

119TH CONGRESS  
1ST SESSION

# H. R. 6303

To improve Federal efforts with respect to the prevention of maternal mortality, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 25, 2025

Ms. KELLY of Illinois introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Workforce, and Ways and Means, 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

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## A BILL

To improve Federal efforts with respect to the prevention of maternal mortality, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Community Access,  
5 Resources, and Empowerment for Moms Act” or the  
6 “CARE for Moms Act”.

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

1           (1) Every year, across the United States, nearly  
2           4,000,000 women give birth, more than 1,000  
3           women suffer fatal complications during pregnancy,  
4           while giving birth or during the postpartum period,  
5           and about 70,000 women suffer near-fatal, partum-  
6           related complications.

7           (2) The maternal mortality rate is often used as  
8           a proxy to measure the overall health of a popu-  
9           lation. While the infant mortality rate in the United  
10          States has reached its lowest point, the risk of death  
11          for women in the United States during pregnancy,  
12          childbirth, or the postpartum period is higher than  
13          such risk in many other high-income countries. The  
14          estimated maternal mortality rate (deaths per  
15          100,000 live births) for the 48 contiguous States  
16          and Washington, DC, increased from 14.5 percent in  
17          2000 to 32.0 in 2021. The United States is the only  
18          industrialized nation with a rising maternal mor-  
19          tality rate.

20          (3) The National Vital Statistics System of the  
21          Centers for Disease Control and Prevention has  
22          found that in 2021, there were 32.9 maternal deaths  
23          for every 100,000 live births in the United States.  
24          That ratio continues to exceed the rate in other  
25          high-income countries.

1           (4) It is estimated that more than 80 percent  
2 of maternal deaths in the United States are prevent-  
3 able.

4           (5) According to the Centers for Disease Con-  
5 trol and Prevention, the maternal mortality rate var-  
6 ies drastically for women by race and ethnicity.  
7 There are about 26.6 deaths per 100,000 live births  
8 for White women, 69.9 deaths per 100,000 live  
9 births for non-Hispanic Black women, and 32.0  
10 deaths per 100,000 live births for American Indian/  
11 Alaska Native women. While maternal mortality dis-  
12 parately impacts Black women, this urgent public  
13 health crisis traverses race, ethnicity, socioeconomic  
14 status, educational background, and geography.

15           (6) In the United States, non-Hispanic Black  
16 women are about 3 times more likely to die from  
17 causes related to pregnancy and childbirth compared  
18 to non-Hispanic White women, which is one of the  
19 most disconcerting racial disparities in public health.  
20 This disparity widens in certain cities and States  
21 across the country.

22           (7) According to the National Center for Health  
23 Statistics of the Centers for Disease Control and  
24 Prevention, the maternal mortality rate heightens  
25 with age, as women 40 and older die at a rate of

1 138.5 per 100,000 births compared to 20.4 per  
2 100,000 for women under 25. This translates to  
3 women over 40 being 6.8 times more likely to die  
4 compared to their counterparts under 25 years of  
5 age.

6 (8) The COVID–19 pandemic has exacerbated  
7 the maternal health crisis. A study of the Centers  
8 for Disease Control and Prevention suggested that  
9 pregnant women are at a significantly higher risk  
10 for severe outcomes, including death, from COVID–  
11 19 as compared to non-pregnant women. The  
12 COVID–19 pandemic also decreased access to pre-  
13 natal and postpartum care. A study by the Govern-  
14 ment Accountability Office found that COVID–19  
15 contributed to 25 percent of maternal deaths in  
16 2020 and 2021.

17 (9) The findings described in paragraphs (1)  
18 through (8) are of major concern to researchers,  
19 academics, members of the business community, and  
20 providers across the obstetric continuum represented  
21 by organizations such as—

22 (A) the American College of Nurse-Mid-  
23 wives;

24 (B) the American College of Obstetricians  
25 and Gynecologists;

- 1 (C) the American Medical Association;
- 2 (D) the Association of Women’s Health,  
3 Obstetric and Neonatal Nurses;
- 4 (E) the Black Mamas Matter Alliance;
- 5 (F) the Black Women’s Health Imperative;
- 6 (G) the California Maternal Quality Care  
7 Collaborative;
- 8 (H) EverThrive Illinois;
- 9 (I) the Illinois Perinatal Quality Collabo-  
10 rative;
- 11 (J) the March of Dimes;
- 12 (K) the National Association of Certified  
13 Professional Midwives;
- 14 (L) RH Impact: The Collaborative for Eq-  
15 uity and Justice;
- 16 (M) the National Partnership for Women  
17 & Families;
- 18 (N) the National Polycystic Ovary Syn-  
19 drome Association;
- 20 (O) the Preeclampsia Foundation;
- 21 (P) the Society for Maternal-Fetal Medi-  
22 cine;
- 23 (Q) the What To Expect Project;

1 (R) Tufts University School of Medicine  
2 Center for Black Maternal Health and Repro-  
3 ductive Justice;

4 (S) the Shades of Blue Project;

5 (T) the Maternal Mental Health Leader-  
6 ship Alliance;

7 (U) the Tulane University Mary Amelia  
8 Center for Women’s Health Equity Research;

9 (V) In Our Own Voice: National Black  
10 Women’s Reproductive Justice Agenda; and

11 (W) Physicians for Reproductive Health.

12 (10) Hemorrhage, cardiovascular and coronary  
13 conditions, cardiomyopathy, infection or sepsis, em-  
14 bolism, mental health conditions (including sub-  
15 stance use disorder), hypertensive disorders, stroke  
16 and cerebrovascular accidents, and anesthesia com-  
17 plications are the predominant medical causes of  
18 maternal-related deaths and complications. Most of  
19 these conditions are largely preventable or manage-  
20 able. Even when these conditions are not prevent-  
21 able, mortality and morbidity may be prevented  
22 when conditions are diagnosed and treated in a  
23 timely manner.

