United States Galactic Health Act of 2025

Preamble

119th CONGRESS

1st Session

H.R. ____

IN THE HOUSE OF REPRESENTATIVES

December 5, 2025

Mr. Timothy Harrington Nordyke (for himself and cosponsors) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and Oversight and Accountability, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To establish a universal zero-out-of-pocket healthcare system for all citizens and legal permanent residents, permanently eliminate medical bankruptcy, reduce national health expenditures to an average below 7 percent of gross domestic product within twenty years, accelerate the largest biomedical and longevity innovation boom in history, and generate fiscal surpluses equivalent to 1–2 percent of gross domestic product annually by 2040 for debt reduction, infrastructure, education, scientific research, space exploration, and direct taxpayer rebates while preserving maximum individual choice and aligning national biology with multiplanetary imperatives.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

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TITLE I: GENERAL PROVISIONS

CHAPTER 1: SHORT TITLE, TABLE OF CONTENTS, FINDINGS, AND PURPOSES

Section 1. Short Title; Table of Contents

(a) Short Title.—This Act may be cited as the "United States Galactic Health Act of 2025".

(b) Table of Contents.—The table of contents for this Act is as follows:

Section 2. Findings and Purposes
(a) Findings.—Congress finds the following:
(1) The United States spends 18.5 percent of gross domestic product on healthcare in 2025, exceeding all peer nations while producing a life expectancy of 78.4 years (versus an average of 82.5 among comparable countries) and an infant mortality rate of 5.6 per 1,000 live births (more than three times rates in leading peers like Japan and Norway).
(2) Medical debt is the leading cause of bankruptcy in the United States.
(3) Administrative inefficiencies and fragmented financing systems increase costs and reduce access, with administrative waste accounting for 25–30 percent of spending.
(4) Biomedical innovation is hindered by misaligned incentives and variable market pricing.
(5) Future multiplanetary settlement requires advances in human biology, including extended healthy lifespan, radiation resilience, and long-duration mission viability.
(6) Interstellar-range missions require median population lifespans exceeding 120 years and radiation countermeasures capable of mitigating exposures exceeding 1 Sievert.
(7) A unified national health system can reduce expenditures, eliminate medical bankruptcy, expand access, and accelerate innovation.
(b) Purposes.—The purposes of this Act are to:
(1) Provide universal zero-out-of-pocket healthcare coverage for all qualified individuals.
(2) Permanently eliminate medical bankruptcy.
(3) Achieve verifiable average health spending below 7 percent of gross domestic product by 2045, confirmed annually by the Congressional Budget Office, with interim milestones of 10 percent by 2040.
(4) Accelerate the largest medical, longevity, and human-performance innovation boom in history.
(5) Generate fiscal surpluses equivalent to 1–2 percent of gross domestic product annually by 2040 for debt reduction, infrastructure, education, scientific research, space exploration, and direct taxpayer rebates, audited by the Government Accountability Office.
CHAPTER 2: DEFINITIONS
Section 3. Definitions
In this Act:
(1) Qualified individual.—Any United States citizen or legal permanent resident. Emergency care extends to any person present in the United States.
(2) Medically necessary services.—Services determined by evidence-based guidelines issued by the Galactic Department of Health (formerly the Department of Health and Human Services), including services supporting longevity and multiplanetary biological readiness, with verifiable

longevity interventions defined as those with at least a 75 percent evidence-based probability of extending healthspan by 5 or more years per National Institutes of Health guidelines.
(3) Galactic Department of Health (GDOH).—The independent agency established under section 4.
(4) Policy Simulator.—The public artificial intelligence dashboard required under section 20.
(5) Galactic Health Innovation Fund (GHIF).—The fund established under section 9.
(6) Longevity Moonshot Fund.—The fund established under section 9 for advanced longevity research.
(7) Longevity Priority Enterprise.—An entity dedicating at least 50 percent of operations to certified longevity or human-performance therapies.
(8) Determinable outcome metric.—Any key performance indicator trackable via the Policy Simulator with less than a 5 percent margin of error.
(9) Payroll contribution.—The combined employer and employee contributions established under section 6(e), calculated as a percentage of—
(A) all wages, salaries, tips, and other employee compensation subject to taxation under chapter 1 of the Internal Revenue Code of 1986; and
(B) for any trade or business (including pass-through entities), net earnings from self-employment and distributive shares of partnership income or S corporation income, whether or not distributed.
Such contributions shall fully replace and offset the employer and employee portions of taxes imposed under sections 3101 and 3111 (Social Security and Medicare) and all private health insurance premiums for qualified individuals.
TITLE II: ESTABLISHMENT AND COVERAGE
CHAPTER 1: GALACTIC DEPARTMENT OF HEALTH
Section 4. Establishment of the Galactic Department of Health
(a) Establishment.—There is established the Galactic Department of Health (GDOH), an independent agency operating as a single-payer system for qualified individuals. The GDOH shall incorporate the entirety of the Department of Health and Human Services and any subsequent programs, consolidating redundant administrations.
(b) Coverage.—Beginning January 1, 2027, the GDOH shall provide zero-out-of-pocket coverage for all medically necessary services, including:
(1) Hospital inpatient and outpatient care.
(2) Physician and specialist services.
(3) Mental health and substance use disorder treatment.
(4) Dental, vision, and hearing services.
(5) Prescription drugs and biologics.
(6) Rehabilitative and habilitative services.
(7) Preventive and wellness services.
(8) Maternity, newborn, and fertility care.
(9) Long-term care and home health services.
(10) Emergency services, including for non-qualified individuals.
(11) Evidence-based social-determinants-of-health services, including nutrition assistance when prescribed as part of a covered care plan.
(c) Phased Rollout with State Pilots.—Full national implementation shall commence on January 1, 2035. Pilot Selection.—States shall be selected by the Secretary of Health and Human

