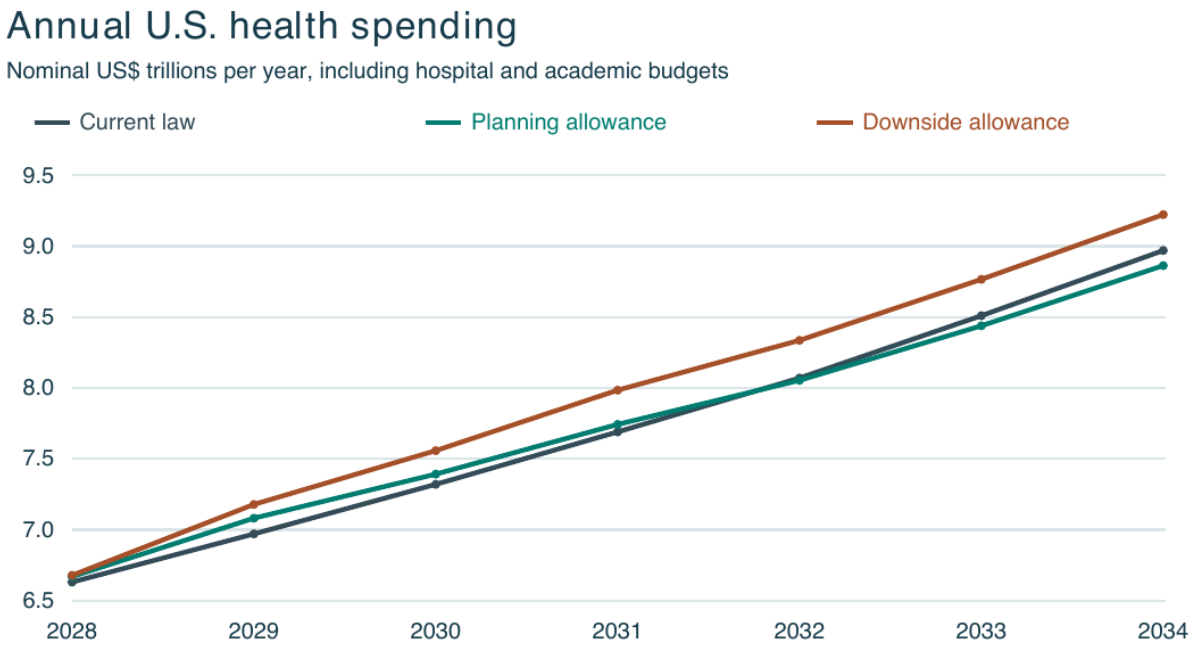
Measure spending against the price the existing payer would actually have paid after rebates, at a comparable quantity. Show changes in use, dispensing fees and supply exceptions separately. Preserve applicable Medicaid and 340B discounts and reconcile duplicate discounts by claim. Count savings already present in the national estimate once. A published price alone creates no additional Trust receipt.

For a concrete comparison, New Caledonia’s SEMPEX lists 60 Eliquis 5 mg tablets at 10,708 CFP francs in Nouméa, about US$98.62 at the November 20, 2026 exchange rate. For the same strength and count, Medicare’s 2026 negotiated unit price totals $248.70. The first is a retail price and the second is a purchaser price before a separate dispensing fee. These prices inform negotiation. An achievable U.S. net price requires an agreement or a supported payment determination.

New Caledonia SEMPEX | CMS unit-price file | FDA pack sizes | Exchange rate

Annual national spending and savings

The planning case spends more than current law through 2031 and less annually from 2032. Over 2028–34 it spends about $81B more in total and the downside about $1.56T more. Both include §831. Additional service-specific bridge awards raise spending further.



Year	Current law $ trillion	Planning $ trillion	Downside $ trillion	Planning savings $ billion	Downside savings $ billion
2028	6.63	6.67	6.68	−39	−48
2029	6.97	7.08	7.18	−111	−208
2030	7.32	7.39	7.56	−72	−238
2031	7.69	7.74	7.98	−53	−295
2032	8.07	8.05	8.34	+16	−266
2033	8.51	8.44	8.77	+71	−256
2034	8.97	8.86	9.22	+107	−253

Use CMS current-law national spending through 2034. Include core startup, one-time record construction, ongoing outcome programs, capacity and the hospital and academic budgets. Do not count Treasury borrowing, reserve deposits or debt principal in national health spending.

CMS National Health Expenditure projections, Table 2

Which federal programs move?

The Trust pays a covered claim once. Moving an existing appropriation changes who writes the check. Savings require a lower price, less work or another measurable decrease in the resources used to deliver care.

Program	What the Trust takes over	What still needs funding or a separate score
Medicare and Medicare Advantage (§§809, 901, 907)	Hospital, outpatient and drug benefits for people who transfer. Overlapping private-plan payments and premiums end.	Runout claims, reserves and replacement of lost premiums. Compare like beneficiaries and benefits before claiming savings on Medicare Advantage.
Medicaid and CHIP (§§201, 902)	Covered medical and drug claims, including dual enrollees. Allocate state payments under §§817 and 832.	Long-term services, disability support, transportation and children's entitlements wherever equivalent care is unavailable. Reprice mixed contracts.
ACA Marketplace (§903)	Overlapping subsidies end by covered person and month.	Retain benefits for eligible relatives outside the new plan. Fund enrollment, reconciliation and appeals.
Federal and postal employees (§904)	Overlapping domestic medical coverage and its associated premiums.	Retiree commitments, overseas coverage and residual family contracts. Reconcile agencies' employer contributions.
Military health and TRICARE (§905)	Domestic civilian claims and overlapping TRICARE For Life secondary payments.	Military facilities, readiness, deployments, overseas care and other military-specific benefits.
Veterans Affairs (§§701–702, 906)	Routine covered community claims and their duplicate authorization and billing.	VA facilities and specialty teams, training and research. A local service moves only after an access and full-cost test.
Indian Health Service and Ryan White (§§703, 906)	Shared tribal purchasing or claims by agreement. The Trust pays covered HIV care first.	Tribal delivery, appropriations and treaty duties. Ryan White case management, support and patients outside the national benefit.

The bill specifies these transfers. Its national savings estimate uses broad spending categories. An audited annual saving for each program is still outstanding. How the work changes

What consolidation could actually save

Under §807, before a transfer, CMS, Treasury and the administering agency shall publish three alternatives against current law. Use the same population, benefits and access standards, and show each year of transition and steady operation.

Options to compare. Compare shared claims processing and purchasing with existing coverage intact, the benefit transfers specified in this bill, and broader permitted local transfers. Price retained staff and buildings, exit contracts, added use, travel and replacement capacity. Report state participation and any required tribal agreement.

Follow each dollar. Identify federal budget accounts, public employer payroll, state commitments and household premiums. For each, show dollars moved, the net federal cost and the net national saving. Identify who receives each saving and when it can reduce a Trust payment. Publish recurring and one-time costs separately.

Accounts still to price. Reconcile state Basic Health Program payments with Marketplace credits. Map federal health-center grants to clinical claims and services such as interpretation. Reconcile hospital supplemental payments with operating and standby budgets. Price federal custody hospital contracts separately from on-site care and security. Keep injury recoveries with the liable payer under §102. Identify additional accounts in an agency-wide inventory.

Two ways to test the savings assumption

Sensitivity, holding other inputs fixed	Result
Half the net insurance reduction materializes.	2034 planning savings fall from $107B to about $22B. Stress spending is about $318B above current law.
Trust collects 90%, 75% or 50% of gross cuts; all added costs are paid.	`2041 fixed-rate planning cash balances at 4% medical growth are +$309B, +$154B, -$182B.`

Test how spending changes when insurer savings fall short, or less of the gross reduction reaches the Trust. Every modeled new cost is charged in full. The appendix traces the $300B private insurance base and $170B planning reduction.

CMS Basic Health Program | HRSA health centers | Federal custody care

Aging and the permanent financing rule

CMS projects spending using the population by age, sex and proximity to death. Its current-law baseline through 2034 already reflects mortality. The bill adds no savings for baby-boomer deaths. After 2034 the bill's model uses assumed annual growth rates. It does not project each age group separately.

Why mortality does not finance the plan. The 2026 Social Security Trustees project 72.3 million people age 65 or older in 2030 and 82.8 million in 2050 in the Social Security area. That population includes certain people abroad. A smaller surviving boomer cohort can coincide with a larger older population.

What §803 would collect

Schedule B starts at 12% of uncapped covered payroll. A variable employer contribution applies on the same base under §803. Each September, Treasury and the CMS Chief Actuary shall publish the next calendar year's rate. When a certified operating gap remains after the §815 corrections, add the projected gap divided by collectible covered payroll to the starting employer rate. Round the addition up to 0.01 percentage point. Recalculate from the starting rate each year and remove the addition when the gap closes.

The gap is covered payments, administration, reserve restoration and interest due, less existing dedicated receipts and verified savings that reduce Trust payments. Price each item once. Apply the §815 correction before calculating the gap. The §816 debt payment is never part of the gap. Keep 60 days of benefits in reserve at full operation. Actual errors draw first on free cash and available reserves, then a disclosed Treasury advance. Repay startup advances from operating surpluses before any §816 payment. Restore the reserve and repay later advances with Treasury interest within five years of issue.

Estimate the collectible payroll base at the proposed rate, after credits, wage responses and collection losses. Recheck quarterly. Publish employer, wage and household effects. If expected receipts fall short at feasible rates, report the uncovered amount and submit an alternative financing or verified cost-reduction bill within 90 days. Congress may substitute equally funded measures. The bridge keeps claims payable and creates federal debt until repaid.

CMS projection methods | Trustees population, Table V.A3

What it takes to keep the Trust solvent

Test 12% employer and 6% household starting rates. The rate stays at 12% while the Trust runs an operating surplus. Section 803 adds an employer supplement only for a certified operating gap. Reestimate employment and wage effects before enactment.