24 (11) According to a study published by the  
25 Journal of Perinatal Education, doula-assisted

1 mothers are 4 times less likely to have a low-birth-  
2 weight baby, 2 times less likely to experience a birth  
3 complication involving themselves or their baby, and  
4 significantly more likely to initiate breastfeeding and  
5 human lactation. Doula care has also been shown to  
6 produce cost savings resulting in part from reduced  
7 rates of cesarean and pre-term births.

8 (12) Intimate partner violence is one of the  
9 leading causes of maternal death, and women are  
10 more likely to experience intimate partner violence  
11 during pregnancy than at any other time in their  
12 lives. It is also more dangerous than pregnancy. In-  
13 timate partner violence during pregnancy and  
14 postpartum crosses every demographic and has been  
15 exacerbated by the COVID–19 pandemic.

16 (13) Oral health is an important part of  
17 perinatal health. Reducing bacteria in a woman’s  
18 mouth during pregnancy can significantly reduce her  
19 risk of developing oral diseases and spreading decay-  
20 causing bacteria to her baby. Moreover, some evi-  
21 dence suggests that women with periodontal disease  
22 during pregnancy could be at greater risk for poor  
23 birth outcomes, such as preeclampsia, pre-term  
24 birth, and low-birth weight. Furthermore, a woman’s  
25 oral health during pregnancy is a good predictor of

1 her newborn’s oral health, and since mothers can  
2 unintentionally spread oral bacteria to their babies,  
3 putting their children at higher risk for tooth decay,  
4 prevention efforts should happen even before chil-  
5 dren are born, as a matter of pre-pregnancy health  
6 and prenatal care during pregnancy.

7 (14) In the United States, death reporting and  
8 analysis is a State function rather than a Federal  
9 process. States report all deaths—including mater-  
10 nal deaths—on a semi-voluntary basis, without  
11 standardization across States. While the Centers for  
12 Disease Control and Prevention has the capacity and  
13 system for collecting death-related data based on  
14 death certificates, these data are not sufficiently re-  
15 ported by States in an organized and standard for-  
16 mat across States such that the Centers for Disease  
17 Control and Prevention is able to identify causes of  
18 maternal death and best practices for the prevention  
19 of such death.

20 (15) Vital statistics systems often underesti-  
21 mate maternal mortality and are insufficient data  
22 sources from which to derive a full scope of medical  
23 and social determinant factors contributing to ma-  
24 ternal deaths, such as intimate partner violence.  
25 While the addition of pregnancy checkboxes on death

1 certificates since 2003 have likely improved States'  
2 abilities to identify pregnancy-related deaths, they  
3 are not generally completed by obstetric providers or  
4 persons trained to recognize pregnancy-related mor-  
5 tality. Thus, these vital forms may be missing infor-  
6 mation or may capture inconsistent data. Due to  
7 varying maternal mortality-related analyses, lack of  
8 reliability, and granularity in data, current maternal  
9 mortality informatics do not fully encapsulate the  
10 myriad medical and socially determinant factors that  
11 contribute to such high maternal mortality rates  
12 within the United States compared to other devel-  
13 oped nations. Lack of standardization of data and  
14 data sharing across States and between Federal en-  
15 tities, health networks, and research institutions  
16 keep the Nation in the dark about ways to prevent  
17 maternal deaths.

18 (16) Having reliable and valid State data ag-  
19 gregated at the Federal level are critical to the Na-  
20 tion's ability to quell surges in maternal death and  
21 imperative for researchers to identify long-lasting  
22 interventions.

23 (17) Leaders in maternal wellness highly rec-  
24 ommend that maternal deaths and cases of maternal  
25 morbidity, including complications that result in

1 chronic illness and future increased risk of death, be  
2 investigated at the State level first, and that stand-  
3 ardized, streamlined, de-identified data regarding  
4 maternal deaths be sent annually to the Centers for  
5 Disease Control and Prevention. Such data stand-  
6 ardization and collection would be similar in oper-  
7 ation and effect to the National Program of Cancer  
8 Registries of the Centers for Disease Control and  
9 Prevention and akin to the Confidential Enquiry in  
10 Maternal Deaths Programme in the United King-  
11 dom. Such a maternal mortalities and morbidities  
12 registry and surveillance system would help pro-  
13 viders, academicians, lawmakers, and the public to  
14 address questions concerning the types of, causes of,  
15 and best practices to thwart, maternal mortality and  
16 morbidity.

17 (18) The United Nations' Millennium Develop-  
18 ment Goal 5a aimed to reduce by 75 percent, be-  
19 tween 1990 and 2015, the maternal mortality rate,  
20 yet this metric has not been achieved. In fact, the  
21 maternal mortality rate in the United States has  
22 been estimated to have more than doubled between  
23 2000 and 2014.

24 (19) The United States has no comparable, co-  
25 ordinated Federal process by which to review cases

1 of maternal mortality, systems failures, or best prac-  
2 tices. The majority of States have active Maternal  
3 Mortality Review Committees (referred to in this  
4 section as “MMRC”), which help leverage work to  
5 impact maternal wellness. For example, the State of  
6 California has worked extensively with their State  
7 health departments, health and hospital systems,  
8 and research collaborative organizations, including  
9 the California Maternal Quality Care Collaborative  
10 and the Alliance for Innovation on Maternal Health,  
11 to establish MMRCs, wherein such State has deter-  
12 mined the most prevalent causes of maternal mor-  
13 tality and recorded and shared data with providers  
14 and researchers, who have developed and imple-  
15 mented safety bundles and care protocols related to  
16 preeclampsia, maternal hemorrhage, peripartum car-  
17 diomyopathy, and the like. In this way, the State of  
18 California has been able to leverage its maternal  
19 mortality review board system, generate data, and  
20 apply those data to effect changes in maternal care-  
21 related protocol.

