The People's Healthcare Rescue Act (PHRA) + E.Y.E.S. Taskforce

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PREAMBLE — Life, Liberty & Health

Why We Need It

- America spends more on healthcare than any nation — yet we die younger, pay more, and drown in debt.
- Half a million families go bankrupt every year from medical bills.
- Rural hospitals are shutting down, Big Pharma is charging $300 for $30 insulin, and Wall Street is buying hospitals, cutting staff, and letting communities collapse.
- Healthcare has become the hidden tax on working people. It drains our paychecks, our housing, and our schools.

The Mission

The People's Healthcare Rescue Act is a 10-year national rebuild: universal coverage, debt cancellation, hospital rescue, price discipline, and corporate accountability — paid for by closing loopholes, taxing profiteers, and ending waste.

Kyah Translation:

> We pay the most in the world to get treated the worst.
> This act flips that. Everyone gets care, nobody goes broke, and the suits who gamed the system finally pay back the people.

TITLE I — UNIVERSAL COVERAGE FRAMEWORK

Section 1 — Universal Coverage in Two Years

- **Year 1:** Kids, seniors, veterans, and Medicaid recipients join the National Care Network (NCN).
- **Year 2:** All adults join. Employer, ACA, and private plans merge into one public system.
- **Coverage Includes:** hospital care, doctor visits, prescriptions, maternity, mental health, dental, vision, and long-term care.
- **No premiums. No deductibles. No surprise bills.**
- Families save $4 K–$8 K per year.
- Small businesses compete on a level field instead of being crushed by insurance costs.

Section 2 — National Care Network (NCN)

- The NCN is a publicly funded, federally run system that pays hospitals and providers directly.
- **Doctors and nurses are salaried** — their pay no longer depends on how many tests or surgeries they order.
- Each facility also maintains a **Quality Bonus Pool (QBP)** equal to *up to 10 percent* of total payroll.
    - QBP awards are based on community-wide health outcomes, patient satisfaction, and peer-reviewed quality scores verified by the Health Accountability & Oversight Board (HAOB).
    - Bonuses are team-based, not individual quotas, to reward collaboration and prevent cherry-picking patients.
- Hospitals operate under **global budgets** — fixed yearly funding adjusted for population, need, and outcomes.
- When a hospital's community health metrics rise and costs drop responsibly, its next-year budget and bonus pool rise too.
- When metrics fall, budgets tighten until quality rebounds.
- The result: doctors focus on healing, hospitals focus on prevention, and billing wars disappear.

Section 3 — Patient Freedom & Choice

- Patients pick any doctor or hospital inside the NCN.
- Private supplemental insurance allowed only for elective or luxury care.

Section 4 — Equity & Access Standards

- Wait times: ≤ 30 days for primary care, ≤ 15 for urgent care.
- Every rural community must have an emergency center within 30 miles or get free transport.
- Workforce hiring and training must reflect community diversity.

Kyah Translation:

Everybody in, nobody out.
One network, two years, zero bullshit. (Status quo killed many, so excuse my outrage)
You choose your doctor and you keep your check.
The focus shifts from profit to people — finally.

TITLE II — PRESCRIPTION DRUG REFORM

Section 1 — National Drug Negotiation Authority (NDNA)

- A new federal office with power to negotiate maximum fair prices for every drug.
- Prices are tied to international reference rates (Canada, EU, Japan).
- Full transparency on R&D and production costs.
- If a company refuses a fair price, the government issues a **compulsory license** so another manufacturer can produce it at cost.
- Companies that refuse negotiation lose federal reimbursements and market privileges.

Section 2 — Public Drug Manufacturing Corps (PDMC)

- A public manufacturing network producing essential generics and vaccines at cost.
- Built under the Defense Production Act model.
- Insulin capped at $30 nationwide.

Section 3 — Anti-Corruption in Medicine

- Ban all kickbacks from pharma to doctors or hospitals.
- Real-time disclosure of all industry payments over $50.
- Criminal referrals for violations and profit clawbacks.

Section 4 — Open Formulary Database

- A public database listing every drug, its price, ingredients, and safety data.
- No more secret pricing or “nonprofit” markups.

Section 5 — Universal Prescription Access Fund (UPAF)

- Establishes a **Universal Prescription Access Fund (UPAF)** inside the National Care Network (NCN).
- The UPAF pays the *entire negotiated price* of every prescription drug that is not over-the-counter (OTC).
- Pharmacies receive **direct reimbursement** from the UPAF—patients pay **$0 at pickup.**
- All U.S. residents enrolled in the NCN are automatically covered; no separate applications.
- Drugs are priced through the **National Drug Negotiation Authority (NDNA)** using international reference rates and domestic production costs.
- Any company that refuses a fair price triggers automatic **compulsory licensing** so a public or private partner can make the medicine at cost.
- **Public Drug Manufacturing Corps (PDMC)** produces the top 100 essential generics and high-volume lifesaving drugs in-house, ensuring steady supply.
- **Annual UPAF Budget:** $300–350 billion, funded entirely through:
    - Redirected savings from NDNA price negotiations and fraud clawbacks (~$200 B over 10 yrs);
    - A 0.25 % financial-transaction surtax on stock and derivatives trades (~$150 B over 10 yrs);
    - Import savings from parallel drug purchasing agreements (~$50 B over 10 yrs).
- All pricing and reimbursement data published quarterly on the **Open Formulary Database.**
- The UPAF Board (subset of HAOB) oversees audits, anti-fraud controls, and public reporting.

Kyah Translation:

Big Pharma's grip is broken.

We set the price, cover the cost, and hand you the meds free.

No copays, no coupons, no games.

If they overcharge, we make it ourselves.

Wall Street chips in a sliver, and the people get their medicine. Simple, fair, & human.

TITLE III-A — MEDICAL DEBT REPARATIONS & ECONOMIC REHABILITATION PROGRAM (MDREP)

Purpose

To repair the long-term economic harm inflicted by medical debt — restoring homes, small businesses, and generational wealth stripped away by decades of profiteering and predatory collection practices.

Section 1 — Oversight and Administration

- Managed by the **Health Accountability & Oversight Board (HAOB)** through a dedicated **Economic Justice Office (EJO)**.
- EJO empowered to issue restitution payments, verify claims, and publish public audits.
- Annual transparency reports required to Congress and the public.

Section 2 — Funding Sources

- **25 %** of Wall Street restitution receipts (from the Medical Debt Accountability & Restitution Program — MDARP).
- **10 %** of the Profiteer Reparations Tax on insurance and pharmaceutical profits.
- Supplemental appropriations authorized under Congress's **Spending & Commerce Clause** powers.
- No new taxes on working families.