Services in consultation with the Comptroller General, ensuring that at least 50 percent of selected pilots represent bipartisan balance (defined as one Democratic-leaning and one Republican-leaning state per region, per the Cook Partisan Voting Index for the most recent gubernatorial election). [Retain existing text on funding/anti-rationing.] If fewer than 80 percent of metrics (enrollment ≥90 percent, denials <2 percent, spending <13 percent of gross domestic product) are achieved across pilots in any fiscal year, as verified quarterly by the Congressional Budget Office, the Galactic Department of Health shall provide a federal backstop funding equivalent to 0.1 percent of the prior fiscal year's federal health expenditures, drawn from the transitional reinsurance pool under section 6(b)(4), to stabilize provider reimbursements without increasing overall Trust Fund outflows. Data from pilots shall inform surpluses via the Policy Simulator under section 20, addressing federal overreach concerns while preserving automatic enrollment nationwide post-pilot. Full national implementation shall commence on January 1, 2035, provided that if at least 15 pilots achieve 95 percent of metrics by fiscal year 2032, as certified by the Government Accountability Office, such date shall accelerate to January 1, 2033.

(d) Anti-Rationing Guarantee.—

(1) The GDOH may not deny or delay any medically necessary service to a qualified individual under age 75 that credible peer-reviewed evidence shows has at least a 10 percent probability of extending healthy lifespan by 5 or more years or restoring capacity for work or independent living. Evidence shall mean randomized controlled trials or meta-analyses published in journals indexed by PubMed with impact factor ≥10, as listed annually by NIH guidelines; disputes resolved by binding arbitration under Federal Rules of Civil Procedure.

(2) All such services shall be funded through a dedicated High-Value Care Account that may not exceed 5 percent of total annual GDOH expenditures in any fiscal year.

(3) If demand exceeds limit, prioritize by expected healthy years gained per $1,000 incremental cost, using NIH-validated models; top 80% fully covered if pilots under Sec. 4(c) demonstrate <5% denial rates.

(e) Enrollment.—Automatic enrollment for all qualified individuals, with opt-out options under section 5.

(f) Integration of Social Security.—Existing Social Security accounts are grandfathered, with benefits payable as under current law. New accounts may be created, but funding shall derive from the National Health and Longevity Trust Fund, including payroll contributions and surplus dividends allocated under this Act, with a fiscal bridge fund equivalent to 0.1 percent of the prior fiscal year's federal health expenditures for the first five years to cover overlaps during payroll shifts.

CHAPTER 2. OPT-OUT PROVISIONS AND VOUCHER SYSTEM

Section 5. Opt-Out Provisions and Voucher System

(a) Opt-Out Eligibility.—Qualified individuals may opt out of GDOH coverage annually, receiving a risk-adjusted voucher equivalent to 100 percent of per-capita GDOH spending, scaled by CMS risk-adjustment factors for high-risk/older individuals, with annual recoupment of unused funds exceeding 10 percent.

(b) Voucher Use.—Vouchers may fund:

(1) Private health plans.

(2) Health savings accounts.

(3) Direct primary care arrangements.

(c) Private Plan Restrictions.—Private plans funded by vouchers are limited to 2 percent

administrative and 8 percent profit margins. Re-enrollment in GDOH is penalty-free. Opt-out rates shall be tracked as a determinable outcome metric with a target below 10 percent.

(d) State Supplements.—States may offer additional benefits without federal preemption.

TITLE III: FUNDING AND TRANSITION

CHAPTER 1: FUNDING MECHANISMS AND TRANSITION

Section 6. Funding Mechanisms and Transition

(a) National Health and Longevity Trust Fund.—All revenues under this section shall be deposited into a dedicated National Health and Longevity Trust Fund.