22 (20) Hospitals and health systems across the  
23 United States lack standardization of emergency ob-  
24 stetric protocols before, during, and after delivery.  
25 Consequently, many providers are delayed in recog-

1 nizing critical signs indicating maternal distress that  
2 quickly escalate into fatal or near-fatal incidences.  
3 Moreover, any attempt to address an obstetric emer-  
4 gency that does not consider both clinical and public  
5 health approaches falls woefully under the mark of  
6 excellent care delivery. State-based perinatal quality  
7 collaboratives, or entities participating in the Alli-  
8 ance for Innovation on Maternal Health (AIM), have  
9 formed obstetric protocols, tool kits, and other re-  
10 sources to improve system care and response as they  
11 relate to maternal complications and warning signs  
12 for such conditions as maternal hemorrhage, hyper-  
13 tension, and preeclampsia. These perinatal quality  
14 collaboratives serve an important role in providing  
15 infrastructure that supports quality improvement ef-  
16 forts addressing obstetric care and outcomes. State-  
17 based perinatal quality collaboratives partner with  
18 hospitals, physicians, nurses, midwives, patients,  
19 public health, and other stakeholders to provide op-  
20 portunities for collaborative learning, rapid response  
21 data, and quality improvement science support to  
22 achieve systems-level change.

23 (21) The Centers for Disease Control and Pre-  
24 vention reports that 22 percent of deaths occurred  
25 during pregnancy, 25 percent occurred on the day of

1 delivery or within 7 days after the day of delivery,  
2 and 53 percent occurred between 7 days and 1 year  
3 after the day of delivery. Yet, for women eligible for  
4 the Medicaid program on the basis of pregnancy in  
5 States without Medicaid postpartum extension, such  
6 Medicaid coverage lapses at the end of the month on  
7 which the 60th postpartum day lands.

8 (22) The experience of serious traumatic  
9 events, such as being exposed to domestic violence,  
10 substance use disorder, or pervasive and systematic  
11 racism, can over-activate the body's stress-response  
12 system. Known as toxic stress, the repetition of  
13 high-doses of cortisol to the brain, can harm healthy  
14 neurological development and other body systems,  
15 which can have cascading physical and mental health  
16 consequences, as documented in the Adverse Child-  
17 hood Experiences study of the Centers for Disease  
18 Control and Prevention.

19 (23) A growing body of evidence-based research  
20 has shown the correlation between the stress associ-  
21 ated with systematic racism and one's birthing out-  
22 comes. The undue stress of sex and race discrimina-  
23 tion paired with institutional racism has been dem-  
24 onstrated to contribute to a higher risk of maternal  
25 mortality, irrespective of one's gestational age, ma-

1 ternal age, socioeconomic status, educational level,  
2 geographic region, or individual-level health risk fac-  
3 tors, including poverty, limited access to prenatal  
4 care, and poor physical and mental health (although  
5 these are not nominal factors). Black women remain  
6 the most at risk for pregnancy-associated or preg-  
7 nancy-related causes of death. When it comes to  
8 preeclampsia, for example, for which obesity is a risk  
9 factor, Black women of normal weight remain at a  
10 higher at risk of dying during the perinatal period  
11 compared to non-Black obese women.

12 (24) The rising maternal mortality rate in the  
13 United States is driven predominantly by the dis-  
14 proportionately high rates of Black maternal mor-  
15 tality.

16 (25) Compared to women from other racial and  
17 ethnic demographics, Black women across the socio-  
18 economic spectrum experience prolonged, unrelenting  
19 stress related to systematic racial and gender dis-  
20 crimination, contributing to higher rates of maternal  
21 mortality, giving birth to low-weight babies, and ex-  
22 perencing pre-term birth. Racism is a risk-factor for  
23 these aforementioned experiences. This cumulative  
24 stress, called weathering, often extends across the  
25 life course and is situated in everyday spaces where

1 Black women establish livelihood. Systematic racism,  
2 structural barriers, lack of access to quality mater-  
3 nal health care, lack of access to nutritious food, and  
4 social determinants of health exacerbate Black wom-  
5 en’s likelihood to experience poor or fatal birthing  
6 outcomes, but do not fully account for the great dis-  
7 parity.

8 (26) Black women are twice as likely to experi-  
9 ence postpartum depression, and disproportionately  
10 higher rates of preeclampsia compared to White  
11 women.

12 (27) Racism is deeply ingrained in United  
13 States systems, including in health care delivery sys-  
14 tems between patients and providers, often resulting  
15 in disparate treatment for pain, irreverence for cul-  
16 tural norms with respect to health, and  
17 dismissiveness. However, the provider pool is not  
18 primed with many people of color, nor are providers  
19 (whether maternity care clinicians or maternity care  
20 support personnel) consistently required to undergo  
21 implicit bias, cultural competency, respectful care  
22 practices, or empathy training on a consistent, on-  
23 going basis.

24 (28) Women are not the only people who can  
25 become pregnant or give birth. Nonbinary,

1 transgender, and gender-expansive people can also  
2 become pregnant. The terms “birthing people” or  
3 “birthing persons” are also used to describe preg-  
4 nant or postpartum people in a way that is inclusive  
5 of individuals who experience gender beyond the bi-  
6 nary.

7 (29) Substance misuse among pregnant women,  
8 including the use of substances that are illegal or  
9 criminalized, misuse of prescribed medications, and  
10 binge drinking, has increased year after year for the  
11 past decade. Pregnant people with Substance Use  
12 Disorder, particularly those with opioids, amphet-  
13 amines, and cocaine use disorders, are at greater  
14 risk of severe maternal morbidity, including condi-  
15 tions such as eclampsia, heart attack or failure, and  
16 sepsis.

17 **SEC. 3. IMPROVING FEDERAL EFFORTS WITH RESPECT TO**  
18 **PREVENTION OF MATERNAL MORTALITY.**

19 (a) FUNDING FOR STATE-BASED PERINATAL QUAL-  
20 ITY COLLABORATIVES DEVELOPMENT AND SUSTAIN-  
21 ABILITY.—

22 (1) IN GENERAL.—Not later than one year  
23 after the date of enactment of this Act, the Sec-  
24 retary of Health and Human Services (referred to in  
25 this subsection as the “Secretary”), acting through

1 the Division of Reproductive Health of the Centers  
2 for Disease Control and Prevention, shall establish a  
3 grant program to be known as the State-Based  
4 Perinatal Quality Collaborative grant program under  
5 which the Secretary awards grants to eligible entities  
6 for the purpose of development and sustainability of  
7 perinatal quality collaboratives in every State, the  
8 District of Columbia, and eligible territories, in  
9 order to measurably improve perinatal care and  
10 perinatal health outcomes for pregnant and  
11 postpartum women and their infants.