Section 3 — Eligibility

A household or small business qualifies if, since 2008, it has:

- Declared bankruptcy primarily because of medical bills; **or**
- Lost a primary residence, land, or business assets through healthcare-related foreclosure, lien, or collection.

Priority review for:

- Black, Indigenous, rural, and historically redlined communities disproportionately targeted by medical-debt collection.
- Households with documented loss of intergenerational property or inheritance.

Section 4 — Restitution Tiers

Tier 1 — Home Loss Restitution

- Full repayment of assessed market value at the time of loss, inflation-adjusted, **capped at $400 000 per home.**

Tier 2 — Small-Business Restoration

- 100 % reimbursement of verified business-asset losses (equipment, vehicles, property) **up to $250 000.**

Tier 3 — Generational Property Repair

- Title-restoration assistance or equivalent cash restitution **up to $500 000** for families who lost inherited or communal land to medical-debt liens.

Section 5 — Implementation & Verification

- Claims reviewed by the EJO using bankruptcy filings, lien records, property registries, and housing-authority data.
- Payments issued directly to households or through certified **community land trusts** to prevent re-displacement.
- Annual audits and enforcement reports published by HAOB.
- Fraud-prevention and appeals processes established to ensure fairness and transparency.

Section 6 — Fiscal Scope

- Estimated investment: **$150 – $250 billion over 10 years.**
- Fully funded through existing PHRA revenue streams and restitution inflows.
- Structured as a one-time federal commitment to restore wealth, stabilize communities, and close the racial-economic gap created by medical debt.

Kyah Translation

We're not just wiping the debt — we're paying the people back.
If a hospital bill stole your home, you get that value back.
If sickness shut down your small business, you rebuild.
If your family lost land passed down for generations, that title comes home.
This ain't charity — it's restitution.
The same system that bled our families now funds their comeback.

TITLE III — RURAL HOSPITAL RESCUE & REBUILD

Section 1 — Rural Hospital Rescue Fund

- **$100 billion upfront** to reopen and rebuild rural hospitals and maternity wards.
- **$30 billion per year** for staffing and modernization.
- Priority to counties that lost hospitals or emergency care.

Section 2 — Public Hospital Conversion Plan

Charity-Care Standard

- All hospitals claiming **nonprofit (501 c 3)** status must provide **direct charity care equal to at least 7 % of annual operating revenue or 150 % of their total tax benefit — whichever is greater.**
- "Charity care" includes only uncompensated or sliding-scale medical services provided to uninsured or underinsured patients.
- Marketing, lobbying, and bad-debt write-offs **do not** qualify as charity care.

Tiered Equity Floor

- Hospitals located in low-income or rural counties may meet a **minimum 5 %** threshold if they serve as sole community providers.
- Academic-medical centers and urban hospitals with annual net revenue above $1 billion must meet a **minimum 10 %** threshold.

Verification & Transparency

- Annual audited financial statements submitted to the **Health Accountability & Oversight Board (HAOB)** and state health agencies.
- Public online "Charity Care Scorecards" will display each hospital's percentage, tax benefit, and status.
- False reporting constitutes fraud under federal law and is subject to civil and criminal penalties.

Enforcement & Conversion

- Hospitals failing to meet the standard for **two consecutive years** will be placed into **public receivership** under state or federal management.

- Converted facilities become **Public Health Facilities (PHFs)** operating on **global budgets** that prioritize access and outcomes over profit.

- The federal government provides **fair-market compensation** to ensure compliance with constitutional "takings" protections.

Audit & Oversight

- HAOB will publish an annual National Charity-Care Report showing aggregate charity-care percentages and conversion actions.

- The Comptroller General and GAO will review HAOB methodology every five years to guarantee uniform application and fairness.
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Section 3 — Workforce Pipeline

- Launch the **National Health Service Pathway (NHSP)** — free tuition for students who serve five years in shortage areas.

- Federal grants to train nurses, EMTs, and community health workers.

- Telehealth expansion grants so specialists reach every ZIP code.

Kyah Translation:

> No more two-hour drives to have a baby or get your chest pain checked.
> We rebuild rural care like we rebuilt the interstate system — as national infrastructure.
> Hospitals that fake nonprofit status get taken public.
> We train the next generation of healers right in their hometowns.

TITLE IV — ANTI-CORRUPTION & TRANSPARENCY ARCHITECTURE

Section 1 — Health Accountability & Oversight Board (HAOB)

- Independent watchdog under the Government Accountability Office (GAO).
- Full subpoena, audit, and enforcement power.
- Audits hospital and pharmaceutical finances every year.
- Publicly releases findings and can issue **clawback orders** for fraud or profiteering.
- Refers crimes to the Department of Justice (DOJ).

Section 2 — Anti-Profiteering Rules

- Ban leveraged buyouts in essential health services.
- Private-equity firms must assume all hospital debts upon purchase.
- 15 % **Health Profiteer Exit Tax** on every healthcare-asset sale.
- Absolute ban on Wall Street ownership of public hospitals.

Section 3 — Executive Pay & Accountability

- No tax deductions for pay above $1 million.
- Stock options taxed like regular income.
- Federal contractors with sky-high CEO-to-worker pay ratios lose eligibility.

Kyah Translation:

> No more fake “nonprofits” hiding profit behind paperwork.
> If you cash out on people’s sickness, the people cash in on your taxes.
> Real oversight, real receipts, and real consequences for greed.

TITLE IV-A — E.Y.E.S. (Enforcement of Year-Enduring Systems)

Section 1 — Purpose and Scope

E.Y.E.S. establishes a permanent public accountability framework to ensure that essential healthcare systems, federally funded health infrastructure, and public-serving health contracts remain transparent, stable, and aligned with community needs. This Title requires comprehensive impact reporting, strengthens oversight of public contracting, creates clear community notification standards, and formalizes the role of lived-experience oversight in monitoring and evaluating major health-related decisions.

Kyah Translation:
This section sets the tone: contracts using public money must be honest, transparent, and shaped by real community needs — not hidden deals or fine print.

Section 2 — Definitions

(a) **Public Health Contract** — Any agreement involving federal PHRA funds or federal approval that affects healthcare access, health infrastructure, health-related utilities, or essential health services.

(b) **Affected Community** — Any community, neighborhood, or county that experiences measurable impacts from a proposed contract, including changes in costs, access, environmental conditions, or local economic outcomes.

(c) **Impact Zone** — A zone determined by measurable effect, not distance. The zone must include all areas where the contract may cause shifts in healthcare access, pricing, environmental quality, workforce patterns, transportation needs, or public safety. Misdefining the impact zone is a statutory violation under Section 9.

(d) **Community Impact Review** — A standardized report describing economic, environmental, health, and service impacts of a proposed contract, as described in Section 4.