(b) Transition Phase (Fiscal Years 2027–2036).—Funding sourced from:

(1) Redirection of existing federal health expenditures (Medicare, Medicaid, CHIP, VA, ACA, Department of Health and Human Services programs).

(2) Employer and employee health premiums converted to payroll contributions.

(3) Revenue-neutral tax adjustments to reduce net taxpayer burden, including phase-in of the 1 percent financial transaction tax on trades exceeding $10 million via reconciliation.

(4) Temporary high-cost reinsurance pool for claims exceeding 0.05 percent of gross domestic product per enrollee per year during the transition phase, funded exclusively by the National Health and Longevity Trust Fund and modeled on the Affordable Care Act transitional reinsurance program and state 1332 waiver reinsurance programs.

(5) Disproportionate share hospital and graduate medical education funds following patients to ease provider transition.

(6) Consolidation of nutrition and social determinants programs.—Effective January 1, 2028, the Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), school lunch and breakfast programs under the Richard B. Russell National School Lunch Act, the Emergency Food Assistance Program, and all discretionary and block-grant programs administered by the Department of Health and Human Services (other than those already transferred under paragraphs (1)–(5)) shall be transferred to and administered by the GDOH as part of the National Health and Longevity Trust Fund. Such programs shall be reformed and integrated as evidence-based social-determinants-of-health interventions, with eligibility automatically aligned to GDOH enrollment and benefits expanded to include preventive nutrition and housing supports where demonstrated to reduce total cost of care by at least 5 percent per enrollee cohort, as verified annually by the Policy Simulator.

(c) Ongoing Funding (Phased to Fiscal Year 2047).—Sources include:

(1) Payroll taxes as specified in subsection (e).

(2) Federal health program budgets.

(3) Most-favored-nation-minus-20 percent pricing for pharmaceuticals through GDOH contracts.

(4) A 1 percent financial transaction tax reallocation on trades exceeding $10 million.

(5) Reallocated 1 percent of existing excise taxes on luxury goods and unhealthy products. All non-payroll sources limited to 20% of Trust Fund inflows, sourced solely from verified efficiencies under Sec. 13.

(6) 12 percent of import tariffs.

(d) Fiscal Circuit Breakers.—If expenditures exceed 13 percent of gross domestic product, tax rates freeze until compliance. Surpluses trigger automatic tax reductions (e.g., 1 percentage point cut to top marginal income tax rate per surplus equivalent to 0.6 percent of gross domestic product). If surpluses exceed 0.2 percent of gross domestic product, up to 8 percent shall be

allocated to provider bonuses for improved outcomes.
(e) Payroll Tax Cap and Allocation.—The total combined payroll tax rate (including employer and employee shares) shall be capped at 15 percent. Of this 15 percent, 45 percent shall be dedicated to the National Health and Longevity Trust Fund for health, longevity, and integrated Social Security purposes, with 27.5 percent allocated to previous federal tax allocations and 27.5 percent to previous state tax allocations, reduced by the actuarial value of employer-sponsored health premiums paid in the prior taxable year. The combined payroll contribution shall be reduced dollar-for-dollar by existing sections 3101/3111 taxes and prior-year employer premiums, with CBO pre-enactment certification required for neutrality in 95% of income quintiles; if shortfall >5%, automatic phase-in delay by 1 year. This cap and allocation shall be phased in over seven years following the date of enactment, with exemptions for income below 0.05 percent of gross domestic product per capita and 50 percent rebates to low earners via Earned Income Tax Credit expansion. All sources under subsections (b) and (c) shall be pre-scored by the Congressional Budget Office within 90 days of enactment, with alternatives triggered if shortfalls exceed 10 percent of projections.
(f) Escalator and Delay Provisions.—
(1) Health Inflation Escalator.—If the annual percentage change in the Consumer Price Index for All Urban Consumers (CPI-U), as published by the Bureau of Labor Statistics for the Medical Care component, exceeds 3 percent in any fiscal year during the phase-in period under subsection (e), the combined payroll contribution rate shall automatically increase by 1 percentage point for the following fiscal year, with such increase allocated proportionally to the National Health and Longevity Trust Fund and offset by equivalent reductions in the employer-sponsored health premium deductions under subsection (e), as certified neutral by the Congressional Budget Office prior to implementation.
(2) Auto-Delay Mechanism.—Any phase-in delay under subsection (e) due to shortfalls greater than 5 percent shall apply exclusively to individuals in the top 20 percent income quintile, as determined by Internal Revenue Service adjusted gross income thresholds for the prior taxable year, with full implementation maintained for all other quintiles.
(3) IRS Pre-Audit Requirement.—Prior to the phase-in of any payroll contribution adjustments under this section, the Internal Revenue Service, in consultation with the Congressional Budget Office, shall conduct and publish a pre-audit of all offsets against sections 3101 and 3111 taxes and prior-year employer premiums, ensuring dollar-for-dollar neutrality in at least 95 percent of income quintiles. If the audit identifies discrepancies exceeding 2 percent, implementation shall be delayed by 6 months, with quarterly updates tracked via the Policy Simulator under section 20
CHAPTER 2: PRIVATE INSURANCE TRANSITION AND SUPPLEMENTAL OPTIONS
Section 7. Private Insurance Transition and Supplemental Options
(a) Transition.—No new duplicative private policies may be issued after 540 days post-enactment. Existing policies are grandfathered for up to 7 years in cohorts with satisfaction rates exceeding 80 percent per Consumer Assessment of Healthcare Providers and Systems surveys, with up to 0.2 percent of the prior fiscal year's federal health expenditures allocated as a retraining fund for displaced workers.
(b) Supplemental Insurance.—Unrestricted for non-duplicative benefits. Private carriers may contract with GDOH at fees not exceeding 5 percent.
(c) Employer Plans.—Employers may offer supplemental insurance or contribute to vouchers.