12 (2) GRANT AMOUNTS.—Grants awarded under  
13 this subsection shall be in amounts not to exceed  
14 \$250,000 per year, for the duration of the grant pe-  
15 riod.

16 (3) STATE-BASED PERINATAL QUALITY COL-  
17 LABORATIVE DEFINED.—For purposes of this sub-  
18 section, the term “State-based perinatal quality col-  
19 laborative” means a network of teams that—

20 (A) is multidisciplinary in nature and in-  
21 cludes the full range of perinatal and maternity  
22 care providers;

23 (B) works to improve measurable outcomes  
24 for maternal and infant health by advancing

1 evidence-informed clinical practices using qual-  
2 ity improvement principles;

3 (C) works with hospital-based or out-  
4 patient facility-based clinical teams, experts,  
5 and stakeholders, including patients and fami-  
6 lies, to spread best practices and optimize re-  
7 sources to improve perinatal care and outcomes;

8 (D) employs strategies that include the use  
9 of the collaborative learning model to provide  
10 opportunities for hospitals and clinical teams to  
11 collaborate on improvement strategies, rapid-re-  
12 sponse data to provide timely feedback to hos-  
13 pital and other clinical teams to track progress,  
14 and quality improvement science to provide sup-  
15 port and coaching to hospital and clinical  
16 teams;

17 (E) has the goal of improving population-  
18 level outcomes in maternal and infant health;  
19 and

20 (F) has the goal of improving outcomes of  
21 all birthing people, through the coordination,  
22 integration, and collaboration across birth set-  
23 tings.

24 (4) AUTHORIZATION OF APPROPRIATIONS.—For  
25 purposes of carrying out this subsection, there is au-

1       thorized to be appropriated \$35,000,000 per year  
2       for each of fiscal years 2026 through 2030.

3       (b) EXPANSION OF MEDICAID AND CHIP COVERAGE  
4 FOR PREGNANT AND POSTPARTUM WOMEN.—

5           (1) REQUIRING COVERAGE OF ORAL HEALTH  
6 SERVICES FOR PREGNANT AND POSTPARTUM  
7 WOMEN.—

8           (A) MEDICAID.—Section 1905 of the So-  
9 cial Security Act (42 U.S.C. 1396d) is amend-  
10 ed—

11           (i) in subsection (a)(4)—

12                   (I) by striking “; and (D)” and  
13 inserting “; (D)”;

14                   (II) by striking “; and (E)” and  
15 inserting “; (E)”;

16                   (III) by striking “; and (F)” and  
17 inserting “; (F)”;

18                   (IV) by striking the semicolon at  
19 the end and inserting “; and (G) oral  
20 health services for pregnant and  
21 postpartum women (as defined in sub-  
22 section (jj));”;

23           (ii) by adding at the end the following  
24 new subsection:

1       “(jj) ORAL HEALTH SERVICES FOR PREGNANT AND  
2 POSTPARTUM WOMEN.—

3           “(1) IN GENERAL.—For purposes of this title,  
4 the term ‘oral health services for pregnant and  
5 postpartum women’ means dental services necessary  
6 to prevent disease and promote oral health, restore  
7 oral structures to health and function, and treat  
8 emergency conditions that are furnished to a woman  
9 during pregnancy (or during the 1-year period be-  
10 ginning on the last day of the pregnancy).

11           “(2) COVERAGE REQUIREMENTS.—To satisfy  
12 the requirement to provide oral health services for  
13 pregnant and postpartum women, a State shall, at  
14 a minimum, provide coverage for preventive, diag-  
15 nostic, periodontal, and restorative care consistent  
16 with recommendations for perinatal oral health care  
17 and dental care during pregnancy from the Amer-  
18 ican Academy of Pediatric Dentistry and the Amer-  
19 ican College of Obstetricians and Gynecologists.”.

20           (B) CHIP.—Section 2103(c)(6) of the So-  
21 cial Security Act (42 U.S.C. 1397cc(e)(6)) is  
22 amended—

23           (i) in subparagraph (A)—

1 (I) by inserting “or a targeted  
2 low-income pregnant woman” after  
3 “targeted low-income child”; and

4 (II) by inserting “, and, in the  
5 case of a targeted low-income child  
6 who is pregnant or a targeted low-in-  
7 come pregnant woman, satisfy the  
8 coverage requirements specified in  
9 section 1905(jj)” after “emergency  
10 conditions”; and

11 (ii) in subparagraph (B), by inserting  
12 “(but only if, in the case of a targeted low-  
13 income child who is pregnant or a targeted  
14 low-income pregnant woman, the bench-  
15 mark dental benefit package satisfies the  
16 coverage requirements specified in section  
17 1905(jj))” after “subparagraph (C)”.

18 (2) REQUIRING 12-MONTH CONTINUOUS COV-  
19 ERAGE OF FULL BENEFITS FOR PREGNANT AND  
20 POSTPARTUM INDIVIDUALS UNDER MEDICAID AND  
21 CHIP.—

22 (A) MEDICAID.—Section 1902 of the So-  
23 cial Security Act (42 U.S.C. 1396a) is amend-  
24 ed—

25 (i) in subsection (a)—

1 (ii) in paragraph (86), by striking  
2 “and” at the end;

3 (iii) in paragraph (87), by striking the  
4 period at the end and inserting “; and”;  
5 and

6 (iv) by inserting after paragraph (87)  
7 the following new paragraph:

8 “(88) provide that the State plan is in compli-  
9 ance with subsection (e)(16).”; and

10 (v) in subsection (e)(16)—

11 (I) in subparagraph (A), by strik-  
12 ing “At the option of the State, the  
13 State plan (or waiver of such State  
14 plan) may provide” and inserting “A  
15 State plan (or waiver of such State  
16 plan) shall provide”;

17 (II) in subparagraph (B), in the  
18 matter preceding clause (i), by strik-  
19 ing “by a State making an election  
20 under this paragraph” and inserting  
21 “under a State plan (or a waiver of  
22 such State plan)”; and

23 (III) by striking subparagraph  
24 (C).