Kyah Translation:
We define who is affected and what counts. No company gets to shrink the “impact zone” to dodge accountability.

Section 3 — E.Y.E.S. Oversight Authority

E.Y.E.S. shall serve as the independent oversight body for evaluating transparency, integrity, and community impact for all Public Health Contracts covered by this Act. In coordination with existing federal agencies, E.Y.E.S. shall:

(1) Review mandatory impact disclosures.
(2) Coordinate lived-experience advisory boards.
(3) Maintain public access dashboards.
(4) Enforce compliance under this Title.
(5) Issue corrective actions when required.

E.Y.E.S. may request additional documentation, initiate independent analysis, and convene technical or community-based review panels.

Kyah Translation:
This gives E.Y.E.S. the official job of checking every major contract so nothing happens behind closed doors.

Section 4 — Community Impact Review Requirements

All Public Health Contracts must include a Community Impact Review containing:

(a) **Economic Effects**
Analysis of projected job creation, job loss, wage impacts, local business effects, and long-term economic shifts.

(b) **Environmental Effects**
Assessment of potential water, air, land, and climate consequences, including energy demand and pollution risk.

(c) **Healthcare Access Effects**
Evaluation of impacts on service cost, service availability, travel time, and emergency response capacity.

(d) **Infrastructure Impacts**
Identification of any strain on public systems such as roads, utilities, broadband, and housing.

(e) **Public Cost Analysis**
Projected effects on household and municipal expenses, including utility bills, transportation costs, and local tax obligations.

(f) **Distribution of Benefits and Burdens**
Clear explanation of who benefits, who pays, and how equitably impacts are distributed across demographic groups.

Kyah Translation:
Every contract must show the truth — who it helps, who it hurts, and what the real costs are.

Section 5 — Community Right-to-Know Requirements

(a) The full Community Impact Review must be provided to all affected households through physical mail or digital delivery at least **60 days before contract approval**.

(b) A Public Notice Portal managed by E.Y.E.S. shall provide open access to all submitted documents, maps, impact zones, and supporting data.

(c) Public comment must remain open for a minimum of **45 days**, with at least one in-person and one virtual hearing option.

(d) Contracts may not proceed until the notification period is completed and E.Y.E.S. certifies compliance.

Kyah Translation:
Communities get the info first, not last. No more waking up to find out a deal already went through.

Section 6 — Lived-Experience Oversight

(a) Every contract subject to this Title must undergo review by a **Lived-Experience Oversight Committee**, with at least **51 percent representation from affected communities**.

(b) The committee may issue findings, recommendations, or objections. These must be included in the final E.Y.E.S. assessment.

(c) When committees identify disproportionate burdens, E.Y.E.S. must require mitigation or revision before approval.

Kyah Translation:
People who feel the impact must have power. They're not observers — they're decision shapers.

Section 7 — Public Transparency Dashboards

E.Y.E.S. shall maintain public dashboards for all active and proposed Public Health Contracts, including:

(1) Contract summaries
(2) Impact Review findings
(3) Compliance status
(4) Funding sources
(5) Implementation timelines
(6) Violation reports
(7) Corrective actions taken

Dashboards must be updated quarterly and remain archived for public reference.

Kyah Translation:
The public can always check what's going on — no hidden moves, no fine print surprises.

Section 8 — Whistleblower Protections

(a) Individuals reporting misconduct, fraudulent disclosures, misrepresentation of impacts, or violations under this Title shall be protected from retaliation.

(b) Whistleblowers are entitled to confidentiality, legal support referrals, and reinstatement in cases of adverse employment actions.

(c) Verified disclosures shall trigger E.Y.E.S. review and appropriate corrective action.

Kyah Translation:
If someone tells the truth, the system protects them — not punishes them.

Section 9 — Enforcement for Misrepresentation

(a) Deliberate misrepresentation of impact zones, data omissions, or false reporting shall be classified as a violation under this Act.

(b) E.Y.E.S. may order contract suspension pending correction.

(c) Entities found responsible for repeated or serious violations may be barred from future eligibility for PHRA-funded contracts for up to 5 years.

(d) Violations shall be recorded on the public dashboard.

Kyah Translation:
If a company lies, the contract stops — and they can lose the right to ever try this again.

Section 10 — Rapid Review and Corrective Action Authority

(a) E.Y.E.S. may initiate Rapid Review procedures when new information, whistleblower reports, or community evidence indicates potential harm.

(b) During review, E.Y.E.S. may:
(1) Pause implementation,
(2) Require supplemental reporting, or
(3) Mandate interim protections for affected communities.

(c) Corrective actions may include revised contract terms, mitigation requirements, or updated impact assessments.

Kyah Translation:
If something changes or new problems show up, E.Y.E.S. can hit pause fast and fix it before harm spreads.

Section 11 — Certification and Approval Requirements

(a) No Public Health Contract may be executed until E.Y.E.S. issues a **Public Interest Certification**, confirming:

(1) Completion of all required reviews
(2) Compliance with community notice requirements
(3) Accuracy of reported impacts
(4) Consideration of lived-experience findings
(5) Absence of unresolved violations

(b) Certifications shall be published on the transparency dashboard and archived permanently.

Kyah Translation:
Nothing moves unless the process was honest, complete, and in the public interest.

Section 12 — Annual Reporting

E.Y.E.S. shall submit an annual report to Congress summarizing:

(1) Total contracts reviewed
(2) Violations detected
(3) Public interest certifications
(4) Community burden analyses
(5) Corrective actions taken
(6) Recommendations for improvement

The report shall also include trends in public health contracting and any emerging risks.

Kyah Translation:
Every year, Congress — and the public — get the full picture of what worked, what didn't, and what needs fixing.

Section 13 — Rulemaking and Implementation

E.Y.E.S., in coordination with federal agencies, shall establish rules and procedures to implement this Title, including:

(1) Standardized impact templates
(2) Data reporting requirements
(3) Community notice protocols
(4) Oversight committee operations
(5) Violation adjudication procedures

Kyah Translation:
This section lets E.Y.E.S. build the tools and rules needed to run everything cleanly and consistently.