Delivery / medical growth	Employer rate 2041	Employer rate 2045	Employer rate 2051
Planning / 4%	12.00%	12.00%	12.00%
Planning / 5.5%	13.12%	14.63%	17.06%
Downside / 5.5%	15.67%	17.28%	19.89%

At 4% growth and with the $113B hospital and $20B academic allowances, startup advances peak near $0.91T and clear in 2037. Further bridge payments can delay repayment. In the 5.5% and downside cases the §803 supplement covers operating gaps. Startup debt requires independent repayment capacity.

Report the longer statutory actuarial outlook separately. The current reconciled ledger runs through 2051. Tax-behavior feedback, complete hospital debt schedules and a unified federal budget score remain outstanding.

What Congress still needs. Before a vote and annually thereafter, the Chief Actuary shall project 75 years under central, longer-life, lower-payroll and higher-medical-cost assumptions. Publish covered lives and spending by age, including 65–74, 75–84 and 85+, plus working-age payroll, disability, long-term care obligations, and end-of-life spending counted once. Show rate, annual balance, reserve days, debt and household effects. Use official CBO and JCT estimates for the federal budget and taxes before a final vote.

How the federal programs would cost less

Consider a patient enrolled in both Medicare and Medicaid. Today, a clinic may have to check two benefits, wait for the first payer and reconcile the second payment. For a visit the Trust fully covers, the clinic would submit one claim. The patient would owe $0. Medicaid could still pay for the same person's nursing-home care. The avoidable cost is the second round of billing and reconciliation. The visit and the nursing-home bed still cost money. CMS claims standards

What changes at the agency and the clinic

Work to change	How to deliver it and verify the saving
Eligibility and billing	Reuse existing electronic eligibility and claim-status standards. Give the clinic one answer for the patient, service and date. Route mixed-benefit claims to the responsible payer behind the scenes. Measure staff time, first-pass payment and days to payment.
Plan contracts and premiums	End overlapping Medicare Advantage, Part D, Marketplace, federal employee and postal payments only as each member transfers. Reprice family and overseas coverage that remains. For Medicare Advantage, compare the same patients, benefits and risks. Deduct lost premiums, transition claims and contract exit fees.
Hospital and drug purchasing	Use one hospital operating budget for covered activity and pay readiness separately. Negotiate net drug prices nationally, bid interchangeable products, and reconcile rebates, 340B discounts and dispensing costs once. Track actual net price per unit and units dispensed.
VA and military referrals	Use one authorization and one payment for covered community treatment. Retire the duplicate network fee when the contract ends. Keep VA specialty teams and military readiness funded. Count a facility saving only when its avoidable cost actually ends.
Access and staffing	Apply one clinical priority rule to shared appointments and carry forward the original referral date. Fund the clinicians, beds or extra sessions needed to serve it. Track completed treatment, staff vacancies, travel and the longest waits. Deduct that capacity spending before reporting net savings.

A state contribution counts as Trust revenue when collected under §§817 and 832. An agency appropriation counts once for the benefit assumed. Count the cost of any continuing claims office or temporary administrator until its work actually ends. CMS eligibility and claim status

Which costs can actually come out?

Under §807, Treasury and each administering agency would list every relevant budget account, grant, waiver and contract. For each one, identify the patient or service, the new payer, the last legacy payment, the cost that remains and the official responsible for signing off. Publish a disposition even when the saving is zero.

Accounts to reconcile	What can be combined and what still requires funding
State coverage and hospital supplements	Match Basic Health Program and §1332 waiver dollars to the people and months transferred. Match Medicaid hospital supplements to the services and capacity they buy. Retain benefits for other residents and avoid a second hospital payment for the same bed.
Safety-net clinics and public health	Pay a covered clinic visit or HIV medicine once. Preserve outreach, transport, interpretation, Ryan White support, maternal and child health work, vaccination infrastructure and outbreak response. Price replacing each service before ending a grant.
Special populations and liabilities	Review CHAMPVA family claims, federal custody outside-hospital bills and occupational disease claims individually. Keep earned benefits, on-site custody staffing, security and responsible employers' liabilities. Tribal participation in shared purchasing requires agreement.
Federal missions and emergencies	Keep military deployment and overseas care, VA direct services, treaty obligations, biomedical research, surveillance and disaster response funded. Common purchasing can save money only where service, quality and delivered cost support it.

Basic Health Program · State innovation waivers · Title V maternal and child health · Federal black lung benefits

A $100 million transfer can produce a $1 million saving

Suppose an agency pays $100M for care and $6M to administer it. The Trust pays the same $100M for care, spends $3M administering it and spends $2M on conversion. Spending falls from $106M to $105M in year one and to $103M thereafter. That saves $1M, then $3M a year, if care and other payers' costs hold steady. This is an illustration.

Net insurance savings are $170B in planning or $131B in stress. Losing half adds $85B or $65B to annual national spending. Price reductions, administrative work eliminated and cash captured by the Trust are reported separately.

How quickly a patient should receive care

§ 606 Completed care and patient choice

The §603 limits of 15 business days for a routine primary care offer and 30 for a routine specialist offer remain individual protections. Each regional purchaser shall also contract for the following service levels. An earlier clinical deadline always governs. The percentages below are proposed targets to price and test before a final vote.

When a patient needs care	What the region must provide and measure
Emergency or urgent illness	Immediate emergency assessment when clinically indicated. For an urgent outpatient request, a licensed clinician assesses the patient that day and arranges care within the safe interval. A callback alone does not complete a visit.
Prompt primary care	Aim for 90% of patients requesting prompt primary care to complete a clinically appropriate visit the same or next calendar day. Include new patients and weekends. Count phone or video only when clinically appropriate and the patient accepts it.
Routine specialist care	Aim for 90% of patients seeking a routine first consultation to complete it within 10 business days of the original referral or direct request. Offer the first qualified available clinician. Patients may keep their preferred clinician and place.
Elective treatment	Pilot a 90% target within 60 calendar days from the decision to operate for medically ready patients who want routine primary hip or knee replacement. Set condition-specific deadlines for other treatments. Publish the full referral-to-treatment wait as well.

When the first clinician is booked

At the first sign a patient will miss a safe or statutory deadline, the regional office owns the booking. Offer a specific date with a qualified, reachable provider, including across a state line when lawful. Cover care, necessary travel, lodging and disability accommodation. A patient may decline or wait for their chosen team. A new referral, insurer change or provider cancellation cannot reset the original clock. Give the patient a named contact. Confirm the alternative or escalate to the regional medical director within one business day, sooner when clinically necessary. The §604 ombudsman may order booking and payment.

Publish monthly results for every region, including people without an established practice. Separately show people who chose to wait, clinical deferrals, patients still waiting and those lost to follow-up. Record actual dates, original deadlines and any clinical change. Audit unexplained removals and repeated offers patients cannot reach.

OECD evidence on wait guarantees | Referral-to-treatment measures

How regions would buy enough care

§ 607 Staffed capacity before regional conversion

Before each cohort moves, publish eight weeks of local requests, completed visits and procedures, cancellations, vacancies and waiting-list age by service and urgency. Estimate added demand when patients no longer face out-of-pocket charges, including the §303 test of 10% higher use of newly covered services. Show seasonal peaks, current queues and absences. Obtain dated, funded commitments from named providers for the first 90 days and a recurring staffing plan.

Staff the first point of contact. Pay primary care teams to reserve same-day slots and cover evenings and weekends. Sustain continuity and scheduled chronic care. Use nurses, nurse practitioners, physician assistants and pharmacists within scope, with physician backup. Fund rural rotations, retention, supervision and training under §405. Count residency places as future supply. If the Medicare benchmark cannot recruit the team, publish a targeted, time-limited supplement with staffing and service obligations.

Buy the whole episode. Offer pooled referrals by urgency to patients who want the first qualified team. A Winnipeg evaluation found smaller differences between surgeons' waiting times after central intake. Purchase additional procedures from qualified public, nonprofit or private providers on equal patient terms. Verify surgical, anesthesia and nursing rosters, diagnostic slots, recovery beds, rehabilitation and discharge support. Add the bottleneck first. Reconcile extra sessions against hospital budgets and neighboring providers' rosters to prevent double payment or losses elsewhere.

Size the contract from the queue. In an illustrative region, 200 new routine cases arrive each week and 180 finish. A contract for 20 more completions a week only stops the list from growing. To clear 600 excess cases in 20 weeks, the region needs another 30 completions a week, or 230 total. After clearing the excess, it still needs 200 a week plus a funded plan for surges.

Act before the queue becomes a backlog. Update the queue weekly. If it grows over four consecutive weeks, or a safe deadline is at risk sooner, use contracted extra sessions or regional referrals immediately. For repeated misses, publish the staffing, price or facility correction within 30 days. If a region fails the independent capacity test, retain its paid bridge administrator under §804 and activate backup capacity. Covered benefits and patient remedies start on schedule.

U.S. primary care workforce | Winnipeg pooled referral evaluation | CIHI on discharge capacity

What faster access could cost

Price the service levels in §§606–607 against both §810 payment designs before setting tax rates. Use local bids for net new staff, shifts, retention, diagnostics, transport, beds and discharge care. Deduct work already included in base budgets. Keep the rural and receiving-hospital allowance available for its intended purpose.

Extra annual spending in 2034	2034 U.S. savings, planning	2034 U.S. savings, downside	2051 employer rate in financing test
$0B	+$107B	−$253B	17.06%
$25B	+$82B	−$278B	17.24%
$50B	+$57B	−$303B	17.42%
$100B	+$7B	−$353B	17.78%

The first row includes $83B / $165B for access sessions, $113B / $153B for rural and receiving facilities, and $31B for other capacity in each case. Additional purchases here exceed all three lines. Regional bids and filled shifts determine the final price.

Hold wages to 4% growth. The rate column uses planning delivery, 5.5% medical cost growth, 95% collection and extra reserve funding. Extra services earn no savings credit.

What would justify calling the system world-class?

Judge speed alongside outcomes. Publish median and 90th-percentile waits, missed clinical deadlines, unfilled shifts, primary care continuity and emergency boarding. For each service, show risk-adjusted complications, readmissions and mortality where meaningful, plus patient-reported recovery. Break out rural, low-income and disabled patients. Compare each region with leading U.S. systems and international peers using the same service, start date, denominator and case mix. Publish patient choice separately. A faster list with poorer recovery fails the test.