25 (B) CHIP.—

1 (i) IN GENERAL.—Section  
2 2107(e)(1)(J) of the Social Security Act  
3 (42 U.S.C. 1397gg(e)(1)(J)), as inserted  
4 by section 9822 of the American Rescue  
5 Plan Act of 2021 (Public Law 117–2), is  
6 amended to read as follows:

7 “(J) Paragraphs (5) and (16) of section  
8 1902(e) (relating to the requirement to provide  
9 medical assistance under the State plan or  
10 waiver consisting of full benefits during preg-  
11 nancy and throughout the 12-month  
12 postpartum period under title XIX).”.

13 (ii) CONFORMING AMENDMENT.—Sec-  
14 tion 2112(d)(2)(A) of the Social Security  
15 Act (42 U.S.C. 1397ll(d)(2)(A)) is amend-  
16 ed by striking “the month in which the 60-  
17 day period” and all that follows through  
18 “pursuant to section 2107(e)(1),”.

19 (3) MAINTENANCE OF EFFORT.—

20 (A) MEDICAID.—Section 1902(l) of the So-  
21 cial Security Act (42 U.S.C. 1396a(l)) is  
22 amended by adding at the end the following  
23 new paragraph:

24 “(5) During the period that begins on the date of  
25 enactment of this paragraph and ends on the date that

1 is 5 years after such date of enactment, as a condition  
2 for receiving any Federal payments under section 1903(a)  
3 for calendar quarters occurring during such period, a  
4 State shall not have in effect, with respect to women who  
5 are eligible for medical assistance under the State plan  
6 or under a waiver of such plan on the basis of being preg-  
7 nant or having been pregnant, eligibility standards, meth-  
8 odologies, or procedures under the State plan or waiver  
9 that are more restrictive than the eligibility standards,  
10 methodologies, or procedures, respectively, under such  
11 plan or waiver that are in effect on the date of enactment  
12 of this paragraph.”.

13 (B) CHIP.—Section 2105(d) of the Social  
14 Security Act (42 U.S.C. 1397ee(d)) is amended  
15 by adding at the end the following new para-  
16 graph:

17 “(4) IN ELIGIBILITY STANDARDS FOR TAR-  
18 GETED LOW-INCOME PREGNANT WOMEN.—During  
19 the period that begins on the date of enactment of  
20 this paragraph and ends on the date that is 5 years  
21 after such date of enactment, as a condition of re-  
22 ceiving payments under subsection (a) and section  
23 1903(a), a State that elects to provide assistance to  
24 women on the basis of being pregnant (including  
25 pregnancy-related assistance provided to targeted

1 low-income pregnant women (as defined in section  
2 2112(d)), pregnancy-related assistance provided to  
3 women who are eligible for such assistance through  
4 application of section 1902(v)(4)(A)(i) under section  
5 2107(e)(1), or any other assistance under the State  
6 child health plan (or a waiver of such plan) which  
7 is provided to women on the basis of being preg-  
8 nant) shall not have in effect, with respect to such  
9 women, eligibility standards, methodologies, or pro-  
10 cedures under such plan (or waiver) that are more  
11 restrictive than the eligibility standards, methodolo-  
12 gies, or procedures, respectively, under such plan (or  
13 waiver) that are in effect on the date of enactment  
14 of this paragraph.”.

15 (4) INFORMATION ON BENEFITS.—The Sec-  
16 retary of Health and Human Services shall make  
17 publicly available on the internet website of the De-  
18 partment of Health and Human Services, informa-  
19 tion regarding benefits available to pregnant and  
20 postpartum women and under the Medicaid program  
21 and the Children’s Health Insurance Program, in-  
22 cluding information on—

23 (A) benefits that States are required to  
24 provide to pregnant and postpartum women  
25 under such programs;

1           (B) optional benefits that States may pro-  
2           vide to pregnant and postpartum women under  
3           such programs; and

4           (C) the availability of different kinds of  
5           benefits for pregnant and postpartum women,  
6           including oral health and mental health benefits  
7           and breastfeeding services and supplies, under  
8           such programs.

9           (5) FEDERAL FUNDING FOR COST OF EX-  
10          TENDED MEDICAID AND CHIP COVERAGE FOR  
11          POSTPARTUM WOMEN.—

12           (A) MEDICAID.—Section 1905 of the So-  
13          cial Security Act (42 U.S.C. 1396d), as amend-  
14          ed by paragraph (1), is further amended by  
15          adding at the end the following:

16          “(kk) INCREASED FMAP FOR EXTENDED MEDICAL  
17          ASSISTANCE FOR POSTPARTUM INDIVIDUALS.—

18           “(1) IN GENERAL.—Notwithstanding subsection  
19          (b), the Federal medical assistance percentage for a  
20          State, with respect to amounts expended by such  
21          State for medical assistance for an individual who is  
22          eligible for such assistance on the basis of being  
23          pregnant or having been pregnant that is provided  
24          during the 305-day period that begins on the 60th  
25          day after the last day of the individual’s pregnancy

1 (including any such assistance provided during the  
2 month in which such period ends), shall be equal  
3 to—

4 “(A) during the first 20-quarter period for  
5 which this subsection is in effect with respect to  
6 a State, 100 percent; and

7 “(B) with respect to a State, during each  
8 quarter thereafter, 90 percent.

9 “(2) EXCLUSION FROM TERRITORIAL CAPS.—  
10 Any payment made to a territory for expenditures  
11 for medical assistance for an individual described in  
12 paragraph (1) that is subject to the Federal medical  
13 assistance percentage specified under paragraph (1)  
14 shall not be taken into account for purposes of ap-  
15 plying payment limits under subsections (f) and (g)  
16 of section 1108.”.

