A Bill

To establish a comprehensive, voluntary national health care framework that promotes interstate commerce in health services, leverages federal authorities under the Taxing Clause for duties and imposts on foreign trade, and ensures accessibility while respecting individual rights and state sovereignty, in full accordance with the U.S. Constitution.
H.R. 9999

IN THE HOUSE OF REPRESENTATIVES

October 21, 2025

A BILL

To create the American Health Freedom System, a new voluntary national health care framework designed to be fully constitutional by relying on Congress's enumerated powers under Article I, Section 8 of the U.S. Constitution, including the Commerce Clause, the power to lay duties and imposts on foreign trade, and the Necessary and Proper Clause, while avoiding any individual mandates, preserving state authority under the Tenth Amendment, and protecting individual liberties under the Bill of Rights. Funding shall be derived exclusively from a new External Revenue System focused on tariffs and targeted taxes on foreign businesses and trade, replacing reliance on domestic taxes. The system shall provide free health care services, with no premiums, copayments, deductibles, or out-of-pocket costs, to all eligible individuals who are U.S. citizens or lawful permanent residents.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
(a) Short Title.—This Act may be cited as the "American Health Freedom Act of 2025".
(b) Table of Contents.—The table of contents for this Act is as follows:

SECTION 2. FINDINGS AND PURPOSE.(a) Findings.—Congress finds the following:
(1) The U.S. health care system faces challenges including high costs, uneven access, and inefficiencies that affect interstate commerce by impeding the free flow of goods, services, and labor across state lines.
(2) Under Article I, Section 8, Clause 3 of the Constitution (Commerce Clause), Congress has

the authority to regulate activities that substantially affect interstate commerce, such as health insurance and medical services that cross state borders.
(3) Under Article I, Section 8, Clause 1, Congress may lay and collect duties, imposts, and excises on foreign trade and businesses to provide for the general welfare, including funding health care initiatives without burdening domestic taxpayers.
(4) The Tenth Amendment reserves powers not delegated to the Federal Government to the States or the people, necessitating a voluntary, state-opt-in approach to avoid federal overreach.
(5) The Fifth and Fourteenth Amendments protect due process and equal protection, requiring that any system avoid arbitrary discrimination and respect property rights in health care decisions.
(6) The First Amendment protects freedom of speech and association, ensuring no mandates on providers or patients that could infringe on conscience or religious beliefs.
(7) Supreme Court precedents, such as National Federation of Independent Business v. Sebelius (2012), affirm Congress's power to use revenue mechanisms for health care incentives but prohibit coercive mandates under the Commerce Clause.
(8) Historical precedents, including the Tariff Act of 1789, confirm Congress's broad authority to impose tariffs on imports for revenue purposes, as upheld in cases like J.W. Hampton, Jr. & Co. v. United States (1928).
(9) A new system can be accomplished constitutionally by focusing on voluntary participation, federal incentives funded through external revenues, interstate compacts, and market-based reforms to lower costs and increase access, while providing free care to eligible individuals.
(b) Purpose.—The purpose of this Act is to establish a new health care system, the American Health Freedom System (AHFS), that:
(1) Provides universal access through voluntary, market-driven mechanisms without individual or employer mandates.
(2) Reduces costs by promoting competition across state lines.
(3) Ensures constitutionality by limiting federal roles to facilitation, incentives, and oversight, while empowering states and individuals.
(4) Accomplishes implementation through phased incentives, regulatory relief, and public-private partnerships, fully funded via the External Revenue System utilizing tariffs on foreign imports and targeted taxes on foreign businesses operating in the U.S., without reliance on domestic income or sales taxes.
(5) Delivers free health care services—at no cost to the individual, including no premiums, copayments, deductibles, or out-of-pocket expenses—to all U.S. citizens and lawful permanent residents who enroll.

SECTION 3. DEFINITIONS.

In this Act:
(1) Eligible Individual.—The term "eligible individual" means any U.S. citizen or lawful permanent resident.
(2) Health Care Provider.—The term "health care provider" includes licensed physicians, hospitals, clinics, and other entities providing medical services.
(3) Interstate Compact.—The term "interstate compact" means an agreement between two or more States approved by Congress under Article I, Section 10, Clause 3.
(4) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.
(5) State.—The term "State" includes the District of Columbia and U.S. territories.
(6) External Revenue System.—The term "External Revenue System" means the mechanism

established under section 4 to generate funds from tariffs and taxes on foreign trade and businesses.
(7) Free Health Care Services.—The term "free health care services" means comprehensive medical care, including preventive, primary, specialty, hospital, prescription drugs, mental health, and long-term care, provided at no cost to eligible individuals, with all expenses covered by the AHFS.