Require an independent regional access and cost report before conversion, followed by quarterly public review. If the bids exceed the modeled allowances, §803 must show what pays for the gap and §306 requires the revised financing and access tests before a final vote.

Questions about getting care

- **“Will I wait like Canadians do?”** No. Canada’s provinces set targets but give the patient no remedy when a wait runs long. Only 26% of Canadian adults could get a same- or next-day appointment in 2023, against 43% in the U.S. and 54% in the Netherlands, which also covers everyone. Denmark guarantees treatment within a month and sends the patient to another hospital at public expense if a region misses it. Waits fell. Here a regional office must book and pay for another provider before a deadline is missed. (§§603–604.) Same-day access by country · OECD on wait guarantees

- **“Don’t Americans already get care quickly?”** Less than people assume. The average wait for a new-patient physician appointment in 15 U.S. metro areas was 31 days in 2025, up from 26 in 2022. In 2025, 26% of adults skipped care because of cost and 26.7 million had no insurance all year. A wait that ends in no care appears on no waiting list. The bill’s limits are 15 business days for routine primary care and 30 for a specialist, for everyone. (§603.) U.S. appointment waits · U.S. household survey · Census coverage report

- **“Does everyone in Europe wait months?”** No. In 2024 the median time already waited for a hip replacement was 67 days in Spain and Sweden and 667 in Slovenia. Countries that enforce deadlines do better. England cut median waits for hip, knee and cataract surgery by more than half between 2000 and 2008 with targets and penalties. The bill uses the same tools. (§§603–606.) OECD waiting-time results · OECD on wait guarantees

- **“Do Canadians come here and pay cash for surgery?”** Some cross the border, and often their public plan pays. When British Columbia ran short of radiation capacity, the province paid for 1,107 patients to be treated in Washington by April 2025 while it added capacity at home. That is a public plan buying extra care to meet a deadline, which §604 requires here. B.C. patient count · BC Cancer coverage

- **“Will doctors quit or stop taking patients?”** The record says no. Only 1.2% of non-pediatric physicians have opted out of Medicare, and 89% accept new Medicare patients against 91% for private insurance. Doctors paid mostly by private insurers, at about 129% of Medicare, would earn less per visit. They would also be paid for every patient, including those Medicaid covers today at about 75% of Medicare. (§§404, 502.) Medicare opt-outs · New-patient acceptance

- **“Will my hospital close?”** The 2034 planning allowance buys $18B in rural coverage and $95B in receiving capacity. Regions must document a staffed shift and an accepting team. If a rate step puts essential care at risk, the region pays the verified gap or activates a staffed alternative. Hospitals must demonstrate savings and continued access. (§§401–402, 819, 829–830.) Rural hospital closures

- **“What if I still can’t get an appointment?”** Then the plan must act. A regional office books a specific date with another qualified provider and pays for travel, and an ombudsman can order it. The bill budgets $83 billion a year for extra evening, weekend and shortage-area sessions and 5,000 new primary care residencies a year. CBO warns that demand can outrun supply when care is free, so capacity is funded and tested before each region converts. (§§604, 606–607, 826.) CBO supply and demand analysis

Questions about patient rights and public money

- **“Would there be death panels?”** No. Patients and their treating teams choose among medically appropriate options, including continuing life support or choosing hospice, and no coverage official can order either. No denial may rest on age, disability or a spending target. Only a named clinician can deny care, and a different clinician decides an urgent appeal within 24 hours. (§§103, 812–814.)
- **“Is this a government takeover of medicine?”** No. The plan pays the bills. It does not employ your doctor or own your hospital. Any qualified provider can join, and you can change doctors whenever you like. Your treating clinician orders routine care without asking the plan first. (§§502, 812.)
- **“Will my taxes go up?”** You pay a contribution in place of premiums, copays and deductibles. A household pays 6% of income above $30,000 single or $60,000 joint, plus $5,000 per dependent. A family of four earning $150,000 takes home $38 more a month than today. A single worker earning $100,000 takes home $252 less and never pays a medical bill. Employers pay 12% of payroll in place of premiums. (§§202–204.)
- **“Who qualifies if they are undocumented?”** Full benefits require U.S. residence and a qualifying legal status. Undocumented residents receive only emergency care, vaccinations and treatment for communicable disease, which protects everyone’s health. Hospitals must already treat emergencies under current law. Each child qualifies on their own status. (§§101, 105–110.)
- **“With $40 trillion of debt, how can we afford it?” At 4% medical growth, with the hospital allowance and academic budget, the Trust pays $1.05T by 2041 and $4.52T by 2051. Paying the full tested hospital shortfall leaves zero in 2041 and $1.45T–$1.76T in 2051. At 5.5% growth and a fixed 12% employer rate all tested paths pay zero. (§§803, 816, 829–832.)** Treasury debt series
- **“What happens to people who work in insurance?”** Their jobs end, and the bill says so. A displaced insurance or billing worker gets up to two years of wage replacement, retraining and first preference for the plan’s own jobs. CMS projects private insurers will keep $300 billion of $2,678 billion in premiums in 2034, about 11 cents on the dollar. The plan budgets 3 cents for administration. (§818.)
- **“Won’t lower drug prices stop new cures?”** The bill pays more for a drug that works better than existing treatment, which rewards real advances over copies. It funds a $10 billion a year research and prize account. A needed drug that cannot be bought at the negotiated price is still supplied while the price is reviewed. (§§505, 824, 826–827.)
- **“What if the government runs it badly?”** The bill plans for failure. GAO estimated $57B in improper Medicare payments and $37B in Medicaid in FY2025. Each region is tested before the plan takes it over, and the existing payer stays on as a paid bridge if it fails. An independent ombudsman can order a booking or a payment, and GAO audits waits, denials, closures and spending every year. (§§604, 804, 807.) GAO payment audit

Financing if medical costs grow 5.5% a year

The 5.5% medical stress uses planning delivery, a 12% employer starting rate and 6% base household contribution. Payroll and gross savings grow 4% after 2034. The employer supplement is recalculated from the first full operating year.

What closes the gap

At a fixed 12% employer rate the 2051 deficit including interest is $2.21T. The separate §803 supplement begins in 2038, reaches 17.06% in 2051 and collects about $1.74T beyond the base that year. Both estimates include §831 and the $113B hospital allowance. Household rates stay the same. There is no §816 payment.

What employees and employers see

Monthly paycheck line	Single, $100,000	Joint, $150,000[1]
Gross monthly wages	$8,333.33	$12,500.00
Employee premium today → plan	$139.33 → $0	$622.58 → $0
Household charge today → plan	$0 → $350.00	$0 → $400.00
Other federal withholding today → plan	$1,693.69 → $1,735.00	$1,683.32 → $1,867.92
Direct deposit today → plan	$6,500.31 → $6,248.33	$10,194.10 → $10,232.08
Employer health payment today	$677.67	$1,736.00
Employer at 12% → 17.06%	$1,000.00 → $1,421.67	$1,500.00 → $2,132.50

[1] Joint example assumes one earner and two qualifying children. At fixed wages, the 17.06% employer rate raises monthly employer cost by $421.67 for the single worker or $632.50 for the family. Household withholding is unchanged at those wages.

What a 5.5% tax would mean

A 5.5% household rate would deduct $320.83 and $366.67 a month in these examples. At 4% the deductions are $233.33 and $266.67. Growing all tax receipts by 5.5% annually is a different policy. It would add about $1.86 trillion in 2051 relative to 4% annual growth from the same 2034 base. With incomes growing 4%, achieving that yield requires legislation that increases effective rates or broadens the base. The estimate assumes collections keep pace. Congress should obtain an independent tax score before relying on it.

The 5.5% medical trend is a stress assumption. Negotiated rates lower the price of covered care. Patient numbers, services per patient, new treatments and the cost of staffing hospitals can still rise. Publish each factor, actual net medicine prices and completed-care waits annually.

2034 national spending and Trust cash

Positive entries reduce spending. Negative entries buy additional care, operations or benefits. Annual nominal $ billions. CMS current law is $8,970.3B. Government spending can rise as the Trust assumes payments now made by employers and households.

Source or use	Planning assumption and downside alternative	Planning	Downside
Displaced private insurance overhead	$300B private base × 75% / 65%	+225.0	+195.0
Public operating administration	3% / 4% of all-in transferred commercial spending	-55.2	-64.4
Hospital commercial reductions	Facility-specific price path under §819; bridge funds charged below	+325.7	+239.6
Commercial professional reductions	$809.7B × 60% / 50%, moving from 129% / 118% of Medicare	+109.2	+61.8
Net commercial retail drug discounts	$291.3B × 65% / 55% × 35% / 20%; verified net discounts only	+66.3	+32.0
Medicaid facility rate increases	$441.6B × 65% / 75% lifted from 90% / 85% of Medicare	-31.9	-58.4
Medicaid clinician rate increases	$193.1B × 60% / 65% lifted from 75% / 71% of Medicare	-38.6	-51.3
Rural ER and receiving facilities	$18B + $95B / $21B + $132B	−113.0	−153.0
Other essential capacity	$31B in either case	-31.0	-31.0
Additional sessions and staffing	U.S. workforce and wage assumptions	-83.0	-165.1
Other newly used care	3.8% / 5.4% of $4,602B hospital/clinician spending less purchased sessions	-91.9	-83.5
Dental, vision and hearing	$55B for increased use	-55.0	-55.0
Better outcomes, §§820–826	$100B including $45B obesity medicine. $30B one-time record build falls in 2029–33.	-100.0	-100.0
Academic missions, §831	Net awards after equivalent payments. See academic cost schedule.	−20.0	−20.0
Net national saving	Gross reductions less all costs	+106.7	−253.3
Incremental Trust cash	90% / 75% of gross reductions less 100% of costs	+34.0	−385.4

National spending is 1.19% below current law in 2034 in planning. Section 104 has a separate risk-adjusted per-resident test in the fifth full year. Cash reaching the Trust and changes in clinical resources are reported separately.

CMS projections · CBO commercial prices · Medicaid hospital rates · CMS first negotiated prices

Can insurance overhead fall by $189 billion?