17 (B) CHIP.—Section 2105(c) of the Social  
18 Security Act (42 U.S.C. 1397ee(c)) is amended  
19 by adding at the end the following new para-  
20 graph:

21 “(13) ENHANCED PAYMENT FOR EXTENDED  
22 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—  
23 Notwithstanding subsection (b), the enhanced  
24 FMAP, with respect to payments under subsection  
25 (a) for expenditures under the State child health

1 plan (or a waiver of such plan) for assistance pro-  
2 vided under the plan (or waiver) to a woman who is  
3 eligible for such assistance on the basis of being  
4 pregnant (including pregnancy-related assistance  
5 provided to a targeted low-income pregnant woman  
6 (as defined in section 2112(d)), pregnancy-related  
7 assistance provided to a woman who is eligible for  
8 such assistance through application of section  
9 1902(v)(4)(A)(i) under section 2107(e)(1), or any  
10 other assistance under the plan (or waiver) provided  
11 to a woman who is eligible for such assistance on the  
12 basis of being pregnant) during the 305-day period  
13 that begins on the 60th day after the last day of her  
14 pregnancy (including any such assistance provided  
15 during the month in which such period ends), shall  
16 be equal to—

17 “(A) during the first 20-quarter period for  
18 which this subsection is in effect with respect to  
19 a State, 100 percent; and

20 “(B) with respect to a State, during each  
21 quarter thereafter, 90 percent.”.

22 (6) GUIDANCE ON STATE OPTIONS FOR MED-  
23 ICAID COVERAGE OF DOULA SERVICES.—Not later  
24 than 1 year after the date of the enactment of this  
25 Act, the Secretary of Health and Human Services

1 shall issue guidance for the States concerning op-  
2 tions for Medicaid coverage and payment for support  
3 services provided by doulas.

4 (7) ENHANCED FMAP FOR RURAL OBSTETRIC  
5 AND GYNECOLOGICAL SERVICES.—Section 1905 of  
6 the Social Security Act (42 U.S.C. 1396d), as  
7 amended by paragraphs (1) and (5), is further  
8 amended—

9 (A) in subsection (b), by striking “and  
10 (ii)” and inserting “(ii), (jj), (kk), and (ll)”;  
11 and

12 (B) by adding at the end the following new  
13 subsection:

14 “(ll) INCREASED FMAP FOR MEDICAL ASSISTANCE  
15 FOR OBSTETRIC AND GYNECOLOGICAL SERVICES FUR-  
16 NISHED AT RURAL HOSPITALS.—

17 “(1) IN GENERAL.—Notwithstanding subsection  
18 (b), the Federal medical assistance percentage for a  
19 State, with respect to amounts expended by such  
20 State for medical assistance for obstetric or gynecolo-  
21 gical services that are furnished in a hospital that  
22 is located in a rural area (as defined for purposes  
23 of section 1886) shall be equal to 90 percent for  
24 each calendar quarter beginning with the first cal-

1       endar quarter during which this subsection is in ef-  
2       fect.

3               “(2) EXCLUSION FROM TERRITORIAL CAPS.—  
4       Any payment made to a territory for expenditures  
5       for medical assistance described in paragraph (1)  
6       that is subject to the Federal medical assistance per-  
7       centage specified under paragraph (1) shall not be  
8       taken into account for purposes of applying payment  
9       limits under subsections (f) and (g) of section  
10      1108.”.

11              (8) EFFECTIVE DATES.—

12              (A) IN GENERAL.—Subject to subpara-  
13      graphs (B) and (C)—

14              (i) the amendments made by para-  
15      graphs (1), (2), and (5) shall take effect  
16      on the first day of the first calendar quar-  
17      ter that begins on or after the date that is  
18      1 year after the date of enactment of this  
19      Act;

20              (ii) the amendments made by para-  
21      graph (3) shall take effect on the date of  
22      enactment of this Act; and

23              (iii) the amendments made by para-  
24      graph (7) shall take effect on the first day

1 of the first calendar quarter that begins on  
2 or after the date of enactment of this Act.

3 (B) EXCEPTION FOR STATE LEGISLA-  
4 TION.—In the case of a State plan under title  
5 XIX of the Social Security Act or a State child  
6 health plan under title XXI of such Act that  
7 the Secretary of Health and Human Services  
8 determines requires State legislation in order  
9 for the respective plan to meet any requirement  
10 imposed by amendments made by this sub-  
11 section, the respective plan shall not be re-  
12 garded as failing to comply with the require-  
13 ments of such title solely on the basis of its fail-  
14 ure to meet such an additional requirement be-  
15 fore the first day of the first calendar quarter  
16 beginning after the close of the first regular  
17 session of the State legislature that begins after  
18 the date of enactment of this Act. For purposes  
19 of the previous sentence, in the case of a State  
20 that has a 2-year legislative session, each year  
21 of the session shall be considered to be a sepa-  
22 rate regular session of the State legislature.

23 (C) STATE OPTION FOR EARLIER EFFEC-  
24 TIVE DATE.—A State may elect to have sub-  
25 section (e)(16) of section 1902 of the Social Se-

1 curity Act (42 U.S.C. 1396a) and subparagraph  
2 (J) of section 2107(e)(1) of the Social Security  
3 Act (42 U.S.C. 1397gg(e)(1)), as amended by  
4 paragraph (2), and subsection (kk) of section  
5 1905 of the Social Security Act (42 U.S.C.  
6 1396d) and paragraph (13) of section 2105(c)  
7 of the Social Security Act (42 U.S.C.  
8 1397ee(c)), as added by paragraph (5), take ef-  
9 fect with respect to the State on the first day  
10 of any fiscal quarter that begins before the date  
11 described in subparagraph (A) and apply to  
12 amounts payable to the State for expenditures  
13 for medical assistance, child health assistance,  
14 or pregnancy-related assistance to pregnant or  
15 postpartum individuals furnished on or after  
16 such day.