SECTION 4. ESTABLISHMENT OF THE EXTERNAL REVENUE SYSTEM.
(a) In General.—There is established the External Revenue System (ERS), administered by the Secretary of the Treasury in coordination with U.S. Customs and Border Protection, to fund the AHFS exclusively through revenues derived from external sources, without imposing new domestic taxes.
(b) Components of the ERS.—The ERS shall consist of:
(1) Tariffs on Foreign Imports.—Imposition of uniform tariffs ranging from 5% to 25% (based on product category and country of origin) on all imported goods, with exemptions for essential humanitarian items, as determined by the Secretary of the Treasury. Revenues shall be directed solely to the AHFS Trust Fund established under subsection (d).
(2) Taxes on Foreign Businesses.—A 10% excise tax on profits earned by foreign-owned corporations operating in the U.S. from trade-related activities, excluding U.S.-based subsidiaries fully compliant with domestic tax laws. This tax shall apply only to entities with more than 50% foreign ownership and annual U.S. revenues exceeding $100 million.
(3) Trade Adjustment Mechanisms.—Authority for the President to negotiate reciprocal trade agreements that could adjust tariffs downward if foreign nations reduce barriers to U.S. exports, with congressional oversight via fast-track procedures.
(c) Revenue Projections and Allocation.—The ERS is projected to generate at least $500 billion annually (adjusted for inflation and trade volumes), based on current import levels exceeding $3 trillion. All revenues shall be allocated as follows: 80% to AHFS block grants, operations, and full coverage of free health care services; 10% to trade adjustment assistance for affected U.S. industries; and 10% to deficit reduction.
(d) AHFS Trust Fund.—There is established in the Treasury a trust fund to hold ERS revenues, which may only be expended for purposes authorized under this Act, including the provision of free health care services.
(e) Constitutional Accomplishment.—This section is accomplished constitutionally by:
(1) Relying on Article I, Section 8, Clause 1, which explicitly authorizes Congress to lay duties and imposts on foreign trade, ensuring uniformity as required by Clause 4.
(2) Avoiding domestic tax burdens, thus respecting the principle of no taxation without representation for U.S. citizens while funding general welfare programs.
(3) Complying with the Origination Clause (Article I, Section 7) by originating in the House as a revenue bill.
(4) Upholding international obligations under the Supremacy Clause by allowing flexibility in trade negotiations, consistent with precedents like United States v. Curtiss-Wright Export Corp. (1936) affirming broad federal trade powers.

SECTION 5. ESTABLISHMENT OF THE AMERICAN HEALTH FREEDOM SYSTEM.

(a) In General.—There is established the American Health Freedom System (AHFS), a voluntary national framework to facilitate access to free health care services, funded exclusively by the External Revenue System. The AHFS shall operate as a decentralized network of state-administered programs, supported by federal incentives, without requiring

any individual, employer, or state to participate.
(b) Key Components.—The AHFS shall include:
(1) A national clearinghouse for health information and best practices, administered by the Secretary, to promote transparency in pricing and quality metrics.
(2) Voluntary enrollment portals where eligible individuals can access free health care services if they opt in, funded through ERS-derived block grants to states, with all costs covered at the point of service.
(3) Protections against pre-existing condition exclusions in interstate health care markets, enforced via Commerce Clause authority over cross-border transactions.
(4) Coverage of all medically necessary services, including but not limited to preventive care, hospitalizations, prescriptions, mental health, and dental/vision, provided free of charge to enrolled eligible individuals.
(c) Constitutional Accomplishment.—This section is accomplished constitutionally by:
(1) Relying on the Commerce Clause to regulate only interstate aspects, such as cross-state health care provision.
(2) Using ERS revenues under the Taxing Clause (duties and imposts) to provide free services as optional benefits, avoiding mandates per NFIB v. Sebelius.
(3) Respecting the Tenth Amendment by making state participation voluntary, with no penalties for non-participation.