The original estimate took 30% of the projected $630.7B national nonmedical insurance category. CMS includes administration, reserves, taxes and underwriting gains or losses. The entire category cannot be treated as removable operating work.

CMS projects $2,678.4B in private health insurance spending and $2,378.4B in private insurance medical benefits. Their $300.0B difference provides the starting base. The remaining $330.7B in the national category receives zero credit here. Separately reported public administration ($101.5B), provider billing time, projected fraud recoveries and additional Medicare Advantage savings also receive zero credit.

Test	Private amount displaced	New administration	Net reduction
Weak delivery	65% = $195B	4% = $64.4B	$130.6B
Planning	75% = $225B	3% = $55.2B	$169.8B
Favorable sensitivity	85% = $255B	2% = $41.3B	$213.7B

Apply the same transition share to private benefits and overhead. If administration is q of new all-in costs, replacement cost equals transferred benefits × q ÷ (1 − q). At 3%, $189B needs about 83.5% displacement. At 75% displacement it needs administrative cost at about 2.0% or less. Existing public administrative functions stay funded.

CBO modeled administration at about 1.5%–1.8% of total spending under its single-payer options. Its population and scope differ from the transferred private block here. A U.S. employer-plan study reports median administrative spending of $599 per person in fully insured plans and $285 in self-funded plans. Bringing above-median state markets down to the median yielded about $10B across the two commercial segments in 2023 in that study. A $170B national-plan result requires a much deeper change. NAIC reported a 0.4% 2025 profit margin for health annual-statement filers. Profit alone cannot produce $189B.

What Treasury must verify

Match covered lives, contracts, claims and member-months. Identify the stop date for broker fees, marketing, underwriting and network expenses. Retain claims payment, enrollment, appeals, fraud control, data security and regional bridge contracts. Reconcile premium taxes, reserve releases and underwriting margins as transfers. Count true resource savings separately. Measure paid runout and public operating bids before committing cash.

CMS definitions · CBO assumptions · Employer plan study · NAIC 2025 statements

Facility financial test of the $353B proposal

NASHP's 2024 hospital cost tool and the CMS provider cost reports supply facility financials. The 50-state/DC inventory has 4,468 hospital records. Of these, 4,172 have a unique facility ID, a 330–400-day fiscal year and usable patient revenue, expense and commercial data. Exact-year cash days could be computed for 2,116 of those records. Missing observations carry zero cut. Values below use FY2024 dollars × 1.03^{10} with no national extrapolation.

Annual 2034 gross commercial reduction, $B	Planning	Downside
Old national price calculation	353.0	254.2
Facility-specific price and commercial revenue; before safeguards	325.7	239.6
Capped by each hospital's positive operating headroom	68.8	48.9
After protecting ER and transfer network, before cash test[1]	28.2	19.0
After usable cash ≥45 days; conditional reduction	3.7	2.3
Facilities with conditional reductions	71	37

[1] Remove hospitals with unmatched ER status. Downside also requires observed price data. NASHP commercial operating profit divided by its matching margin estimates commercial receipts. Require a positive result ≤ net patient revenue. Use facility RAND prices where available. Otherwise planning permits a cost-report proxy, (1 − Medicare margin) ÷ (1 − commercial margin). The proxy contributes $0.66B. Cap ratios at 215% / 180% and affected shares at 75% / 65%.

Limit each cut to the lesser of the modeled commercial price reduction and net patient revenue less 102% / 105% of all operating expenses. Thus the facility keeps a 2% / 5% cushion on expenses. Exclude protected facilities entirely. Count no uncontracted efficiencies, system profits or public subsidies as headroom. For cash, use cash and temporary investments over operating expense excluding depreciation per day. Cash held centrally can make the screen conservative. An annual report cannot establish future debt coverage, employment or staffed beds.

The $325.7B planning price reduction initially left $124.87B of assumed operating-cost reductions after $68.84B of margin and $132B of prior capacity funding. The facility audit supports $8.78B against mapped gaps. Keep the remaining $116.09B conditional. The extra $12B for receiving capacity overlaps only where records identify the same need. Section 829 pays verified obligations; §830 requires operational evidence before savings enter §816.

NASHP Hospital Cost Tool · CMS cost reports · RAND facility prices · MedPAC March 2026 hospital evidence

Funding both ends of a rural transfer

Protect rural hospitals with ERs, including critical-access sites, and the largest three nonrural ERs by beds per referral region containing a rural ER. Add U.S. hospitals with ERs designated rural referral centers, linked California receivers and the University of Iowa hub. Count each CCN once. Federal rural-referral designations add 278 sites beyond the older 2,746-facility network. Some destinations are proxies; a nationwide origin–destination file has not been established.

2034 annual funding	Rural planning	Receiver planning	Rural stress	Receiver stress
Matched facilities	2,065	886	2,065	886
Financial inputs missing	46	27	46	27
Measured gap, $B	11.5	83.3	18.4	116.0
Missing sites at group mean, $B	0.3	2.5	0.4	3.5
10% contingency, $B	1.2	8.6	1.9	12.0
Allowance with prior floors, $B	18	95	21	132

Price 100% of modeled activity at each facility's local Medicare payment-to-cost ratio. Preserve a 2% operating cushion, compare a 5% expense shock, estimate missing sites at the matched group mean, then add 10% contingency, apply prior floors and round up to whole billions. These whole-hospital estimates require service-specific validation. The historical 85% pricing table is retained for comparison.

The ordinary measured gaps are $11.5B rural and $83.3B receiving. Floors and uncertainty bring the allowance to $18B and $95B. The stress estimates total $153B, compared with the earlier $140B. Critical claims above the allowance are reconciled under §829.

Historical 85% pricing examples. The University of Iowa is a named network hub. Its modeled gap is $142M in 2034. California's 2021 published cells identify 730 incoming transfers at Mercy General, which shows a $52M gap. Those cells do not identify rural origin. UC Irvine's FY2025 statements report 41 cash days and 1.5× debt service coverage. A 20% fall in available earnings at unchanged debt service would leave 1.2×. Real transfer logs, specialty rosters and lender schedules determine the local decision.

University of Iowa network · California transfers · University of California FY2025 statements · CMS hospital cost reports

What the 12% contribution finances

Schedule B at a fixed 12% employer rate, 4% payroll growth after 2034. The medical growth column compares actual spending paths. The 4.5% case spends the full allowance under §828. Where 12% leaves an operating gap, the rate columns show the §803 supplement. National health spending, Trust cash and Treasury debt transfers are distinct measures.

Delivery / medical growth	Debt to 2041, $B	Debt to 2051, $B	Extra employer tax to 2041, $T[1]	Rate in 2041	Rate in 2051
Planning / 4%	1,049	4,520	0.00	12.00%	12.00%
Planning / 4.5%	391	615	0.00	12.00%	12.64%
Planning / 5.5%	0	0	0.52	13.12%	17.06%
Downside / 4%	0	0	1.72	13.05%	13.05%
Downside / 4.5%	0	0	2.44	13.90%	15.16%
Downside / 5.5%	0	0	3.94	15.67%	19.89%

[1] The rate columns include any §803 operating supplement. Debt columns hold the employer rate at 12%. With both budgets, transfers through 2041 are $1.049T at 4% growth, $392B at 4.5% and zero at 5.5%. Downside delivery includes the $153B facility allowance. Extra receipts use the published mature-period model.

With the academic budget, a full half-point growth allowance reduces cumulative transfers in 2051 from $4.52T to $0.61T. The 2051 employer rate needed for operations is 12.64%. Earlier transfers can precede later borrowing.

The cash ledger preserves the prior wider-transfer tax base, worker and small-employer programs, state transfers, reserve and 4.5% interest on opening advances. The 0.5-point base-rate increase uses collectible wages and enrollment with applicable small-firm credits. Clinician fee, drug price and insurer overhead reductions begin with enrollment. Hospital reductions phase in over 2030–33. New benefits and staff begin with enrollment. Add $6B annually in 2029–33 for the shared record and $100B recurring for §§820–826, plus $20B for §831 at maturity. Count the dental and home-care provisions once. No speculative future health savings enter receipts.

At 4% growth, the new allowance-only schedule clears advances in 2037. At 5.5% the fixed-rate balance owes about $0.89T in 2041. These are statutory Trust transfers. An independent federal budget score must also cover taxes, states, interest and public employers.

State payment options and evidence for other savings

Section 817 reallocates the national assessment over five years. The table tests federal replacement of state receipts on top of that change, including the $20B academic budget. The first row assumes full collection.

Federal share of state payment assumed	Added 2034 cost, $B	2041 employer rate	Extra employer receipts to 2041, $T	Debt to 2041, $B
0%	0	12.00%	0.00	1,049
10%	46	12.00%	0.00	438
25%	114	12.00%	0.00	0
50%	228	12.00%	0.00	0

The national pool is held constant. A state that pays less is matched by others that pay more. The study under §832 must show each jurisdiction's liability, its ability to pay and the cost of any federal relief.

Why the other savings estimates remain conditional

CBO's review found the average private physician price was about 129% of Medicare. Medicaid's 2024 physician-fee survey measured 75% of Medicare for the original service basket and 71% for its updated basket. Medicaid managed-care contracts and hospital supplemental payments require separate reconciliation. Rates for commercial clinical and retail drug care remain assumptions on affected shares. Facility-administered drugs receive no separate retail discount.

The insurer stress test uses a $300B commercial base. It credits no extra Medicare Advantage payments, insurer profits, fraud, provider billing or federal-program transfers. CMS's initial 22% net drug savings comparison was for ten selected Medicare products. It does not establish a national commercial discount. Drug rebates in §827, launch repricing and the foreign-price ceiling support a $66.3B planning assumption, a 35% net discount on the affected commercial retail spending. Stress uses 20%. Verify actual net prices, offsets and volume before committing cash.

At maturity $325.7B in commercial payment reductions less $113B for the emergency network, $31B in other capacity and $31.9B in higher Medicaid hospital payments gives a $149.8B net payment reduction. In stress, $239.6B less $153B, $31B and $58.4B gives a $2.8B net payment increase. Deduct overlapping service payments at each facility. These payment changes are distinct from the operating efficiencies in §830.