17 (c) REGIONAL CENTERS OF EXCELLENCE.—Part P  
18 of title III of the Public Health Service Act (42 U.S.C.  
19 280g et seq.) is amended by adding at the end the fol-  
20 lowing:

1 **“SEC. 399V-8. REGIONAL CENTERS OF EXCELLENCE AD-**  
2 **DRESSING IMPLICIT BIAS AND CULTURAL**  
3 **COMPETENCY IN PATIENT-PROVIDER INTER-**  
4 **ACTIONS EDUCATION.**

5 “(a) IN GENERAL.—Not later than one year after the  
6 date of enactment of this section, the Secretary, in con-  
7 sultation with such other agency heads as the Secretary  
8 determines appropriate, shall award cooperative agree-  
9 ments for the establishment or support of regional centers  
10 of excellence addressing implicit bias, cultural competency,  
11 and respectful care practices in patient-provider inter-  
12 actions education for the purpose of enhancing and im-  
13 proving how health care professionals are educated in im-  
14 plicit bias and delivering culturally competent health care.

15 “(b) ELIGIBILITY.—To be eligible to receive a cooper-  
16 ative agreement under subsection (a), an entity shall—

17 “(1) be a public or other nonprofit entity speci-  
18 fied by the Secretary that provides educational and  
19 training opportunities for students and health care  
20 professionals, which may be a health system, teach-  
21 ing hospital, community health center, medical  
22 school, school of public health, school of nursing,  
23 dental school, social work school, school of profes-  
24 sional psychology, or any other health professional  
25 school or program at an institution of higher edu-  
26 cation (as defined in section 101 of the Higher Edu-

1 cation Act of 1965) focused on the prevention, treat-  
2 ment, or recovery of health conditions that con-  
3 tribute to maternal mortality and the prevention of  
4 maternal mortality and severe maternal morbidity;

5 “(2) demonstrate community engagement and  
6 participation, such as through partnerships with  
7 home visiting and case management programs or  
8 community-based organizations serving minority  
9 populations;

10 “(3) demonstrate engagement with groups en-  
11 gaged in the implementation of health care profes-  
12 sional training in implicit bias and delivering cul-  
13 turally competent care, such as departments of pub-  
14 lic health, perinatal quality collaboratives, hospital  
15 systems, and health care professional groups, in  
16 order to obtain input on resources needed for effec-  
17 tive implementation strategies; and

18 “(4) provide to the Secretary such information,  
19 at such time and in such manner, as the Secretary  
20 may require.

21 “(c) DIVERSITY.—In awarding a cooperative agree-  
22 ment under subsection (a), the Secretary shall take into  
23 account any regional differences among eligible entities  
24 and make an effort to ensure geographic diversity among  
25 award recipients.

1 “(d) DISSEMINATION OF INFORMATION.—

2 “(1) PUBLIC AVAILABILITY.—The Secretary  
3 shall make publicly available on the internet website  
4 of the Department of Health and Human Services  
5 information submitted to the Secretary under sub-  
6 section (b)(3).

7 “(2) EVALUATION.—The Secretary shall evalu-  
8 ate each regional center of excellence established or  
9 supported pursuant to subsection (a) and dissemi-  
10 nate the findings resulting from each such evalua-  
11 tion to the appropriate public and private entities.

12 “(3) DISTRIBUTION.—The Secretary shall share  
13 evaluations and overall findings with State depart-  
14 ments of health and other relevant State level offices  
15 to inform State and local best practices.

16 “(e) MATERNAL MORTALITY DEFINED.—In this sec-  
17 tion, the term ‘maternal mortality’ means death of a  
18 woman that occurs during pregnancy or within the one-  
19 year period following the end of such pregnancy.

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—For  
21 purposes of carrying out this section, there is authorized  
22 to be appropriated \$5,000,000 for each of fiscal years  
23 2026 through 2030.”.

24 (d) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM  
25 FOR WOMEN, INFANTS, AND CHILDREN.—Section

1 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42  
2 U.S.C. 1786(d)(3)(A)(ii)) is amended—

3 (1) by striking the clause designation and head-  
4 ing and all that follows through “A State” and in-  
5 serting the following:

6 “(ii) WOMEN.—

7 “(I) BREASTFEEDING WOMEN.—  
8 A State”;

9 (2) in subclause (I) (as so designated), by strik-  
10 ing “1 year” and all that follows through “earlier”  
11 and inserting “2 years postpartum”; and

12 (3) by adding at the end the following:

13 “(II) POSTPARTUM WOMEN.—A  
14 State may elect to certify a  
15 postpartum woman for a period of 2  
16 years.”.

17 (e) DEFINITION OF MATERNAL MORTALITY.—In this  
18 section, the term “maternal mortality” means death of a  
19 woman that occurs during pregnancy or within the one-  
20 year period following the end of such pregnancy.

21 **SEC. 4. FULL SPECTRUM DOULA WORKFORCE.**

22 (a) IN GENERAL.—The Secretary of Health and  
23 Human Services shall establish and implement a program  
24 to award grants or contracts to health professions schools,  
25 schools of public health, academic health centers, State or

1 local governments, territories, Indian Tribes and Tribal  
2 organizations, Urban Indian organizations, Native Hawai-  
3 ian organizations, community-based organizations, or  
4 other appropriate public or private nonprofit entities (or  
5 consortia of any such entities, including entities promoting  
6 multidisciplinary approaches), to establish or expand pro-  
7 grams to grow and diversify the doula workforce, including  
8 through improving the capacity and supply of health care  
9 providers.

10 (b) USE OF FUNDS.—Amounts made available by  
11 subsection (a) shall be used for the following activities:

12 (1) Establishing programs that provide edu-  
13 cation and training to individuals seeking appro-  
14 priate training or certification as full spectrum  
15 doulas.

16 (2) Expanding the capacity of existing pro-  
17 grams described in paragraph (1), for the purpose of  
18 increasing the number of students enrolled in such  
19 programs, including by awarding scholarships for  
20 students who agree to work in underserved commu-  
21 nities after receiving such education and training.