SECTION 6. FEDERAL INCENTIVES FOR STATE PARTICIPATION.
(a) Block Grants.—The Secretary shall provide annual block grants to participating States, funded solely by the ERS, calculated based on population and health needs, totaling not more than $400 billion annually (adjusted for inflation and ERS revenues).
(b) Conditions for Grants.—States may use grants to:
(1) Administer free health care services for all enrolled eligible individuals, covering 100% of costs without any charges to patients.
(2) Expand community health centers to ensure widespread access.
(3) Implement tort reform to reduce malpractice costs and provider reimbursements.
(c) Opt-In Mechanism.—States opt in via legislative resolution; no federal coercion is applied, ensuring Tenth Amendment compliance. Participating states must agree to provide free services as defined.
(d) Constitutional Accomplishment.—Grants are voluntary incentives funded by external revenues under the Taxing Clause, similar to those upheld in South Dakota v. Dole (1987), with conditions rationally related to health care goals but not unduly coercive.

SECTION 7. INTERSTATE HEALTH INSURANCE COMPACTS.
(a) Authorization.—Congress hereby consents to interstate compacts allowing States to form multi-state health care markets, enabling provision across borders without federal mandates.
(b) Standards.—Compacts must ensure:
(1) Portability of free coverage.
(2) Competition to optimize service delivery and reduce administrative costs by at least 20% through deregulation.
(3) Consumer protections via state attorneys general.
(c) Federal Role.—The Secretary shall facilitate compact formation but not dictate terms, with funding for administrative support drawn from the ERS.
(d) Constitutional Accomplishment.—This leverages the Compact Clause (Article I, Section 10) for state cooperation, with congressional consent, while Commerce Clause authority deregulates interstate barriers, as in United States v. Lopez (1995) distinctions for economic

activities.

SECTION 8. HEALTH SAVINGS ACCOUNTS EXPANSION.

(a) Enhancements.—Contribution limits for Health Savings Accounts (HSAs) are increased to $10,000 individual/$20,000 family annually, with tax-free growth and withdrawals for any health expense. No new taxes are imposed; existing tax advantages are preserved. HSAs may be used for supplemental services not covered under AHFS free care.
(b) Eligibility.—Open to all, regardless of enrollment status.
(c) Constitutional Accomplishment.—Expansions promote personal responsibility without mandates or new domestic taxes, aligning with Fifth Amendment property rights and funded indirectly through ERS efficiencies.

SECTION 9. MEDICARE AND MEDICAID REFORMS.
(a) Medicare.—Transition to integration with AHFS, where beneficiaries receive free health care services, maintaining solvency without rationing, with full funding from the ERS.
(b) Medicaid.—Convert to block grants with state flexibility, capping federal growth at inflation plus 1%, funded by the ERS, and ensuring free services for eligible enrollees.
(c) Integration with AHFS.—Allow seamless enrollment into AHFS free care options, phasing out separate programs.
(d) Constitutional Accomplishment.—Reforms use Taxing Clause revenues for entitlement programs, avoiding equal protection issues by phasing in changes equitably and providing uniform free access.

SECTION 10. OVERSIGHT AND ACCOUNTABILITY.

(a) Annual Reports.—The Secretary shall report to Congress on system performance, costs, access metrics, ERS revenue collections, and utilization of free services.
(b) Audits.—Independent audits ensure funds are used efficiently, with no diversion to non-health purposes and verification of zero-cost provision to patients.
(c) Judicial Review.—Provisions are subject to expedited review under the Administrative Procedure Act.
(d) Constitutional Accomplishment.—Oversight ensures accountability under Article I, with separation of powers preserved.

SECTION 11. SEVERABILITY.

If any provision of this Act is held invalid, the remainder shall not be affected, ensuring the system's core remains intact.

SECTION 12. EFFECTIVE DATE.

This Act takes effect 180 days after enactment, with phased implementation over 5 years to allow transitions, beginning with ERS tariff impositions within the first year.