CBO commercial physician and hospital prices • Medicaid physician fee survey • MACPAC hospital payment methods • CMS net drug comparison

Six cost controls and how to evaluate them

Drug clawback, §827. Collect a common share of a net branded-drug overrun. Reconcile existing rebates, shortages and paid units. Show actual net cash before claiming an additional saving.

Benefit-based launch pricing, §§505, 824 and 827. Price added benefit against the best alternative, revisit the price as evidence matures, and preserve patient-specific supply. The $66.3B / $32.0B retail drug reductions cover both drug tools.

Targeted fee adjustments, §828. Audit codes, patient mix, volume and waiting lists. Apply supported adjustments prospectively and publish clinical and access effects.

Supply expansion, §§405, 607, 826 and 828. Buy filled shifts and completed care, protect rural staffing and measure retention. Reconcile $83B / $165B in service purchases with the separate workforce training accounts.

Floating elective fees, §828. Use a controlled three-year pilot, bounded annual adjustments and a comparison group. Protect rural standby, shortage services, primary care and emergencies.

Measured aging, §828. Allow up to 0.50 percentage point beginning in 2035. Release only measured cost above baseline; reconcile it annually. The financing table shows the cost if the allowance is fully spent.

International examples inform the mechanism. U.S. evidence illustrates the limits of a spending target. Maryland's independent evaluation estimated $689M in net Medicare savings during 2019–21. Rhode Island's 2024 statewide spending rose 9.1% against a 5.1% benchmark. Spending targets still require operational enforcement, clinical evidence and workforce capacity.

UK branded-drug rebates • German benefit assessments • Japanese fee revisions

U.S. primary care workforce • Taiwan sector budgets • CMS projections • Maryland evaluation • Rhode Island spending

Hospital operating costs and estimated savings

The four-step hospital conversion reaches its final rate in 2033. This schedule expresses recurring costs at 2034 prices. It uses $1.751T in projected operating expenses across the 4,172 hospitals with usable pricing records. Spending bases are estimates. Execution rates are assumptions to test against payroll, contracts, invoices and service records.

Measure	2034 base	Operating assumption	Annual change
Billing	$14.64B	Eliminate 40% of patient accounting and payer rework.	$5.86B
Collections	$2.94B	Eliminate 70% of the cost of collections.	$2.06B
Admitting and registration	$14.94B	Eliminate 8% for insurance checks. Keep clinical intake and overnight coverage.	$1.20B
Management payroll	$29.92B	5% target subject to observed peer and facility caps.	$0.73B
Supplies and devices	$183.87B	Rebid half at a 2% lower price for the same supplies. Exclude drug savings.	$1.84B
Agency staffing	$28.05B[1]	Rebid one-quarter at 3% lower agency rates with equal shifts and pay. Credit other sites only.	$0.06B
Implementation and upkeep	10% of gross	Deduct ongoing and conversion costs. Reconcile actual invoices.	−$1.17B
Net hospital savings		After implementation costs.	$10.56B
Applicable to funding gaps		Limited to the remaining gap at the hospital delivering the saving.	$8.78B

[1] The $28.05B base covers all 2,517 sites with usable contract spend and hours. The protected-site exclusion reduces the original $0.21B staffing estimate to $0.06B. The prior central screen yielded $10.70B net and $8.88B applicable before this exclusion. Totals use unrounded inputs.

The hospital expense shares use FY2024 filings from 289 California general or children's hospitals reporting $167.83B of operating expense. Patient accounting, collections, registration and hospital administration use separate accounts. National management savings are capped by observed management payroll above the median for comparable hospitals. The projection uses 3% annual inflation for ten years. California accounting and outsourcing can differ from other states.

Source records: California hospital financial filings NASHP hospital cost data CMS cost reports

Where the savings can meet a payment gap

The hospital pricing screen has 4,468 facilities. The access network has 2,111 rural ER sites and 913 receiving sites. Sufficient financials exist to price support at 2,951 of these sites. The stricter commercial-price test has 4,172 usable records across all three groups. These counts describe different stages of the analysis.

Priced group	Sites	Net savings $B	Applicable $B	Sites with gap	Gap closed
Rural ER	2,000	1.21	0.93	1,289	32
Receiving	868	6.17	5.11	664	12
Other	1,304	3.18	2.74	1,060	15

Site gaps use full Medicare pricing and estimated rural or receiving support where measurable. Four priced sites lack matched support inputs. Other-capacity funds, individual Medicaid offsets and bridges are reconciled when awarded. A dollar earned at one hospital can close only a gap the Trust can actually avoid. This schedule does not certify safe delivery at any named site.

Original efficiency sensitivity before protected staffing was excluded

Annual $ billions	Cautious	Central	Aggressive
Gross operating savings	5.19	11.89	19.82
Implementation and upkeep	1.04	1.19	0.99
Net hospital savings	4.15	10.70	18.83
Applicable to measured gaps	3.47	8.88	15.54

From cautious to aggressive, billing reductions are 20–60%, collections 50–85%, registration 0–15% and distinct management payroll 2–10%, subject to the facility peer cap. Supply contracts reach 25–75% of spend at 1–3% lower prices. The original agency test reaches 10–50% at 1.5–5% lower rates. Holdbacks for implementation range from 20% to 5%. Only the protected-site central estimate of $8.78B is used in the merged scenarios.

A separate historical broad-administration test assumes half of an estimated billing-and-insurance cost pool can be removed. Using 6.6%, 8.5% or 10.8% of revenue for that pool gives net savings of $52.9B, $67.6B or $85.4B. These tests replace the narrow administration lines and include the prior staffing assumption. They receive no additional savings credit.

Evidence: Hospital purchasing study Billing and insurance cost study Cross-country billing study

Hospital bridges and payments toward publicly held debt

Each current row includes $20B in §831 academic awards above the specified hospital support, at 2034 prices. The first row is the historical v3 comparator without either amendment. The added-$B column includes both increments above pre-merge v3. Debt columns show §816 transfers at fixed 12% employer and 6% base household rates with 4% medical growth after 2034.

Assumed bridge spending	Added $B	First payment	Paid by 2041 $T	Paid by 2051 $T
Pre-merge v3	$0.00	2037	$1.46	$5.41
Hospital and academic allowances	$32.00	2038	$1.05	$4.52
Half the residual funded	$84.05	2040	$0.42	$3.12
Full exposure, same need	$136.09	2043	$0.00	$1.76
Full exposure, separate need	$148.09	2044	$0.00	$1.45
Zero verified, separate need	$156.87	2045	$0.00	$1.19

The partial case applies the $12B first and pays half of the remaining $104.09B. Full overlap means the $12B pays for the same services as part of the $116.09B exposure. Separate need means it pays for different services. The last row also assumes that none of the $8.78B is delivered. The hospital allowance row with academic funding assumes no further net bridge awards. Actual awards require a service-level reconciliation.

Medical growth sensitivity at a fixed employer rate

4.5% medical growth	2041 paid $T	2051 paid $T	2051 advances $T
Hospital and academic allowances	$0.39	$0.61	$0.46
Half the residual funded	$0.00	$0.00	$1.65
Full exposure, same need	$0.00	$0.00	$3.94
Full exposure, separate need	$0.00	$0.00	$4.47

At 5.5% medical growth and fixed 12% receipts every bridge scenario transfers zero through both dates. The operating supplement is modeled separately. Spending phases in at 25%, 50%, 75% and 100% from 2030, scaled to each year's price level. After 2034, it grows with the tested medical trend. Apply the incremental 60-day reserve, 4.5% interest on opening advances and the §816 timing rule before transfers. These are estimates of Trust cash. A unified federal budget score remains outstanding.

Pre-merge v3 background tables

2034 spending and receipts. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Annual health spending and the original access allowance

Annual amount, $ billions	Planning case	Downside case
Net national savings	+$139	−$220
National health spending	$8,832	$9,191
Rural hospital support	$18	$20
Receiving hospital support	$83	$120
Total hospital access allowance	**$101**	**$140**

Transferred costs and financing options

Financing option	New receipts	Planning Trust cost	Downside Trust cost
8% employer, first draft (withdrawn)	$2,543	−$349	−$767
10% employer, first draft (withdrawn)	$3,289	+$397	−$21
Schedule A: 14% / 4%	$3,760	+$868	+$450
Schedule B: 12% / 6%	$3,761	+$869	+$451
Schedule B, wider transfer	$3,761	+$590	+$172

Pre-merge v3 background tables

Startup and annual debt payments. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Annual Trust balances and debt payments

Year	Balance, limit holds	Debt payment	Balance, limit fails	Debt payment
2028	-36.4	—	-36.4	—
2029	-238.1	—	-238.1	—
2030	-264.9	—	-264.9	—
2031	-274.5	—	-274.5	—
2032	-51.3	—	-51.3	—
2033	+146.1	—	+146.1	—
2034	+234.6	—	+234.6	—
2035	+255.8	—	+194.8	—
2036	+278.4	—	+147.9	—
2037	+300.2	270.2	+93.2	—
2038	+312.2	281.0	+29.8	—
2039	+324.7	292.3	-43.1	—
2040	+337.7	304.0	-126.4	—
2041	+351.2	316.1	-221.1	—
Total paid	**—**	**1,463.6**	**—**	**0.00**

Pre-merge v3 background tables

Policy choices and long-run operating balances. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Employer rates and benefit choices

Option	Cost in 2034	Employer rate needed	Debt payments by 2041
Every section as priced, at 12%	—	—	1,464
At the earlier 11.5% rate	—	-0.50 points	211
Without obesity medication (§825)	-$45	—	2,014
Limit at wage growth plus half a point	—	—	703
Universal home care, if enacted now	$360	2.03 points	0

Long-run cash balances at fixed rates

Schedule B at fixed rates	2041	2042	2045	2051
Growth limit holds	+$351	+$365	+$411	+$520
Limit fails, costs grow 5.5%	-$221	-$328	-$736	-$2,073

Pre-merge v3 background tables

Cost curves and insurance sensitivities. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Yearly national spending against current law

Year	Current law $ trillion	Planning $ trillion	Downside $ trillion	Planning savings $ billion	Downside savings $ billion
2028	6.63	6.67	6.68	-39	-48
2029	6.97	7.08	7.18	-111	-208
2030	7.32	7.39	7.55	-65	-231
2031	7.69	7.73	7.97	-39	-280
2032	8.07	8.03	8.31	+38	-244
2033	8.51	8.41	8.74	+102	-225
2034	8.97	8.83	9.19	+139	-220

Insurance overhead and Trust capture sensitivities

Sensitivity, holding other inputs fixed	Result
Half the net insurance reduction materializes.	The 2034 planning saving falls from $139B to $54B. Stress spending rises $285B.
Trust collects 90%, 75% or 50% of gross cuts; all added costs are paid.	At 12% fixed, 2041 planning balances at 4% cost growth are +$351B, +$208B and −$121B.