TITLE IV: PRICING AND INNOVATION REFORMS

CHAPTER 1: PRICING REFORMS FOR PHARMACEUTICALS AND MEDICAL DEVICES

Section 8. Pricing Reforms for Pharmaceuticals and Medical Devices

(a) Galactic Golden Ticket System.—Tiered pricing:

(1) Tier 1: Most-favored-nation.

(2) Tier 2: Most-favored-nation-minus-10 percent for high-value innovations.

(3) Tier 3: For longevity priorities (e.g., Alzheimer's cures, radiation hardening), 5-year price freedom, 100 percent research and development prizes, and government equity options (capped at 5 percent per entity). Equity stakes shall be non-voting and automatically distributed pro-rata to all American citizens via a sovereign wealth account upon liquidity events, with validation required from the National Institutes of Health and the Food and Drug Administration for at least 10 percent lifespan extension in Phase III trials.

(4) Data-Sharing and Clawback Provisions.—Entities receiving Tier 3 benefits shall mandatorily share all Phase IV post-market surveillance data, including real-world evidence on efficacy, with the Food and Drug Administration and National Institutes of Health via a public API accessible through the Policy Simulator under section 20. If such data demonstrates less than a 5 percent extension in healthspan or equivalent longevity metric, as verified by NIH epigenetic clock models within 24 months of market entry, the Secretary shall impose clawbacks equivalent to 150 percent of excess revenues above most-favored-nation-minus-20 percent pricing, deposited into the Galactic Health Innovation Fund, with disputes resolved by binding arbitration under Federal Rules of Civil Procedure.

(b) Non-Compliance.—Leads to compulsory licensing at generic rates.

(c) Competition and Transparency Boosts.—All providers and facilities shall mandate machine-readable, API-accessible pricing for all Current Procedural Terminology, Diagnosis-Related Group, and National Drug Code identifiers, enforced via penalties equivalent to 0.5 percent of annual revenue per violation, consistent with Medicare eligibility withholdings and 2025 transparency rules. In state pilots under section 4(c), repeal barriers including Certificate of Need laws and physician-owned hospital bans to enable direct primary care and voucher competition, incorporating site-neutral payments for market efficiencies without eroding universal coverage.

CHAPTER 2: GALACTIC HEALTH INNOVATION FUND, LONGEVITY MOONSHOT FUND, AND INCENTIVES

Section 9. Galactic Health Innovation Fund and Performance-Gated Longevity Prize System

(a) Galactic Health Innovation Fund (GHIF).—

(1) Establishment.—There is established in the Treasury the Galactic Health Innovation Fund.

(2) Funding source.—Beginning in fiscal year 2028 and each fiscal year thereafter, an amount equal to not less than 1 percent and not more than 20 percent of the verified reduction in national health expenditures below the pre-enactment baseline (as certified annually by the Congressional Budget Office compared to its January 2025 baseline) shall be transferred to the GHIF. No transfer shall occur in any year in which national health expenditures equal or exceed the pre-enactment baseline.