Explanation of How the Bill Would Be Accomplished

This updated example bill modifies the American Health Freedom System (AHFS) to provide free health care services—with no premiums, copayments, deductibles, or out-of-pocket costs—exclusively to U.S. citizens and lawful permanent residents (eligible individuals), while maintaining full constitutionality. Funding remains solely from the External Revenue System (ERS) via tariffs and foreign business taxes, ensuring no domestic tax burden. Administration handled solely by the Secretary of the Treasury and U.S. Customs and Border Protection. Here's a detailed breakdown of how it would be accomplished, step by step, in practice:

1. Legislative Passage and Enactment: The bill would be introduced in the House (as H.R. 9999, originating here as required for revenue bills under Article I, Section 7), debated in committees (e.g., Ways and Means for revenue aspects, Energy and Commerce for health provisions), amended as needed, passed by both chambers, and signed by the President. This follows Article I's bicameralism and presentment requirements.
2. Establishment and Implementation of the ERS: Upon enactment, the Secretary of the Treasury would issue regulations within 90 days to impose tariffs (e.g., 10% on consumer electronics from non-reciprocal trade partners) and excise taxes on qualifying foreign businesses (e.g., via audits conducted by the Department of the Treasury). Revenues would flow into the AHFS Trust Fund automatically through existing customs collection mechanisms, scaled based on trade data from the U.S. International Trade Commission. Initial projections use current $3+ trillion import volumes to ensure $500 billion+ annually (potentially scaled up if needed for full free coverage), with adjustments via annual congressional appropriations. This avoids any involvement with international agencies facing constitutional scrutiny.
3. State Opt-In and Block Grant Distribution: States voluntarily join via resolutions, receiving ERS-funded block grants distributed formulaically (e.g., per capita plus health disparity adjustments). Within 1 year, grants would enable states to set up enrollment portals and infrastructure for free service delivery, with at least 30 states opting in based on the appeal of "free" federal funding from external sources, covering 70% of the population without state budget impacts. States would reimburse providers directly, ensuring zero cost to patients.
4. Market Reforms and Interstate Compacts: Within 2 years, states form compacts (e.g., a National Health Market Compact) to allow cross-border service provision, optimizing delivery and reducing administrative costs via competition. Federal facilitation, funded by a small ERS allocation (under 1%), includes technical support for deregulation, enforced under the Commerce Clause to remove state barriers.
5. Individual Access and Free Services: Eligible individuals (U.S. citizens and lawful permanent residents) enroll voluntarily through state or federal portals, accessing comprehensive free health care services immediately upon enrollment. Coverage includes all medically necessary care, paid fully by AHFS funds. Phased rollout over 3 years minimizes disruptions, starting with high-need populations (e.g., elderly, low-income), with automatic eligibility verification via existing systems like Social Security or immigration records. Non-eligible individuals (e.g., Dual Citizenship, non-permanent residents) are excluded to maintain focus and constitutionality.
6. Integration with Existing Programs: Medicare and Medicaid integrate into AHFS over 5 years, converting to free service models for eligible beneficiaries, with ERS funds bridging any gaps to preserve and expand benefits. This eliminates separate premiums

or costs, allowing states to innovate (e.g., telehealth expansions) while reducing overall administrative overhead by 15% through centralized ERS funding.

7. Oversight, Adjustments, and Trade Negotiations: Annual reports track metrics like enrollment rates (target: 95% of eligible), cost savings (target: 15% reduction via efficiency), patient satisfaction, and ERS revenues (with safeguards against trade disruptions via presidential negotiation authority under domestic law). If revenues fall short (e.g., due to trade shifts), Congress can adjust tariffs upward uniformly or reallocate within the Trust Fund. Audits ensure no patient charges occur. Judicial challenges would likely fail due to the voluntary nature, external funding focus, and alignment with precedents like NFIB v. Sebelius (no mandates) and tariff cases (broad congressional discretion).
8. Overall Impact and Constitutionality Assurance: The system achieves near-universal free coverage for eligible individuals through incentives and full funding, projecting 95% enrollment via the appeal of zero-cost care. It's constitutional because:
    - Funding via tariffs and foreign taxes uses the Taxing Clause (duties/imposts), which must be uniform and for general welfare.
    - No domestic tax burdens, individual mandates, or coercion (avoids Commerce Clause overreach per NFIB; enrollment is opt-in).
    - Voluntary state involvement (Tenth Amendment).
    - Equal protection for eligible groups (Fifth/Fourteenth Amendments), with free services rationally tied to citizenship/residency status.
    - Flexibility in trade respects the President's Article II foreign affairs powers while maintaining congressional control, without reference to any potentially unconstitutional international agencies.
    - Protections for rights (e.g., no conscience violations for providers) under the Bill of Rights.

This is an example; real bills would require economic impact assessments (e.g., by the Congressional Budget Office), actuarial modeling for full free coverage costs, and consultations with trade and health experts to ensure compliance with domestic laws.