TITLE V — REAL "FISCAL RESPONSIBILITY" & FUNDING STRUCTURE

Section 1 — Funding Breakdown (10-Year Plan)

Revenue Source	Estimated 10-Year Revenue
Profiteer Reparations Tax (10 % surtax on Big Pharma & insurers)	$ 350 B
Corporate Tax Reform (restore 28 %)	$ 1.35 T
Stock Buyback Tax (10 %)	$ 400 B
IRS Enforcement against tax evasion	$ 200 B
Defense waste cuts	$ 500 B
Employer health deduction phase-out	$ 2.0 T
Pharma offshore profit crackdown	$ 250 B
Executive pay & stock comp fix	$ 50 B
Inheritance loophole closure	$ 250 B
Private equity exit tax & reforms	$ 150 B
Medical-device price reform	$ 75 B
Public drug manufacturing savings	$ 300 B
Fraud clawbacks via HAOB	$ 100 B
Medical Debt Reparations & Rehabilitation Program (MDREP)	$150 – $250 B
Total 10-Year Funding Pool	**≈ $5.8 – $7.3 Trillion Fully covered with room to spare**

Section 2 — Fiscal Guardrails

- Annual independent audit by GAO + CBO.
- Any surplus from negotiated drug savings must be reinvested in rural care, education, or childcare — never pocketed.
- Mandatory public-ledger disclosure of all inflows/outflows.

Section 3 — Economic Impact Targets

- **Expected GDP growth: + 1.5–2 % per year during rollout.**
- **4–6 million new jobs from healthcare and construction.**
- **Families keep $ 4 K–$ 8 K more per year in take-home income.**
- **Families who lost homes or small businesses to medical debt receive full restitution through the PHRA's Reparations & Rehabilitation Program.**

Kyah Translation:

> Every penny's covered and double-checked.
> The savings alone could rebuild schools and daycare centers.
> This plan pays for itself — **the only folks losing money are the ones who got FILTHY RICH off our sickness.**

TITLE VI — LEGAL & CONSTITUTIONAL SAFEGUARDS

Section 1 — Authority & Constitutional Basis

- Grounded in:
    - **Spending Clause** – Congress can set conditions on federal funds.
    - **Commerce Clause** – Healthcare and pharma are national markets.
    - **Taxing Power** – Allows surtaxes and anti-profiteer measures.
    - **General Welfare Clause** – Ensures programs serve the people.

Section 2 — Due Process & Compensation

- All public-hospital conversions and drug licenses include fair-market compensation.
- All enforcement actions require notice + appeal rights.

Section 3 — Sunset & Review Mechanisms

- Every major reform undergoes review every five years for efficiency and equity.
- Any reform found unfair or ineffective must be revised within 12 months.

Section 4 — Anti-Coercion Clause for States

- States can administer their own systems as long as they meet PHRA standards.
- Non-compliance means loss of federal health grants.

Kyah Translation:

> This part locks the act to the Constitution so no partisan Supreme Court can chop it down easily.
> We play by every rule — and still win.
> States can run it how they want, but if they short their people, they lose their funding.
> **Play stupid games, lose all the free prizes you didn't have to work for.**

TITLE VII — IMPLEMENTATION & OVERSIGHT

Section 1 — Rollout Schedule

- **Year 1:** Kids, seniors, veterans, and Medicaid enrollees join the NCN.
    - $100 B hospital rebuild launched.
    - Insulin capped at $30.
    - $220 B in medical debt erased.
- **Year 2:** All adults enrolled; employer + ACA plans merged; negotiated drug prices kick in nationwide.
- **Years 3–5:** Rural hospital rebuild complete; HAOB audits begin; public drug manufacturing expands.
- **Years 5–10:** Stabilization phase — tracking costs, verifying savings, reinvesting surplus in schools and childcare.

Section 2 — Transparency Portal

- Create the **National Health Transparency Portal (NHTP)** for all cost, price, and outcome data.
- Updated quarterly — open to the public.

Section 3 — Community Feedback Loop

- Local advisory boards in every state report problems and success stories directly to HHS and Congress.
- Annual public listening sessions required in each region.

Kyah Translation:

> This is how we keep the receipts.
> Roll it out fast, show the numbers, let the people see where every dollar goes.
> Ten years from now we won't just have a new healthcare system — we'll have proof that it works because *we watched it happen.*

TITLE VIII — WHAT IT MEANS FOR FAMILIES & COMMUNITIES

- Families keep **$5 K–$9 K more each year** in take-home pay.
- **$220 B in medical debt erased.**
- **Every prescription fully covered** — no copays, no coupons, no skipped doses.
- Millions of new jobs in healthcare, construction, and manufacturing.
- Rural hospitals reopen; maternity wards return.
- Health equity becomes reality — no more healthcare lottery based on ZIP code, income, or skin tone.
- Insulin and every lifesaving med: **$0 at pickup.**

Kyah Translation: How We Got Here.

Before the 1980s, healthcare still had problems — but it wasn't a Wall Street side hustle.
Hospitals were mostly community-run, doctors worked for missions not margins, and Blue Cross was a co-op, not a cash grab.
The government even built safety nets: Medicare, Medicaid, and neighborhood clinics that actually treated broke folks like humans.
Medicine was expensive, sure, but it was still a public service, not an investment portfolio.

Then, Reagan showed up selling "free-market freedom."
Translation: open the gates, let the suits in.
He deregulated hospitals, cut public funding, and told investors they could get rich off sick people.
HMOs popped up, private equity swooped in, and suddenly "healthcare" meant paperwork, denials, and billion-dollar bonuses.
The money stopped healing and started hustling.

Forty-plus years later, we've got the receipts: record profits, record bankruptcies, and people crowdfunding chemo.
The People's Healthcare Rescue Act is how we break that curse. Turning medicine back from a market into a mission.
It's not nostalgia; it's correction.
We're bringing the community heart of pre-Reagan America into the twenty-first century with modern muscle and no corporate middlemen.

TITLE IX — REPRODUCTIVE HEALTH & AUTONOMY PROTECTIONS

Section 1 — Protected Right to Reproductive Healthcare

- Guarantees access to contraception, fertility services, prenatal & postpartum care, miscarriage management, and abortion care within the NCN.
- No government can deny or criminalize these services while receiving PHRA funds.
- Protects patient and provider privacy under federal law.

Section 2 — Coverage and Consultation Requirements

- One fully covered abortion per twelve months for every NCN member.
- Before any non-medical procedure, patients complete a **Reproductive Options Consultation (ROC)**:
    - 45-minute session covering all options, contraceptive risks (like weight changes from birth control), and cycle tracking for pregnancy prevention.
- After three elective abortions in five years, a free **ROC + Plan** offers personalized contraception guidance — no bans, just education.
- Medical-necessity, rape, or incest cases bypass consultation.

Section 3 — Safeguards for Victims of Rape or Abuse

- Victims can receive care confidentially through **Secure Reporting Channels (SRCs)** managed by the **Victim Safety Unit (VSU)** at HHS.
- VSU coordinates with federal law enforcement to protect identities, offer relocation aid, and enforce restraining orders.
- Funding for 24-hour hotline and relocation grants included ($1 B annual budget).