(3) Use of funds.—Amounts in the GHIF shall be available without further appropriation solely for—

(A) prize purses under subsection (b);

(B) advance market commitments and milestone payments for longevity and multiplanetary biological readiness technologies; and
(C) technology prizes open to any domestic or international entity.
(4) Carryover.—Unobligated balances shall remain available indefinitely and shall not revert to the general fund.
(b) Longevity and Multiplanetary Prize Program.—
(1) In general.—The Secretary shall use amounts in the GHIF to offer large, pre-announced, independently verified prize purses and advance market commitments for achieving specific, measurable scientific and clinical milestones that significantly and verifiably extend healthy human lifespan or enable increased human immune and physiological fortitude.
(2) No grants or traditional research funding.—None of the amounts in the Fund may be used for grants, cooperative agreements, contracts (other than prize administration contracts), or general research appropriations. Money may only be obligated or expended upon independent verification that a claimant has fully achieved a pre-announced milestone.
(3) Milestone categories.—The Secretary shall prioritize (but is not limited to) prizes for:
(A) Rejuvenation of mammalian (including human) healthspan by 10 percent or more in a randomized controlled trial using FDA-recognized biomarkers (Tier 1 prize: not less than $100,000,000), scaling to 20 percent or more (Tier 2 prize: not less than $500,000,000);
(B) Radiation countermeasures permitting healthy survival after cumulative exposure of 1.5 Sievert with less than 5 percent loss of function (Tier 1: $100,000,000 for 1.0 Sievert threshold, scaling to full milestone);
(C) [Retain existing (C)–(E), with analogous tiering: e.g., 10-year reversal at Tier 1 ($100,000,000), full 15-year at Tier 2 ($1,000,000,000).]
(F) Stretch goals.—For each milestone category, the Secretary shall establish one or more stretch goals exceeding the base threshold by at least 50 percent (e.g., 30 percent healthspan rejuvenation), with prize amounts scaled accordingly up to $5,000,000,000, verified under paragraph (5).
(4) Prize size flexibility.—Prizes shall range from $100 million to $5 billion per milestone, scaled by NIH-estimated population benefit (e.g., $X per healthy life-year gained), with total annual GHIF outlays capped at 5% of verified Sec. 6 surpluses.
(5) Transparency and verification.—All prize rules, judging criteria, and verification protocols shall be published at least 18 months in advance. Verification shall be performed by an independent panel appointed jointly by the National Academy of Sciences and the Food and Drug Administration.
(6) Seed Milestone Allocation.—Not more than 20 percent of amounts in the Galactic Health Innovation Fund may be allocated annually for seed prizes or advance commitments for preliminary milestones (e.g., Phase II trial demonstrations of at least 5 percent healthspan gain), provided such milestones are independently verified by a panel appointed jointly by the National Academy of Sciences and the Food and Drug Administration, with results published in the Federal Register at least 6 months prior to award. Unobligated seed funds shall carry over to subsequent fiscal years.
(c) Rule of Construction.—Nothing in this section shall be construed to authorize any appropriation or mandatory spending except from verified savings as provided in subsection (a)(2).

TITLE V: PROVIDER AND WORKFORCE REFORMS

CHAPTER 1: PROVIDER PAYMENT REFORMS AND WORKFORCE INCENTIVES

Section 10. Provider Payment Reforms and Workforce Incentives

(a) Payment Models.—Global budgets for hospitals with 150 percent savings retention if outcomes improve by at least 10 percent per Healthcare Effectiveness Data and Information Set scores; outcome-based pay for clinicians with up to 5x multipliers.

(b) Workforce Incentives.—Up to 170 percent funding and loan forgiveness for underserved areas; interstate licensing facilitation; and up to 0.1 percent of the prior fiscal year's federal health expenditures for artificial intelligence-assisted training targeting a 20 percent increase in rural providers by 2032.

(c) Penalties.—Fines equivalent to 300 percent of the overbilled amount and debarment for overbilling or fraud.

TITLE VI: FISCAL SAFEGUARDS AND SURPLUSES

CHAPTER 1: SURPLUS ALLOCATION AND FISCAL SAFEGUARDS

Section 11. Surplus Allocation and Fiscal Safeguards

(a) Surplus Threshold.—If revenues exceed 102 percent of projected expenditures:

(1) 10 percent to contingency reserves.

(2) 70 percent to national debt reduction.

(3) 10 percent to infrastructure, education, research, and space exploration.

(4) 10 percent to direct universal health dividends, including 10 percent of savings as automatic tax credits deposited every April 15 into every taxpayer's chosen bank account or federally compliant digital wallet or by mailed paper check, echoing 2025 Medicare enhancements such as $35/month insulin caps, with 20 percent to multiplanetary research and development.

(b) Safeguards.—Annual audits and automatic adjustments to prevent deficits, including a surplus verifier via Government Accountability Office audit projecting debt paydown trajectory.

CHAPTER 2: ADMINISTRATION AND GOVERNANCE

Section 12. Administration and Governance

(a) Board.—A 19-member independent board, appointed by the President with Senate confirmation, requiring supermajority votes for major decisions, with at least 30 percent from state pilot experts. All meetings live-streamed.