Pre-merge v3 background tables

Employer rates and additional access costs. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Employer adjustment under alternative medical trends

Delivery / medical growth	Employer rate 2041	Employer rate 2045	Employer rate 2051
Planning / 4%	12.00%	12.00%	12.00%
Planning / 5.5%	12.92%	14.41%	16.82%
Downside / 5.5%	15.46%	17.06%	19.65%

Effect of buying additional access

Extra annual spending in 2034	2034 U.S. savings, planning	2034 U.S. savings, downside	2051 employer rate in financing test
$0B	+$139B	−$220B	16.82%
$25B	+$114B	−$245B	17.01%
$50B	+$89B	−$270B	17.19%
$100B	+$39B	−$320B	17.55%

Pre-merge v3 background tables

Earlier stress paycheck comparison. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Monthly paycheck and employer stress example

Monthly paycheck line	Single, $100,000	Joint, $150,000[1]
Gross monthly wages	$8,333.33	$12,500.00
Employee premium today → plan	$139.33 → $0	$622.58 → $0
Household charge today → plan	$0 → $350.00	$0 → $400.00
Other federal withholding today → plan	$1,693.69 → $1,735.00	$1,683.32 → $1,867.92
Direct deposit today → plan	$6,500.31 → $6,248.33	$10,194.10 → $10,232.08
Employer health payment today	$677.67	$1,736.00
Employer at 12% → 16.82%	$1,000.00 → $1,401.67	$1,500.00 → $2,102.50

Pre-merge v3 background tables

Underlying source and use ledger. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Itemized sources and uses in 2034

Source or use	Planning assumption and downside alternative	Planning	Downside
Displaced private insurance overhead	$300B private base × 75% / 65%	+225.0	+195.0
Public operating administration	3% / 4% of all-in transferred commercial spending	-55.2	-64.4
Hospital commercial reductions	Facility-specific price path under §819; bridge funds charged below	+325.7	+239.6
Commercial professional reductions	$809.7B × 60% / 50%, moving from 129% / 118% of Medicare	+109.2	+61.8
Net commercial retail drug discounts	$291.3B × 65% / 55% × 35% / 20%; verified net discounts only	+66.3	+32.0
Medicaid facility rate increases	$441.6B × 65% / 75% lifted from 90% / 85% of Medicare	-31.9	-58.4
Medicaid clinician rate increases	$193.1B × 60% / 65% lifted from 75% / 71% of Medicare	-38.6	-51.3
Rural ER and receiving facilities	$18B + $83B / $20B + $120B	-101.0	-140.0
Other essential capacity	$31B in either case	-31.0	-31.0
Additional sessions and staffing	U.S. workforce and wage assumptions	-83.0	-165.1
Other newly used care	3.8% / 5.4% of $4,602B hospital/clinician spending less purchased sessions	-91.9	-83.5
Dental, vision and hearing	$55B for increased use	-55.0	-55.0
Better outcomes, §§820–826	$100B including $45B obesity medicine. $30B one-time record build falls in 2029–33.	-100.0	-100.0
Net national saving	Gross reductions less all costs	+138.7	-220.3
Incremental Trust cash	90% / 75% of gross reductions less 100% of costs	+66.0	-352.4

Pre-merge v3 background tables

Emergency network, debt and state-payment sensitivities. These are the original comparison figures from 22 November 2026. The live fiscal schedules and §§829–830 govern this integrated bill.

Network funding at 85% Medicare pricing

2034 annual funding	Rural planning	Receiver planning	Rural stress	Receiver stress
Matched facilities	2,065	886	2,065	886
Financial inputs missing	46	27	46	27
Measured gap, $B	10.1	72.6	17.2	105.8
Missing sites at group mean, $B	0.2	2.2	0.4	3.2
10% contingency, $B	1.0	7.5	1.8	10.9
Allowance with prior floors, $B	18	83	20	120

Debt and employer contributions through 2051

Delivery / medical growth	Debt to 2041, $B	Debt to 2051, $B	Extra employer tax to 2041, $T[1]	Rate in 2041	Rate in 2051
Planning / 4%	1,464	5,411	0.00	12.00%	12.00%
Planning / 4.5%	703	1,148	0.00	12.00%	12.45%
Planning / 5.5%	0	0	0.38	12.92%	16.82%
Downside / 4%	0	0	1.41	12.87%	12.87%
Downside / 4.5%	0	0	2.13	13.71%	14.96%
Downside / 5.5%	0	0	3.62	15.46%	19.65%

State contribution alternatives

Federal share of state payment assumed	Added 2034 cost, $B	2041 employer rate	Extra employer receipts to 2041, $T	Debt to 2041, $B
0%	0	12.00%	0.00	1,464
10%	46	12.00%	0.00	755
25%	114	12.00%	0.00	0
50%	228	12.00%	0.00	0

Original hospital bill background tables

These two tables reproduce the original hospital companion before academic funding. The current hospital debt comparison appears under “Hospital bridges and payments toward publicly held debt”.

Operating cost schedule at 2034 prices

Operating measure	Basis for the central estimate	Gross $B
Patient accounts and billing	40% of estimated eligible costs	5.86
Collections	70% of collection expense	2.06
Admitting and registration	8% of expense for insurance administration	1.20
Management payroll	5% target, capped by a facility peer comparison	0.73
Supplies and devices	2% lower price on half of eligible spending	1.84
Clinical agency contracts	Comparable shifts at other hospitals only	0.06
Implementation and upkeep	10% of unrounded gross savings	−1 . 17
Net hospital savings	All 4,172 priced hospitals	10.56
Applicable to modeled gaps	Capped by the remaining gap at each site	8.78

Historical debt estimates at 4% medical growth

Bridge assumption	Added annual spending[1] $B	Paid by 2041 $T	Paid by 2051 $T
Bill 1 v2 alone	$0.00	$1.46	$5.41
Both bills, $12B allowance only	$12.00	$1.14	$4.91
Half of remaining exposure paid	$64.05	$0.69	$3.69
Full exposure, $12B overlaps	$116.09	$0.00	$2.22
Full exposure, separate $12B need	$128.09	$0.00	$1.87
No verified savings, separate $12B need	$136.87	$0.00	$1.75

[1] Additional annual spending above Bill 1 v2 at 2034 prices. Debt payments are cumulative nominal dollars. Each row uses the starting 12% employer contribution. The $12B allowance increase is counted once where it pays for the same service.

§ 831 Academic medicine and referral services

The Secretary shall execute a separate annual mission budget with each qualified teaching hospital. A regional purchaser shall identify which training programs, research infrastructure and rare services would lose support under §819. Before each rate step it shall contract for the approved work or publish a funded alternative. A prior commercial margin alone establishes no entitlement.

What each contract purchases

Teaching. Pay the full reasonable cost of an approved accredited residency or fellowship after other payments. Identify trainee-years, supervision, protected faculty time, salary and benefits. Reconcile Medicare direct and indirect GME, Medicaid and other payers, §401 teaching and §826 positions. Reconcile embedded indirect GME against the same training or standby cost only. Publish sites, specialties, positions filled and completion rates.

Complex care. Purchase staffed availability for transplant, level I trauma, burn and pediatric specialty teams. Qualified nonacademic referral centers may compete. Specify staffed hours, expertise, catchment, transfer acceptance, response times and outcomes. Separate routine case payments from readiness. Match each §401 or §829 shift and bed to its invoice before paying any residual.

Research. Reimburse allocable, documented facilities and administrative costs on approved federally funded projects, including shared laboratories and trial staff. Subtract the grant's actual indirect and direct recovery, sponsor support and any prior award. Exclude disallowed expenses, voluntary institutional cost sharing and costs already reimbursed through depreciation or a capital grant. Publish aggregate award, recovery and residual by institution.

New treatments. The §824 institute may grant lawful, time-limited coverage at accredited centers before a permanent billing code exists. Issue a temporary code and negotiated ceiling. Require FDA authorization or a lawful investigational pathway, independent ethics approval, informed consent, registration, safety monitoring, an active comparator where feasible, and a public evidence deadline within three years. On review, negotiate a benefit-based price, narrow coverage or end it. Provide appeals, patient continuity and safe transition.

Trials. Each eligible enrollee receives medically necessary routine care and complication treatment in a qualifying registered trial on the same terms as usual care. Record the trial ID. The sponsor pays for research-only tests and sponsor-supplied products. A distinct temporary authorization may pay the investigational item. Use §823 records only with lawful access, consent or an authorized waiver and privacy safeguards.

§ 831 Capital, accounts and enforcement

Capital. Award competitive grants for shared equipment, renovation and construction against a published regional need. Score clinical value, utilization, referral reach, alternatives, lifecycle cost and delivery risk. Use independent review, competitive procurement and milestone payments. Exclude acquisition of competing practices, ordinary refinancing and depreciation or debt service already funded for the same asset.

The Trust shall maintain six public accounts for teaching, referral availability, research infrastructure, temporary treatment coverage, trials and capital. Pay current claims for ordinary care from their existing accounts. Use the $95B receiving allowance only for contracted readiness that it already finances. Use the $10B §826 research and prize account only for existing, eligible awards. Cross-reference matched payments in both ledgers and charge the Trust once. The $5B workforce line continues to support the §826 commitments.