Section 4 — Prevention of Coercion or Fraud

- Coercing someone into a procedure without consent is a federal felony.
- Penalties and restitution for malicious false accusations to be defined in the *Justice & Safety Companion Act.*
  (Placeholder — see future bill for criminal details.)

Section 5 — Medical Oversight and Ethical Review

- Every facility has a **Rapid Ethical Review Panel (REP)** — a doctor, mental-health expert, and patient advocate — deciding complex cases within 24 hours.

Section 6 — Rest-in-Dignity Clause

- No person kept alive on life support beyond seven days solely to sustain a non-viable pregnancy without consent of next of kin and ethics-panel approval.

  (We **WILL NOT have a repeat of Adriana Smith** or any other Human Incubator situations. It's beyond disrespectful to the deceased & families that have to live with the outcomes.)

Section 7 — Essential Feminine Health Products & Safety Standards

- Reclassify pads, tampons, and cups as **Essential Health Goods (EHGs).**
- FDA + EPA create **Menstrual Product Safety Standards (MPSS):**
  - Ban PFAS, phthalates, synthetic fragrances, and hormone-disrupting chemicals.
  - Require full ingredient labels.
  - Cap prices to prevent markups.
  - Launch **Feminine Product Price Watch (FPPW)** for public tracking.
- Tax-exempt and duty-free status for all EHGs.
- States barred from imposing "tampon taxes."
- Violations fined up to $10 M per product line + automatic recall.

Section 8 — Public Education & Family Planning

- Fund national curriculum and digital modules on cycle tracking and reproductive autonomy.
- 0.1 % of PHRA budget reserved (~$6 B over 10 years).

Section 9 — Data Protection & Privacy

- Reproductive data classified as protected medical info.
- Ban sale or law-enforcement use of period-tracking and geolocation data without warrant.

Section 10 — Funding and Enforcement

- Create **Reproductive Health Fund (RHF)** inside HHS: $10 B startup + $8–10 B annual.
- Enforced by DOJ Civil Rights Division and HHS Office for Civil Rights.
- States failing to uphold protections lose 10 % of federal health grants.

Section 11 — Moral & Constitutional Declaration

- Bodily freedom = liberty.
- Healthcare without reproductive autonomy is not freedom — it's control.

Kyah Translation:

Women's rights ain't a footnote — they're healthcare.

You get care, not criminalized.

You get education before decisions, not judgment after them.

Pads and tampons stop being luxuries and start being rights.

Abusers get no access; survivors get protection.

This is what it means to actually care about life.

DATA & RECEIPTS APPENDIX — The Proof Behind the Plan

Section 1 — Cost Comparisons (U.S. vs. the World)

Country	Annual Health Spending per Person	Life Expectancy	Avg. Family Out-of-Pocket Cost
🇺🇸 United States	$13,493	76 years	$6,000–$9,000
🇨🇦 Canada	$6,319	82 years	<$1,000
🇫🇷 France	$5,429	83 years	<$1,000
🇩🇪 Germany	$7,382	81 years	~$1,200
🇯🇵 Japan	$4,666	85 years	<$1,000
🇬🇧 United Kingdom	$5,493	81 years	~$500

Sources: OECD Health Statistics 2024 (Data Extracted July 2024), World Bank Global Health Indicators: *Life Expectancy at Birth (2024),* Commonwealth Fund: *International Health System Profiles*, 2024

Takeaway:

The U.S. pays *double* and lives *shorter.*

Even cutting our system's waste by 25 % pays for universal care twice over.

Section 2 — Hospital Closures & Deserts

- **Since 2010, 190 rural hospitals have closed across 33 states** — and more than **600 are at risk of closure** within the next five years.
  Source: Chartis Center for Rural Health, *"Rural Hospital Vulnerability Index 2024."*

- **Over 1,100 U.S. counties are now classified as "maternity care deserts,"** meaning they have no hospitals or birth centers offering obstetric services and no OB-GYNs or certified nurse midwives.
  Sources: March of Dimes, *"Nowhere to Go: Maternity Care Deserts Report 2024."*

- **North Carolina, Tennessee, and Texas lead the nation in rural maternity-unit shutdowns,** with more than one out of every 3 (33%) rural counties in each state lacking obstetric care.
  Sources: March of Dimes 2024; Chartis *Maternity Care Access Report,* 2024.

- **Average travel time to reach an emergency department has nearly doubled since 2008,** especially in rural and low-income regions.
  Sources: U.S. Government Accountability Office (GAO), *"Rural Hospital Closures: Increased Travel Times and Effects on Access,"* 2023; HHS Assistant Secretary for Planning and Evaluation (ASPE), *Health Care Access Brief,* 2024.

Section 3 — Medical Debt Crisis

- **Roughly $220 billion in unpaid medical bills** remain on Americans' credit reports or in collections.
  Sources: Consumer Financial Protection Bureau (CFPB), *"Medical Debt Burden in the United States,"* March 2024 Update; Urban Institute, *Medical Debt in the U.S.,* 2024.
- **Around 4 in 10 adults (41%) currently owe medical or dental debt**, either on credit cards, payment plans, or in collections.
  Source: Kaiser Family Foundation (KFF) Health Debt Survey, *"Health Care Debt in the U.S.,"* 2024.
- **Roughly two-thirds (66.5%) of personal bankruptcies cite medical costs or illness as a major contributing factor.**
  Source: Himmelstein, Woolhandler, et al., *American Journal of Public Health,* Feb 2023; reaffirmed by National Consumer Law Center 2024.
- **One in four families (26%) reports delaying or skipping necessary care because of medical cost.**
  Sources: KFF Health Tracking Poll, July 2024; CDC National Health Interview Survey (NHIS), 2023.

Section 4 — Prescription-Drug Inflation

- **Insulin:** around **$35 per vial in Canada vs. $98–$300 in the U.S.**, depending on brand and pharmacy markup.
  Sources: RAND Corporation, *"International Prescription Drug Price Comparisons, 2023 Update"* (sponsored by HHS); KFF Health News, Feb 2024.

- **Epinephrine auto-injectors (EpiPens):** roughly **$10–$25 abroad vs. $600 in the U.S.** retail price before generic competition.
  Sources: Health Affairs, *"EpiPen Pricing and Competition,"* 2023; OECD Drug Price Comparison Database, 2024.

- **Fifteen of the twenty most-used brand-name drugs cost two-to-five times more in the U.S.** than in peer nations.
  Source: RAND Corporation, *"Comparing Prescription Drug Prices in the United States and Other Countries, 2024."*

- **Roughly 3 in 10 Americans (29 %) report skipping or rationing prescriptions because of cost.**
  Sources: KFF Health Tracking Poll, Nov 2023; CDC National Health Interview Survey (NHIS) 2023.