(b) Operations.—GDOH administers coverage, payments, and funds with a maximum 2.5 percent administrative overhead after the third year.

TITLE VII: PERFORMANCE, ENFORCEMENT, AND PROTECTIONS

CHAPTER 1: PROJECTIONS AND PERFORMANCE METRICS

Section 13. Projections and Performance Metrics

(a) Projections.—GDOH shall project:

(1) Health spending below 10 percent of gross domestic product by 2040 and an average below 7 percent by 2045.

(2) National debt elimination by 2057.

(3) Healthy life expectancy exceeding 132 years by 2257, contingent on Longevity Moonshot Fund milestones, with interim healthspan targets of 85 years by 2050 modeled via Policy Simulator.

(4) Annual taxpayer savings equivalent to 1–2 percent of per-capita gross domestic product.

(b) Metrics.—Track all available indicators, including access, outcomes, and innovation rates such as infant mortality below 3 per 1,000 live births by 2030 and a 50 percent rise in Food and Drug Administration approvals for longevity technologies by 2035. Adaptive thresholds shall trigger independent review and adjustments if metrics lag by 10 percent.

Section 14. Anti-Corruption and Enforcement Measures

(a) Prohibitions.—10-year bans from health-related industries for convicted violators; felony charges for bribery or fraud.

(b) Enforcement.—Dedicated inspector general with whistleblower protections.

Section 15. Malpractice Reform and Patient Protections

(a) Reforms.—Caps on non-economic damages at $500,000, adjusted for inflation; mandatory arbitration options.

(b) Protections.—Right to appeal denials; transparency in provider outcomes.

Section 16. Non-Discrimination, Equity, and Health Justice Provisions

(a) Comprehensive Non-Discrimination Requirement.—

(1) In general.—No qualified individual shall be denied, delayed, or received inferior coverage or care under this Act on the basis of race, color, ethnicity, national origin, tribal affiliation, sex, sexual orientation, religion, age, disability, genetic information, socioeconomic status, geographic location (including rural or urban residency), criminal history, health status, pre-existing conditions, or any other protected characteristic recognized under Federal civil rights laws or enumerated in this section.

(2) Application to providers.—Any provider, facility, contractor, or entity receiving funds or participating in the GDOH system shall be prohibited from engaging in any discriminatory practice described in paragraph (1).

(3) Language access.—All services, notices, and materials shall be provided in the preferred language of the individual at no cost, with mandatory availability of qualified interpreters (in-person, video, or telephonic) meeting or exceeding standards under Title VI of the Civil Rights Act of 1964 and Section 1557 of the Patient Protection and Affordable Care Act.

(b) Affirmative Equity Obligations.—

(1) Health Equity Investment Fund.—Beginning in fiscal year 2028, GDOH shall allocate 3% of expenditures (fixed through 2035) to Health Equity Fund, with outcomes tracked via Policy Simulator metrics showing >10% disparity reduction annually and excess allocated to surpluses under Sec. 11, for:

(A) eliminating disparities in maternal mortality, infant mortality, life expectancy, and chronic disease outcomes, targeting maternal mortality below 20 per 100,000 live births by 2035;

(B) constructing, expanding, or modernizing healthcare facilities in federally designated Health Professional Shortage Areas, Medically Underserved Areas, and rural communities;

(C) broadband and telehealth infrastructure deployment to achieve 100 percent high-speed connection availability in every county by 2032;

(D) loan repayment, scholarship, and residency programs targeting underrepresented minorities and individuals from disadvantaged backgrounds;

(E) community health worker and navigator programs in high-need areas; and

(F) culturally and professionally competent mental health and substance-use-disorder services.

(2) Rural and Frontier Protections.—

(A) No facility closures or service reductions in counties with population density below 100 persons per square mile without prior approval through a public hearing process and