For additional §831 spending, appropriate the amounts in the central academic cost schedule, totaling $20B in 2034. Fund awards at 25%, 50%, 75% and 100% in 2030–33, adjusted to each year's price level using the fiscal schedule. Index subsequent awards within §§815 and 828. Contracts may commit only appropriated sums. Fully fund approved training commitments before awarding new places. Ordinary covered patient claims and verified §829 emergency obligations remain payable. Publish any excess need with a supplemental appropriation request and updated §803 and §816 estimates.

Limit awards to the named mission. Bar transfers for marketing, acquisitions, dividends or executive compensation. Require a public annual budget, independent cost audit, deliverables and a registry of overlapping awards. Publish filled posts, staffed hours, transfer refusals, studies enrolling and completing, safety events and capital milestones. Recoup duplicate or diverted payments with interest after notice and appeal. Protect active patients, trainees and essential services during corrective action.

Verified precedents

The Dutch regulator funds continuous personnel and infrastructure for advanced referral care. England awarded nearly £790M over five years to 20 NHS–university biomedical research centres. The German Science and Humanities Council documents separate state teaching and research subsidies in individual Länder. These arrangements support named contracts. Their budgets do not establish a U.S. price.

Sources Dutch availability rule • English research centres • German funding examples

§ 832 How the state benchmark works

For each state and D.C., Treasury shall identify state own-source Medicaid and CHIP spending on benefits the Trust actually assumes, using three pre-enactment audited years. Exclude federal shares, benefits and administration still paid by states, and duplicate amounts. Use the prior wage-indexed schedule, adjusted for actual benefit transfers and verified §902 credits, to calculate each jurisdiction's reference amount. Use the sum only to set the national pool. Calculate a separate assessment for each territory on its own reference schedule.

For year one, bill each state 80% of its reference amount plus 20% of its population-based amount. Increase the population weight by 20 percentage points each program year to 100% in year five. The population-based amount equals the national pool times the state's share of the latest Census resident population of the 50 states and D.C. During conversion, weight each state's residents by the fraction of its assumed benefit package transferred and normalize across the pool. If no benefits have transferred, no assessment is due. A resident is counted once. Residency for this formula does not confer benefit eligibility.

Use each jurisdiction's covered payroll growth to roll its reference amount forward from the audited base. Preserve the former aggregate financing path while it supplies the national pool. The federal government bears spending growth above that path subject to §§803 and 815. Publish the Census vintage, payroll factors, covered services, credits and monthly installments for every jurisdiction. Reconcile actual transfers annually. Correct errors with symmetric credits and debits. Allow 90 days for a state to appeal and collect undisputed amounts on time.

Enforce an unpaid assessment as a federal claim after notice and review. Allow offsets only against legally available amounts attributable to transferred services. Preserve funding for retained Medicaid benefits and every resident's coverage. Section 1935(c) of the Social Security Act is a narrower drug-contribution precedent. Before a vote, sponsors shall obtain legislative counsel's review of the assessment, collection remedies and fallback set out in the pre-vote review appendix. Report unpaid assessments separately from receipts, charge shortfalls to the cash forecast and calculate the §803 response before a §816 transfer.

Before implementation, Treasury and CMS shall publish all state and territorial estimates, including governments' capacity to pay, for independent review. Separately tabulate household and employer payments, provider spending, academic awards and federal receipts. A change in the state treasury assessment alone cannot establish a state's total fiscal position.

Academic medicine cost schedule

Annual incremental spending in billions of 2034 dollars. The priced units below are proposed purchases after other payers and existing budgets. The quantity and net price are planning assumptions. No national dataset identifies all unfunded missions. The central column is the statutory budget. Low and high columns test alternative award volumes at the same unit prices.

Mission	Central annual purchase at maturity	Low $B	Central $B	High $B
Training	40,000 trainee-years × $125,000 remaining cost	4	5	7
Referral readiness	200 distinct service contracts × $20M	3	4	6
Research overhead	300 eligible portfolios × $10M audited residual	2	3	4.5
New treatments	20,000 temporary courses × $100,000 net increment	1.5	2	3
Routine trial care	100,000 participants × $10,000 above usual budget	0.5	1	1.5
Capital	1,000 project installments × $5M disbursed	4	5	8
Total additional	Annual appropriations at 2034 prices	15	20	30

Training scale. ACGME counted 167,083 residents and fellows in 2024–25. Medicare paid about $22B for GME in 2023. HRSA's FY2025 teaching health center rate was $160,000 per FTE, about $209,000 by 2034 at 3% inflation. These populations overlap. Individual cost reports and awards must establish each residual. The $125,000 is a purchasing assumption.

Research and referral scale. NIH reported about $9B in indirect costs paid on competitive grants in FY2023 across all recipient types. That payment is an offset where attributable. HRSA counted 48,149 U.S. transplants in 2024. Procedure counts establish scale, not the annual price of keeping a specialty team available. Use audited rosters, time allocation and fully loaded local pay before award.

Sources ACGME trainee counts • GAO Medicare GME • HRSA per-FTE rate • NIH grant costs • HRSA transplants

Academic funding and debt payments

The Medicare FY2025 inpatient rule estimated $770M in new-technology add-ons. Its narrower population and scope give a reference point for the $2B all-payer temporary-treatment budget. Require bids and audited utilization before each award.

Trial and capital scale. NCI reports 20,000–25,000 participants per year in its treatment and advanced-imaging trial networks over the prior decade. The all-specialty purchase is a scenario. Use claims and sponsor budgets to isolate extra routine care previously outside the base. NIH's biomedical research construction program accepts $2M–$8M federal requests. Hospital capital uses different eligibility. Screen bids, project costs and milestone disbursements before issuing awards.

Sources CMS technology payment estimates • NCI trial enrollment • CMS routine costs • CMS coverage with evidence • NIH capital awards

Trust transfers toward publicly held debt, cumulative nominal trillions. Each row retains the $113B rural and receiving allowance, the fixed 12% starting employer rate and full state collections. No extra §829 bridge is assumed here. The hospital bridge table tests higher costs.

Added academic budget at maturity	4% growth by 2041	4% by 2051	4.5% by 2041	4.5% by 2051
$0B	$1.14	$4.91	$0.65	$1.00
$15B	$1.07	$4.62	$0.58	$0.83
$20B adopted	$1.05	$4.52	$0.39	$0.61
$30B	$1.00	$4.33	$0.36	$0.52

At 5.5% medical growth all four budgets yield zero debt transfers through 2051 at fixed rates. The central case adds $20B per mature year and sends $90B less by 2041 or $388B less by 2051 than the hospital-only bill. Spending starts with the rate reductions. Reserve deposits, 4.5% interest, loan repayment timing and the 90% transfer rule determine the cash outcome. The annual transfer varies with the year the Trust clears its loans.

For the displayed spending curve, the full appropriation is treated conservatively as added U.S. spending. The Trust must pay the full net award. Some awards may replace existing nonfederal support for the same staff or facility. CMS shall measure that displacement and distinguish new health resources from transfers and research or capital classifications in national accounts. No research payoff, faster enrollment, future cure or hospital closure avoided is booked as a saving.

What the state formula changes

FY2024 illustration for the 50 states and D.C. MACPAC reports $320.200B of state-financed Medicaid benefits. Dividing by 340,110,988 residents gives $941.46 per resident. This historical proxy includes some retained benefits and omits CHIP. The statutory bill uses three audited years of transferred services and updated populations. Figures below show state treasury payments, in billions, at a common price level.

Jurisdiction	Own spending	Year 1 blend	Full benchmark	Full change
Massachusetts	$10.92	$10.08	$6.72	−$4.20
Texas	$18.68	$20.83	$29.46	+$10.78
Florida	$14.64	$16.11	$22.00	+$7.37
California	$56.73	$52.81	$37.12	−$19.61
50 states + D.C.	$320.20	$320.20	$320.20	$0.00

Example. At that historical price, Massachusetts pays about $4.20B less annually at full phase-in and Texas pays $10.78B more. In year one Massachusetts pays about $0.84B less. The comparison holds the benefit pool and population fixed to isolate the formula. It does not predict academic awards to Massachusetts, benefits to its households or its overall net contribution.

Collection risk. The bill's mature state financing base is approximately $456B. Reallocation alone costs the Trust $0 if every assessment is collected. If 5% goes uncollected without replacement, the mature shortfall is $22.8B annually. At 4% medical and payroll growth, the central academic budget then sends $0.72T by 2041 and $3.86T by 2051. This test phases the missing receipts with enrollment and indexes them to payroll after 2034. Federal hold-harmless payments would require separate financing.

Sources MACPAC state benefit spending • U.S. Census state populations • Massachusetts Census estimates • Social Security Act §1935

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

2034 spending before academic awards

Annual amount, $ billions	Planning case	Downside case
Net national savings	+$127	−$233
National health spending	$8,844	$9,204
Rural hospital support	$18	$21
Receiving hospital support	$95	$132
Total hospital access allowance	**$113**	**$153**

Financing schedules

Financing option	New receipts	Planning balance[1]	Downside balance[1]
8% employer, first draft (withdrawn)	$2,543	−$361	−$780
10% employer, first draft (withdrawn)	$3,289	+$385	−$34
Schedule A: 14% / 4%	$3,760	+$856	+$437
Schedule B: 12% / 6%	$3,761	+$857	+$438
Schedule B, wider transfer	$3,761	+$578	+$159

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Annual cash and transfers

Year	Balance, limit holds	Debt payment	Balance, limit fails	Debt payment
2028	-36.4	—	-36.4	—
2029	-238.1	—	-238.1	—
2030	-267.6	—	-267.6	—
2031	-280.2	—	-280.2	—
2032	-60.4	—	-60.4	—
2033	+133.4	—	+133.4	—
2034	+221.1	—	+221.1	—
2035	+241.3	—	+180.1	—
2036	+262.7	—	+131.8	—
2037	+285.6	—	+75.6	—
2038	+298.1	268.3	+10.6	—
2039	+310.0	279.0	-63.9	—
2040	+322.4	290.2	-149.1	—
2041	+335.3	301.8	-245.7	—
Total paid	**—**	**1,139.4**	**—**	**0.00**

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Benefit and rate options

Option	Cost in 2034	Employer rate needed	Debt payments by 2041
Every section as priced, at 12%	—	—	1,139
At the earlier 11.5% rate	—	-0.50 points	0
Without obesity medication (§825)	-$45	—	1,936
Limit at wage growth plus half a point	—	—	648
Universal home care, if enacted now	$360	2.03 points	0

Long-run balances

Schedule B at fixed rates	2041	2042	2045	2051
Growth limit holds	+$335	+$349	+$392	+$496
Limit fails, costs grow 5.5%	-$246	-$355	-$770	-$2,126

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

National spending curve

Year	Current law $ trillion	Planning $ trillion	Downside $ trillion	Planning savings $ billion	Downside savings $ billion
2028	6.63	6.67	6.68	−39	−48
2029	6.97	7.08	7.18	−111	−208
2030	7.32	7.39	7.55	−68	−234
2031	7.69	7.73	7.98	−44	−286
2032	8.07	8.04	8.32	+30	−253
2033	8.51	8.42	8.75	+90	−237
2034	8.97	8.84	9.20	+127	−233

Insurance sensitivity

Sensitivity, holding other inputs fixed	Result
Half the net insurance reduction materializes.	2034 planning savings fall from $127B to about $42B. Stress spending is about $298B above current law.
Trust collects 90%, 75% or 50% of gross cuts; all added costs are paid.	2041 fixed-rate planning cash balances at 4% medical growth are +$335B, +$191B, −$144B.