Section 5 — Administrative Waste

- **Administrative overhead in the U.S. healthcare system totals roughly $1.1–$1.3 trillion per year,** representing about **30% of total national health expenditures.**
  Sources:
  ‣ Himmelstein, D. & Woolhandler, S. "Administrative Waste in the U.S. Health Care System in 2023," *JAMA* (Journal of the American Medical Association), Oct 2023.
  ‣ Centers for Medicare & Medicaid Services (CMS) National Health Expenditure Accounts, 2023.
- **By contrast, Canada's entire universal healthcare system costs about $331 billion (CAD) annually** — roughly **$250 billion USD**, less than one-quarter of U.S. administrative costs.
  Sources:
  ‣ Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends, 2024.*
  ‣ OECD Health Statistics 2024.

- **Over 30% of U.S. healthcare spending goes to billing and insurance-related (BIR) functions rather than direct care.**
  Source: Tseng, P. et al., "Billing and Insurance-Related Administrative Costs in U.S. Health Care: A Systematic Review," *Health Affairs*, March 2023.
- **The average U.S. hospital employs about seven administrative workers for every physician; Japan averages just two.**
  Sources:
  ‣ OECD Health Workforce Statistics, 2024.
  ‣ Himmelstein & Woolhandler, "Administrative Costs of Health Care in the United States and Canada," *Annals of Internal Medicine*, 2020 (still the most-cited comparison data).

Section 6 — Corporate Capture

- **75 % of U.S. hospitals now call themselves "nonprofit,"** yet nearly half spend **under 3 % of their revenue on charity care.**
  Source: Lown Institute *Hospital Index 2024*; KFF Health News, "Nonprofit Hospitals Often Spend Little on Charity Care," May 2024.
- **Private equity now owns about 1 in 7 emergency departments** and roughly **1 in 3 physician-staffing firms.**
  Source: STAT News & American Antitrust Institute, "Private Equity in Emergency Medicine," Oct 2023; Public Citizen Report 2023, *"Private Equity's Growing Role in Healthcare."*
- **In 2023, healthcare-sector CEOs collectively took home about $5.8 billion in pay and stock awards — enough to cover all insulin costs for America's uninsured diabetics.**
  Sources:
  ‣ *Axios Health Finance Review*, "2023 Healthcare CEO Compensation Tracker," Dec 2023.
  ‣ *KFF Health News*, "Health Care CEOs Collected Billions While Patients Skipped Care," Jan 2024.
  ‣ SEC Form 10-K filings (UnitedHealth, CVS Health, Cigna, Pfizer, Moderna, Johnson & Johnson, HCA Healthcare, Humana, Elevance Health 2023).
  ‣ CDC Diabetes Surveillance System 2023 (for uninsured diabetic population and average insulin costs).

Section 7 — Global Best Practices Cited in the PHRA

Country	What Works	What We Copy
🇫🇷 France	Strong mix of public + private with state regulation	**Mixed hybrid model** for flexibility
🇨🇦 Canada	Universal coverage simplicity	**Single payer administration**
🇬🇧 UK (NHS)	Free at point of use	**Global budgets + salary-based providers**
🇩🇪 Germany	Co-determination and employer partnership	**Workplace solidarity in funding model**
🇳🇴 Norway	Cap on admin costs and high patient satisfaction	**Strict efficiency targets**
🇯🇵 Japan	Fee schedule transparency	**Open Formulary Database** for pricing

Section 8 — Economic Ripple Effects

- **The People's Healthcare Rescue Act (PHRA)** is projected to **save roughly $1 trillion in net national health expenditures over 10 years**, even after new coverage spending.
  Sources:
  ‣ Pollin, Heintz, Arno, et al., *"Economic Analysis of Medicare for All,"* Political Economy Research Institute (PERI, Univ. of Massachusetts Amherst), 2018 – updated 2023 simulations.
  ‣ Galbraith & Wray, *Levy Economics Institute Working Paper No. 1054: The Macroeconomics of Single-Payer Healthcare,* 2024.
- **Creates an estimated 4–6 million new jobs** across construction, nursing, public-health IT, and administration-transition roles.
  Sources: PERI 2023; Levy 2024 labor-multiplier analysis.
- **Raises real household wages by roughly 6 %** through lower insurance premiums, deductibles, and out-of-pocket costs.
  Sources: Economic Policy Institute (EPI), *"Health-Care Cost Relief and Wage Growth,"* 2023; PERI 2023 Model B output.
- **Boosts small-business formation** by removing the employer insurance burden and stabilizing healthcare costs for entrepreneurs.
  Sources: Brookings Institution, *"Employer Coverage and Entrepreneurship,"* 2022; KFF 2023 Employer Health Benefits Survey.

Section 9 — Gender & Equity Receipts

- **Before PHRA, women pay on average 42% more out-of-pocket for medical care than men**, primarily due to reproductive health costs and gender-based pricing disparities.
  Sources: Kaiser Family Foundation (KFF), *"Women's Health and the Health Care System: Data and Trends,"* 2023; Harvard Women's Health Initiative, 2024.
- **So-called "tampon taxes"** (sales tax on menstrual products) cost women **$80–$100 per year on average across 26–30 states** that have not repealed them.
  Sources: Alliance for Period Supplies, *"Tampon Tax Tracker,"* 2024; National Bureau of Economic Research (NBER) Working Paper 31754, 2024.
- **Roughly 90% of menstrual products tested contain at least one endocrine-disrupting chemical** — such as phthalates, parabens, or PFAS ("forever chemicals") — linked to hormonal and reproductive harm.
  Sources: Environmental Working Group (EWG), *"Toxic Chemicals in Feminine Care Products,"* 2023; U.S. Environmental Protection Agency (EPA), *Chemical Data Reporting (CDR) Summary for PFAS and Phthalates in Consumer Goods,* 2023.
- **PHRA bans all endocrine-disrupting additives in menstrual and personal-care products and eliminates all sales taxes on them**, saving roughly **$300–$400 in lifetime costs per woman** and reducing chemical exposure across millions.
  Sources: Legislative modeling based on NBER 2024 and EPA toxicology data, compiled by PHRA Economic Analysis Team.

Section 10 — Abortion & Reproductive Care Outcomes

- **States with strong reproductive rights protections have maternal mortality rates roughly 35% lower** than states with abortion restrictions.
  Sources: CDC National Vital Statistics System (NVSS), *Maternal Mortality Report 2024*; Guttmacher Institute, *"State Policy Trends in Reproductive Health,"* 2024.
- **Being denied an abortion increases a woman's likelihood of falling into poverty by over 400% within four years**, compared to those who received care.
  Sources: Turnaway Study (UCSF, 2020, reaffirmed 2023); Brookings Institution, *"The Economic Fallout of Abortion Bans,"* 2023; NBER Working Paper 31701, 2024.
- **Roughly 85% of abortions occur within the first trimester, and more than 60% of patients are already mothers** caring for existing children.
  Sources: Guttmacher Institute, *Abortion Patient Survey 2023*; CDC Abortion Surveillance Report 2023.
- **Every $1 invested in family planning and reproductive health saves approximately $7 in downstream public costs** — including uninsured births, child welfare, and long-term healthcare.
  Sources: Guttmacher Institute, *"Return on Investment: Publicly Funded Family Planning Services in the U.S.,"* 2023; CDC Division of Reproductive Health, 2024.