demonstration of zero net loss of access.
(B) Mandatory site-neutral and distance-based reimbursement enhancements of at least 125 percent of urban rates for critical access hospitals and rural health clinics.
(C) Annual “fly-in/fly-out” and mobile clinic funding sufficient to guarantee every rural resident is within 60 minutes ground travel or 30 minutes air-medical response time of emergency care.
(c) Data Collection, Monitoring, and Public Reporting.—
(1) GDOH shall collect, analyze, and publicly report standardized data on health outcomes, access, and quality, disaggregated by every category listed in subsection (a)(1).
(2) Beginning January 1, 2028, and annually thereafter, the GDOH Office of Health Equity shall publish a National Health Disparities and Equity Report Card with letter grades for each state, territory, and tribal nation.
(3) Failure to demonstrate measurable progress toward eliminating disparities for three consecutive years shall trigger automatic corrective action plans and potential withholding of up to 5 percent of administrative funds until compliance is achieved.
(d) Tribal Sovereignty and Consultation.—
(1) Nothing in this Act shall be construed to impair treaty rights, trust responsibilities, or the government-to-government relationship between the United States and federally recognized Indian Tribes, Alaska Native villages, or Native Hawaiian organizations.
(2) Tribes may elect to administer GDOH benefits through compacts or contracts under the Indian Self-Determination and Education Assistance Act, with 100 percent federal funding and no state interference.
(e) Enforcement and Private Right of Action.—
(1) Any individual or class of individuals aggrieved by a violation of this section may bring a civil action in federal district court.
(2) Prevailing plaintiffs shall be entitled to reasonable attorney’s fees, expert fees, and compensatory damages uncapped for systemic violations, defined as discriminatory practices affecting access or outcomes in at least two protected categories under subsection (a)(1) with disparities exceeding 10 percent as measured by the National Health Disparities and Equity Report Card under subsection (c)(2) (e.g., rural access denials impacting geographic location and socioeconomic status); for non-systemic violations, damages shall be capped at $250,000 per claimant. [Retain class action text.] Class actions exceeding 1,000 members shall require Galactic Department of Health certification only if not involving disparities greater than 10 percent under the Report Card; such certification shall be deemed approved within 90 days absent a showing of frivolous claims by clear and convincing evidence.
(3) The Attorney General and the GDOH Inspector General are authorized to initiate enforcement actions independently.
(4) Legal Aid Funding.—The Galactic Department of Health shall allocate not more than 0.5 percent of its annual administrative overhead under section 12(b) to a dedicated Plaintiff Legal Aid Fund for aggrieved individuals under this subsection, prioritizing low-income and rural claimants as verified by Policy Simulator data. Funds shall be administered through grants to qualified non-profit legal aid organizations, with annual audits by the Inspector General.
(f) Severability of Equity Provisions.—If any provision of this section is held invalid with respect to any specific class or circumstance, such invalidity shall not affect the remaining applications of this section.
CHAPTER 2: STATE FLEXIBILITY AND INTERSTATE COMPACTS

Section 17. State Flexibility and Interstate Compacts

(a) Flexibility.—States may innovate within federal guidelines, including waivers for alternative models and voluntary pilots under section 4(c) to test zero-out-of-pocket coverage subsets using redirected Affordable Care Act subsidies, building data for surpluses via the Policy Simulator while enforcing anti-rationing and health spending targets below 9 percent of gross domestic product, with Section 1332 waivers permitted for hybrid models.

(b) Compacts.—Facilitates interstate provider licensing and care delivery.

TITLE VIII: TRANSITIONAL AND OVERSIGHT PROVISIONS

CHAPTER 1: GALACTIC TRANSITION AUTHORITY AND MULTIPLANETARY READINESS

Section 18. Galactic Transition Authority

(a) Establishment.—A temporary authority to oversee the transition, sunsetting in fiscal year 2045.

(b) Duties.—Coordinate enrollment, funding shifts, and system integration, including a contingency reserve equivalent to 0.5 percent of the prior fiscal year's federal health expenditures for provider stabilization if payments drop by more than 2% percent.

Section 19. Multiplanetary Biological Readiness and Human Performance Research

(a) Annual Multiplanetary Biological Readiness Report.—Beginning in fiscal year 2028 and every fiscal year thereafter, the GDOH shall submit to Congress and publish publicly a comprehensive Multiplanetary Biological Readiness Report assessing the nation's progress toward achieving biological capabilities required for safe, sustained human settlement beyond Earth.

(b) Mandatory Minimum Funding Tied to Gross Domestic Product.—

(1) In general.—The Galactic Department of Health shall allocate a base amount equal to 0.1 percent of the prior fiscal year's nominal gross domestic product, drawn exclusively from unobligated carryover balances in the Galactic Health Innovation Fund under section 9(a)(4), if and only if the Longevity Moonshot Fund achieves at least one milestone under section 9(b) in the prior two fiscal years; such base allocation shall escalate by 0.05 percentage points upon verification of any additional milestone via the Policy Simulator under section 20, up to the permanent floor of 0.75 percent.

(A) Extension of maximum healthy human lifespan and healthspan.

(B) Comprehensive genetic and pharmacological radiation countermeasures capable of mitigating cumulative exposures exceeding 1 Sievert without significant loss of function.

(C) Bone, muscle, cardiovascular, and neurovestibular preservation in reduced-gravity and high-radiation environments.

(D) Closed-loop life-support-compatible immunology and microbiome optimization.

(E) Reproductive biology and developmental resilience in partial-gravity and elevated-radiation conditions.

(F) Cognitive enhancement and psychological resilience for long-duration isolation during space travel and exploration.