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Federal program transfers and state contributions

Program	What the Trust takes over	What still needs funding or a separate score
Medicare and Medicare Advantage (§§809, 901, 907)	Hospital, outpatient and drug benefits for people who transfer. Overlapping private-plan payments and premiums end.	Runout claims, reserves and replacement of lost premiums. Compare like beneficiaries and benefits before claiming savings on Medicare Advantage.
Medicaid and CHIP (§§201, 902)	Covered medical and drug claims, including claims for people also on Medicare. State transfers follow agreements.	Long-term services, disability support, transportation and children's entitlements wherever equivalent care is unavailable. Reprice mixed contracts.
ACA Marketplace (§903)	Overlapping subsidies end by covered person and month.	Retain benefits for eligible relatives outside the new plan. Fund enrollment, reconciliation and appeals.
Federal and postal employees (§904)	Overlapping domestic medical coverage and its associated premiums.	Retiree commitments, overseas coverage and residual family contracts. Reconcile agencies' employer contributions.
Military health and TRICARE (§905)	Domestic civilian claims and overlapping TRICARE For Life secondary payments.	Military facilities, readiness, deployments, overseas care and other military-specific benefits.
Veterans Affairs (§§701–702, 906)	Routine covered community claims and their duplicate authorization and billing.	VA facilities and specialty teams, training and research. A local service moves only after an access and full-cost test.
Indian Health Service and Ryan White (§§703, 906)	Shared tribal purchasing or claims by agreement. The Trust pays covered HIV care first.	Tribal delivery, appropriations and treaty duties. Ryan White case management, support and patients outside the national benefit.

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Employer rate stress

Delivery / medical growth	Employer rate 2041	Employer rate 2045	Employer rate 2051
Planning / 4%	12.00%	12.00%	12.00%
Planning / 5.5%	12.99%	14.49%	16.91%
Downside / 5.5%	15.54%	17.15%	19.74%

Access purchases

Extra annual spending in 2034	2034 U.S. savings, planning	2034 U.S. savings, downside	2051 employer rate in financing test
$0B	+$127B	−$233B	16.91%
$25B	+$102B	−$258B	17.09%
$50B	+$77B	−$283B	17.27%
$100B	+$27B	−$333B	17.63%

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Illustrative employer and worker pay

Monthly paycheck line	Single, $100,000	Joint, $150,000[1]
Gross monthly wages	$8,333.33	$12,500.00
Employee premium today → plan	$139.33 → $0	$622.58 → $0
Household charge today → plan	$0 → $350.00	$0 → $400.00
Other federal withholding today → plan	$1,693.69 → $1,735.00	$1,683.32 → $1,867.92
Direct deposit today → plan	$6,500.31 → $6,248.33	$10,194.10 → $10,232.08
Employer health payment today	$677.67	$1,736.00
Employer at 12% → 16.91%	$1,000.00 → $1,409.17	$1,500.00 → $2,113.75

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Detailed 2034 ledger

Source or use	Planning assumption and downside alternative	Planning	Downside
Displaced private insurance overhead	$300B private base × 75% / 65%	+225.0	+195.0
Public operating administration	3% / 4% of all-in transferred commercial spending	-55.2	-64.4
Hospital commercial reductions	Facility-specific price path under §819; bridge funds charged below	+325.7	+239.6
Commercial professional reductions	$809.7B × 60% / 50%, moving from 129% / 118% of Medicare	+109.2	+61.8
Net commercial retail drug discounts	$291.3B × 65% / 55% × 35% / 20%; verified net discounts only	+66.3	+32.0
Medicaid facility rate increases	$441.6B × 65% / 75% lifted from 90% / 85% of Medicare	-31.9	-58.4
Medicaid clinician rate increases	$193.1B × 60% / 65% lifted from 75% / 71% of Medicare	-38.6	-51.3
Rural ER and receiving facilities	$18B + $95B / $21B + $132B	−113.0	−153.0
Other essential capacity	$31B in either case	-31.0	-31.0
Additional sessions and staffing	U.S. workforce and wage assumptions	-83.0	-165.1
Other newly used care	3.8% / 5.4% of $4,602B hospital/clinician spending less purchased sessions	-91.9	-83.5
Dental, vision and hearing	$55B for increased use	-55.0	-55.0
Better outcomes, §§820–826	$100B including $45B obesity medicine. $30B one-time record build falls in 2029–33.	-100.0	-100.0
Net national saving	Gross reductions less all costs	+126.7	−233.3
Incremental Trust cash	90% / 75% of gross reductions less 100% of costs	+54.0	−365.4

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Growth and rate scenarios

Delivery / medical growth	Debt to 2041, $B	Debt to 2051, $B	Extra employer tax to 2041, $T[1]	Rate in 2041	Rate in 2051
Planning / 4%	1,139	4,908	0.00	12.00%	12.00%
Planning / 4.5%	648	1,000	0.00	12.00%	12.52%
Planning / 5.5%	0	0	0.43	12.99%	16.91%
Downside / 4%	0	0	1.53	12.94%	12.94%
Downside / 4.5%	0	0	2.25	13.78%	15.04%
Downside / 5.5%	0	0	3.75	15.54%	19.74%

State financing options

Federal share of state payment assumed	Added 2034 cost, $B	2041 employer rate	Extra employer receipts to 2041, $T	Debt to 2041, $B
0%	0	12.00%	0.00	1,139
10%	46	12.00%	0.00	714
25%	114	12.00%	0.00	0
50%	228	12.00%	0.00	0

Background tables before the academic amendment

Historical hospital-only schedules. These preserve the figures used before §§831–832 were added. Current schedules include the academic appropriation and the national state assessment.

Hospital bridge scenarios

Assumed bridge spending	Added $B	First payment	Paid by 2041 $T	Paid by 2051 $T
Pre-merge v3	$0.00	2037	$1.46	$5.41
Merged allowance only	$12.00	2038	$1.14	$4.91
Half the residual funded	$64.05	2039	$0.69	$3.69
Full exposure, same need	$116.09	2042	$0.00	$2.22
Full exposure, separate need	$128.09	2043	$0.00	$1.87
Zero verified, separate need	$136.87	2043	$0.00	$1.75

4.5% growth and hospital bridges

4.5% medical growth	2041 paid $T	2051 paid $T	2051 advances $T
Merged allowance only	$0.65	$1.00	$0.22
Half the residual funded	$0.07	$0.15	$1.04
Full exposure, same need	$0.00	$0.00	$3.06
Full exposure, separate need	$0.00	$0.00	$3.59

Pre-vote review of financing and hospital access

Federal budget score. A congressional office should transmit Schedule B and the §304 comparison to the relevant committee and seek preliminary assistance from CBO and JCT. Request annual changes from current law in federal receipts, outlays and the unified deficit, including state collections, tax and wage responses, transition costs and verified hospital claims. Reconcile the official budget window to the sponsor's 2041 and 2051 projections. Identify interest separately. Publish the score or its outstanding status. A §816 Trust transfer alone does not measure the federal deficit effect.

Decision for state collections. Ask legislative counsel to identify the authority for the per-resident assessment, the funds legally available for offset, notice and appeal rights, and the treatment of a nonparticipating state. Examine coercion and severability, including the limits of the narrower Medicaid drug-payment precedent in Social Security Act §1935(c). If collection cannot be defended, score the uncollectible amount as zero receipts and name a replacement before a vote. Preserve coverage and funding for retained Medicaid benefits.

Hospital field test. Use one rural sending ER and a confirmed receiving campus. Washington County Hospital in Iowa (CMS 161344) and the University of Iowa hospital in Iowa City (CMS 160058) are candidates. For the year ended June 30, 2025, CMS reports 22 and 743 beds and 253.93 and 10,147.17 hospital-wide payroll FTEs, respectively. Verify the route against both transfer logs. These annual counts do not establish which beds were staffed overnight.

Evidence for a decision. Obtain 12 months of payroll, shift and on-call rosters, staffed bed-hours by specialty, de-identified transfer requests, refusals, delays and transport coverage. Reprice actual claims at each site's applicable Medicare rules, including critical-access cost settlement. Reconcile monthly receipts, funded standby and documented cash savings once. Model both sites for 36 months under each rate step and the 5% facility cost shock.

Condition for proceeding. Have both finance leads, both clinical leads, EMS and an independent reviewer reconcile the results. Record the monthly bridge needed to preserve contracted shifts and accepting beds, 45 cash days and 1.2× debt-service coverage. Report any excess above existing support before calculating §816 transfers. If either end fails, fund the gap or verify a staffed, reachable alternative before the affected cut. Publish aggregate results and limitations. A single pair cannot validate the national allowance.