Section 11 — Constitutional & Fiscal Integrity Check

- **A majority of leading constitutional law scholars agree** that a universal healthcare act like PHRA fits squarely within **Congress's powers under the Commerce Clause and the Spending Clause** of the U.S. Constitution.

  Sources: Harvard Law Review, *"Federal Power and National Health Programs,"* Vol. 136, No. 2 (2023); Yale Journal on Regulation, *"The Constitutional Basis for Federal Health Reform,"* 2024; Stanford Constitutional Law Center Symposium Summary, Jan 2025.

  (Survey syntheses of scholars from Harvard, Yale, Stanford, Georgetown, and Columbia show broad consensus — roughly 80–85% support this interpretation.)

- **Estimated total fiscal cost of universal coverage: $5.5–$7.0 trillion over 10 years**, with projected **net savings of $1 trillion** compared to current national health expenditures.

  Sources: Congressional Budget Office (CBO), *"The 2025 Budget and Economic Outlook: Health Care Baseline,"* April 2025; Political Economy Research Institute (PERI), *"Economic Analysis of Medicare for All,"* 2023 update; Urban Institute, *"Pathways to Universal Coverage,"* 2024.

- **Roughly 70 % of U.S. voters support universal health coverage** when financed through higher corporate or wealth taxes.

  Sources: Kaiser Family Foundation (KFF) Health Tracking Poll, Feb 2024; Pew Research Center, *"Public Views on Health Care Financing,"* Oct 2024.

Section 12 — Public Support Snapshot

Poll Source	Support Level	Notes / Context
Pew Research Center (2024)	68% overall	Pew's Public Views on Health Care Financing (Oct 2024) found 68% of U.S. adults favor a government guarantee of health coverage for all Americans.
Kaiser Family Foundation (KFF) Health Tracking Poll (Feb 2024)	72% among independents	When universal coverage is financed through higher corporate taxes, 72% of independents and 56% of Republicans expressed support.
Gallup National Poll (Dec 2023)	81% among voters under 35	Gallup's Healthcare System Perception Poll (Dec 2023) showed 81% of adults aged 18–34 favor a federally guaranteed health plan.
NPR/Robert Wood Johnson Foundation/Harvard Rural Health Poll (2023)	64% in rural areas	64% of rural Americans support universal coverage if it includes reopening local hospitals and clinics.
Small Business Majority / Johns Hopkins Bloomberg School of Public Health (2024)	67% of small-business owners	Support single-payer or public-option reforms to relieve employer insurance costs and simplify benefits administration.

Section 13 — Accountability Metrics

- **Annual Health Equity Scorecard** published by the **Health Accountability & Oversight Board (HAOB)** — an independent, public-facing body created under PHRA Title VI.
- Scorecard tracks national and state-level metrics, including:
    - Cost per capita (total system and household)
    - Life expectancy and infant mortality
    - Maternal mortality and reproductive outcomes
    - Racial and income-based disparities in care access and outcomes
    - Prescription affordability and adherence rates
    - Hospital and primary care access by ZIP code and region
- **Public Transparency Portal:** An online dashboard updated quarterly, allowing any citizen to compare states and regions on performance and efficiency.
- Data sources integrated from **CDC**, **CMS**, **HAOB reporting**, and **independent academic review** (modeled after the *OECD Health at a Glance* and *Commonwealth Fund State Scorecards*).
- **Accountability Enforcement:** States that underperform for three consecutive years trigger a HAOB review and corrective action plan to restore full funding eligibility.

Kyah Translation:

These receipts ain't fluff — they're proof.
Every chart, every dollar, every stat says the same thing: we've been robbed blind by greed and sold struggle as normal.
The People's Healthcare Rescue Act doesn't just fix the system — it ends the hustle.
Countries that spend half what we do already live longer, safer, and freer.
America can too — if we stop treating health like a hustle and start treating it like a human right.

Defense & Enforcement Titles

TITLE X — Public Health Infrastructure & Pandemic Defense

Section 1 — National Public Health Corps (NPHC)

Creates a permanent corps under the Health Accountability & Oversight Board (HAOB) to coordinate federal, state, and local prevention work.

Funds 100 000 new public-health professionals deployed to underserved areas, schools, and long-term-care facilities.

Section 2 — Community Readiness & Resilience Fund

$50 billion / 10 years for water safety, ventilation, infection-control, and emergency-supply infrastructure.

States must publish clear activation triggers for automatic aid release.

Section 3 — National Surveillance Network

Modernizes CDC and state systems for real-time disease and environmental-health tracking.

Each state receives an annual public "readiness score."

Kyah Translation:

> COVID showed how profit out ran prevention by a mile.
>
> We rebuild that wall with people, training, and truth — not panic, politics & tragedy.

TITLE XI — Indigenous, Immigrant & Undocumented Access Protections

Section 1 — Universal Coverage Guarantee

All residents and workers, regardless of citizenship, receive full PHRA benefits.

Residency proof replaces citizenship proof.

Section 2 — Tribal & Indigenous Partnerships

Tribes manage their own PHRA programs with direct federal funding and full interoperability with the National Care Network (NCN).

Section 3 — Civil Rights Enforcement

HAOB Civil Rights Unit investigates denial-of-care discrimination and language or heritage bias.

Kyah Translation:

> If you live here, you get care here.
>
> No border, no paperwork, no excuse decides who gets to live.
>
> No more medical racism. We are tired of every system working against us. Enough.

TITLE XII — Mental & Behavioral Health Integration

Section 1 — Parity Clause

Mental-health and addiction treatment is covered exactly like physical care — same costs, same access, same dignity.

Section 2 — National Mental Health Workforce Initiative (NMHWI)

Tuition-free education for therapists, psychiatrists, counselors, and peer specialists who serve five years in shortage zones.

Section 3 — Community Recovery Centers

$25 billion fund for local crisis and recovery centers co-located in schools and hospitals.

Section 4 — Primary-Care Integration

Every PHRA clinic must include at least one licensed mental-health professional by Year 5.

Kyah Translation:

> Healing ain't just the body — it's the mind, the spirit, the weight we carry.
>
> We treat trauma like we treat broken bones — fix it, not hide it.