(G) Rapid trauma care and regenerative medicine suitable for austere extraterrestrial environments.

(2) Escalator.—The percentage required under paragraph (1) shall automatically increase by 0.05 percentage points each fiscal year beginning in 2035 until reaching a permanent floor of

0.75 percent of the prior fiscal year's nominal gross domestic product, unless modified by a subsequent Act of Congress (domains as specified in subparagraphs (1)(A)-(G)).

(3) Allocation requirements.—Of the amounts allocated under this subsection:

(A) Not less than 40 percent shall be awarded through milestone-based prizes and advance market commitments open to domestic and international entities. All funding for activities described in this section shall be drawn exclusively from the Longevity and Multiplanetary Prize Trust established under section 9(b). No separate appropriation or mandatory spending is authorized.

(4) Decoupling from Annual Count.—For purposes of the allocation under paragraph (1), milestones shall be assessed on a biennial basis (e.g., fiscal years 2028–2029 as one period), with carryover of unmet milestones to the subsequent period if verified within 12 months. No allocation shall occur in a biennial period with zero verified milestones, but the base 0.1 percent shall remain available as a contingency draw from the National Health and Longevity Trust Fund if health expenditures fall below 10 percent of gross domestic product, as certified by the Congressional Budget Office.

CHAPTER 2: POLICY SIMULATOR, TRANSPARENCY, AND FISCAL ASSESSMENT

Section 20. Policy Simulator and Transparency Requirements

(a) Simulator.—A public artificial intelligence dashboard tracking real-time metrics, comparing this Act to alternatives, with open-source code and independent audits, incorporating state pilot data under section 4(c) to project surpluses, including sensitivity analysis for plus or minus 1 percent gross domestic product growth and a public application programming interface for third-party audits leveraging public AI models like Grok for projections.

(b) Transparency.—All guidelines, decisions, and data publicly accessible, with a revenue dashboard for real-time tracking.

Section 21. Independent Fiscal Impact Assessment

(a) Requirement.—The Congressional Budget Office, Government Accountability Office, and three independent fiscal analysis firms shall publish 10-, 25-, and 50-year projections of the Act's fiscal impacts, including a viability scorecard with at least 90 percent confidence in the below-9-percent-of-gross-domestic-product target.

(b) Public Availability.—All reports shall be publicly posted within 12 months of enactment, with pre-enactment 50-year scoring by the Congressional Budget Office projecting net savings equivalent to 2–3 percent of gross domestic product annually.

TITLE IX: FINAL PROVISIONS

CHAPTER 1: SEVERABILITY, EFFECTIVE DATE, SUNSET, AND EMERGENCY CLAUSE

Section 22. Severability

If any provision of this Act is held invalid, the remainder shall not be affected.

Section 23. Effective Date and Sunset Reauthorization

(a) Effective Date.—This Act takes effect on the date of enactment, with state pilots commencing January 1, 2027, vouchers available January 1, 2028, and full national coverage beginning January 1, 2035, accelerated if pilots achieve 95 percent of metrics.

(b) Sunset.—This Act sunsets on December 31, 2047, unless reauthorized by Congress every 10 years with a Congressional Budget Office gate requiring projected surpluses.

Section 24. Limited Emergency Flexibility and Congressional Oversight

(a) Temporary Emergency Adjustments Authorized Only by Congress.—During a period in

which a joint resolution declaring a qualified national health emergency is in effect (pursuant to the procedures in subsection (b)), the following temporary modifications to fiscal safeguards in this Act are permitted only to the extent expressly authorized by such joint resolution and only for the duration specified therein:

(1) Suspension or modification of the payroll contribution cap under section 6(e) by not more than 2 percentage points;

(2) Temporary increase in the High-Value Care Account limit under section 4(d)(2) from 3.5 percent to not more than 8 percent of total annual GDOH expenditures;

(3) One-time delay of up to 24 months in any scheduled sunset or reauthorization requirement under section 23.

(b) Declaration and Termination of Qualified National Health Emergency.—

(1) A qualified national health emergency may be declared only by a joint resolution enacted by Congress and signed by the President (or enacted over the President's veto).

(2) Any such joint resolution shall terminate automatically after 730 days unless affirmatively reauthorized by a new joint resolution.

(3) Congress may terminate the emergency at any earlier time by simple majority vote in both Houses.

(c) Strict Limits and Transparency.—

(1) No emergency declaration or joint resolution may suspend or modify any individual rights, coverage guarantees, anti-rationing provisions, opt-out rights, or non-discrimination protections in this Act.

(2) All expenditures made under emergency authority shall be separately tracked and reported monthly to Congress and the public via the Policy Simulator required under section 20.

(d) Rule of Construction.—Nothing in this section authorizes the suspension of any provision of the Constitution or any other federal law.