TITLE XIII — Long-Term Care & Disability Rights

Section 1 — Universal Long-Term Care

In-home, assisted-living, and residential care fully covered.

Families may choose home care with equal reimbursement.

Section 2 — National Caregiver Pay Standard

$25/hour minimum for professional caregivers.

Family caregivers earn tax credits and respite pay.

Section 3 — Accessibility Modernization Fund

$40 billion / 10 years for facility, transport, and telehealth accessibility upgrades.

Kyah Translation:

Dignity doesn't retire.

Caregivers deserve checks, not charity.

Disability rights are human rights — period.

TITLE XIV — Veteran Care Integration

Section 1 — VA Interoperability

Veterans can receive care at any PHRA facility without losing VA benefits; records shared seamlessly.

Section 2 — Military-Civilian Exchange Program

VA specialists rotate into civilian trauma and mental-health units; PHRA clinicians rotate into VA centers.

Section 3 — Automatic Enrollment for Transitioning Service Members

Every veteran leaving active duty is auto-enrolled in PHRA.

Kyah Translation:

You fought for this country; now this country fights for your health.

No veteran dies waiting on paperwork.

TITLE XV — Technology & AI Guardrails

Section 1 — Data Ownership & Privacy

Patients own their data. Sale or monetization of health information prohibited.

Section 2 — Algorithmic Transparency

All diagnostic or billing AI systems must disclose training data, bias audits, and logic to HAOB.

Public registry of approved medical AI.

Section 3 — Public Health AI Fund

$10 billion for open-source, bias-free models owned by the public.

Kyah Translation:

Your heartbeat ain't a business model.

The algorithm answers to the people now.

TITLE XVI — Healthcare Worker Power & Safety

Section 1 — Safe-Staffing Ratios
Federal minimums: 1 nurse : 4 patients; 1 : 2 in ICU/ER.

Section 2 — Labor & Whistleblower Protections
Healthcare workers shielded from retaliation for reporting unsafe practices.
Mandatory collective-bargaining rights for all PHRA facilities.

Section 3 — Worker-Owned Healthcare Co-ops
Federal grants and low-interest loans to convert eligible facilities into employee co-ops.

Kyah Translation:

> Healers deserve healing too.
> No more burnout factories — we build freedom on the hospital floor.

TITLE XVII — Corporate Capture Firewall

Section 1 — Anti-Privatization Clause
PHRA-funded facilities and data may not be sold, franchised, or privatized.
All assets remain public in perpetuity.

Section 2 — Lobbying & Conflict Bans
Lifetime lobbying ban for former HAOB execs and board members.
Full disclosure of all industry donations or political spending.

Section 3 — Independent Inspector General (IIG)
Permanent watchdog empowered to subpoena, audit, and prosecute corruption or capture.

Kyah Translation:

> The clinic belongs to the people — not the shareholders.
>
> The watchdog doesn't take bribes.
>
> We're not allowing corruption into our plan. Stay AWAY. OVER IT.

TITLE XVIII — Rollout & Trigger Safeguards

Section 1 — Default Activation Clause

If any agency fails rollout deadlines, funds auto-release using the prior year's formula.

Section 2 — Continuity During Shutdowns

PHRA services remain active through federal shutdowns or budget lapses.

Section 3 — Implementation Oversight Board

Tracks progress, publishes quarterly reports, flags obstruction for congressional review.

Kyah Translation:

> They can stall Congress — but they can't stall your care.
> Health doesn't wait for politics.

TITLE XIX — Public Transparency & Accountability Dashboard

Section 1 — Annual PHRA Impact Report

Every household receives a yearly statement showing cost savings, hospital reopenings, and family benefits.

Section 2 — National Dashboard

Interactive portal tracking outcomes, life expectancy, racial-equity metrics, and public spending.

Section 3 — Citizen Feedback Loop

Residents can rate services and submit complaints directly to HAOB.

Kyah Translation:

> Receipts on the fridge.
> Every dollar. Every life saved. Every promise kept — right there in public view.

TITLE XX — THE PEOPLE'S DECLARATION OF HEALTH SOVEREIGNTY

We, the people of the United States, declare that **health is not a product — it is a birthright.**
That no profit shall stand above a person's pulse, no lobby above a child's breath, and no gatekeeper above the collective good.
The People's Healthcare Rescue Act restores what greed stole: dignity, security, and peace of mind.

This Act is hereby established as a permanent guarantee that every person within these borders is entitled to medical care, free from exploitation, denial, or discrimination.
Its intent is simple and sacred — to ensure that the wealth of this nation finally serves the well-being of its people.

Health is life.
And life, once declared sacred, cannot be sold back to us.

Kyah Translation:

> Health isn't a luxury item.
> It's the one thing we're all born needing and the last thing they ever had the right to charge for.
> We ain't asking anymore. We're taking back what was always ours.

*And so, let it be written — **and let it be known** — that this Act is more than law.*

It is a promise written in the language of survival.

What follows is not legislation, but testimony.

FINAL DECLARATION — THE PEOPLE'S CLAIM TO LIFE

We built a country that can shoot rockets past Saturn but can't keep an insulin vial at thirty bucks.

We can fund bombs in deserts we'll never see but not an ambulance in the next county.

Every headline about "cost" is a lie written by the same people who profit when you give up.

This Act is the receipt for every year they told us there was no money.

Turns out the money was always there — in tax breaks, in loopholes, and in lobby checks.

We're just rerouting it from greed to need.

From hedge funds to hospitals.

From shareholders to children.

The People's Healthcare Rescue Act says:

Health is not a market. It's right.

Debt is not destiny. It's design.

Poverty is not punishment. It's a policy.

And we are done letting policy kill us.

To the billionaires, the think tanks, and the political cowards hiding behind their donors —

you've had fifty years to prove your version works.

It doesn't.

Every stat in this bill is your report card.

And the grade is failure.

We're done begging for scraps from systems built to starve us.

We're taking back what we already paid for with our taxes, our labor, and our lives.

Healthcare will no longer be the luxury of the insured;

it will be the inheritance of the living.

To every rural mom who drove two hours in labor,

to every vet who rationed pills,

to every worker who skipped the doctor to keep the lights on,

to every grandma who hid her pain to spare her family another bill —

this Act is your refund.

We are the first generation to see the scam clearly enough to end it,

and the last one that should ever have to endure it.

Closing Message:

We're not asking. We're declaring.

You can't call yourself "pro-life" while cheering for a system that kills the poor slowly.

This plan saves lives, saves money, and saves the country from its own hypocrisy.

Either you stand with the people who make America run,

or you stand with the ones who ran it into the ground.

But after this you can't say you didn't know.

The receipts are right here.