22 (3) Developing and implementing strategies to  
23 recruit and retain students from underserved com-  
24 munities, particularly from demographic groups ex-  
25 perienceing high rates of maternal mortality and se-



1           “(2) to train providers including obstetrician-  
2           gynecologists, certified nurse-midwives, nurse practi-  
3           tioners, nurses, and midwives to operate and provide  
4           obstetric services, including training and planning  
5           for obstetric emergencies, in such mobile health  
6           units; and

7           “(3) to address access issues, including social  
8           determinants of health and wrap-around clinical and  
9           community services including nutrition, housing, lac-  
10          tation services, and transportation support and re-  
11          ferrals.

12          “(b) NO SHARING OF DATA WITH LAW ENFORCE-  
13          MENT.—As a condition of receiving a grant under this sec-  
14          tion, a State shall submit to the Secretary an assurance  
15          that the State will not make available to Federal or State  
16          law enforcement any personally identifiable information  
17          regarding any pregnant or postpartum individual collected  
18          pursuant to such grant.

19          “(c) GRANT DURATION.—The period of a grant  
20          under this section shall not exceed 5 years.

21          “(d) IMPLEMENTING AND REPORTING.—

22                  “(1) IN GENERAL.—States that receive pilot  
23          grants under this section shall be responsible for—

24                          “(A) implementing the program funded by  
25          the pilot grants; and

1           “(B) not later than 3 years after the date  
2 of enactment of this Act, and 6 years after the  
3 date of enactment of this Act, submitting a re-  
4 port containing the results of such program to  
5 the Secretary, including—

6           “(i) relevant information and relevant  
7 quantitative indicators of the programs’  
8 success in improving the standard of care  
9 and maternal health outcomes for individ-  
10 uals in rural and underserved communities  
11 seen for pre-conception, pregnancy, or  
12 postpartum visits in the rural mobile  
13 health units, stratified by the categories of  
14 data specified in paragraph (2);

15           “(ii) relevant qualitative evaluations  
16 from individuals receiving pre-conception,  
17 pregnant, or postpartum care from rural  
18 mobile health units, including measures of  
19 patient-reported experience of care and  
20 measures of patient-reported issues with  
21 access to care without the rural mobile  
22 health unit pilot; and

23           “(iii) strategies to sustain such pro-  
24 grams beyond the duration of the grant

1           and expand such programs to other rural  
2           and underserved communities.

3           “(2) CATEGORIES OF DATA.—The categories of  
4 data specified in this paragraph are the following:

5           “(A) Race, ethnicity, sex, gender, gender  
6 identity, primary language, age, geography, dis-  
7 ability status, and insurance status.

8           “(B) Number of visits provided for pre-  
9 conception, prenatal, or postpartum care.

10          “(C) Number of repeat visits provided for  
11 preconception, prenatal, or postpartum care.

12          “(D) Number of screenings or tests pro-  
13 vided for smoking, substance use, hypertension,  
14 sexually transmitted diseases, diabetes, HIV,  
15 depression, intimate partner violence, Pap  
16 smears, and pregnancy.

17          “(3) DATA PRIVACY PROTECTION.—The reports  
18 referred to in paragraph (1)(B) shall not contain  
19 any personally identifiable information regarding  
20 any pregnant or postpartum individual.

21          “(e) EVALUATION.—The Secretary shall conduct an  
22 evaluation of the pilot program under this section to deter-  
23 mine the impact of the pilot program with respect to—

24           “(1) the effectiveness of the grants awarded  
25           under this section to improve maternal health out-

1 comes in rural and underserved communities, with  
2 data stratified by race, ethnicity, primary language,  
3 socioeconomic status, geography, insurance type, and  
4 other factors as the Secretary determines appro-  
5 priate;

6 “(2) spending on maternity care by States partici-  
7 pating in the pilot program;

8 “(3) to the extent practicable, qualitative, and  
9 quantitative measures of patient experience; and

10 “(4) any other areas of assessment that the  
11 Secretary determines relevant.

12 “(f) REPORT.—Not later than one year after the  
13 completion of the pilot program under this section, the  
14 Secretary shall submit to the Congress, and make publicly  
15 available, a report containing—

16 “(1) the results of any evaluation conducted  
17 under subsection (e); and

18 “(2) a recommendation regarding whether the  
19 pilot program should be continued after fiscal year  
20 2030 and expanded on a national basis.

21 “(g) AUTHORIZATION OF APPROPRIATIONS.—There  
22 is authorized to be appropriated to the Secretary to carry  
23 out this section \$10,000,000 for each of fiscal years 2026  
24 through 2030.”.

1 **SEC. 6. REQUIRING NOTIFICATION OF IMPENDING HOS-**  
2 **PITAL OBSTETRIC UNIT CLOSURE.**

3 Section 1866(a)(1) of the Social Security Act (42  
4 U.S.C. 1395cc(a)(1)) is amended—

5 (1) in subparagraph (X), by striking “and” at  
6 the end;

7 (2) in subparagraph (Y)(ii)(V), by striking the  
8 period and inserting “, and”; and

9 (3) by inserting after subparagraph (Y) the fol-  
10 lowing new subparagraph:

11 “(Z) beginning 180 days after the date of the  
12 enactment of this subparagraph, in the case of a  
13 hospital, not less than 90 days prior to the closure  
14 of any obstetric unit of the hospital, to submit to the  
15 Secretary a notification which shall include—

16 “(i) a report analyzing the impact the clo-  
17 sure will have on the community;

18 “(ii) steps the hospital will take to identify  
19 other health care providers that can alleviate  
20 any service gaps as a result of the closure; and

21 “(iii) any additional information as may be  
22 required by the Secretary.”.

23 **SEC. 7. REPORT ON MATERNAL HEALTH NEEDS.**

24 (a) IN GENERAL.—Not later than 24 months after  
25 the date of enactment of this Act, the Secretary of Health

1 and Human Services shall prepare, and submit to the Con-  
2 gress, a report on—

3 (1) where the maternal health needs are great-  
4 est in the United States; and

5 (2) the Federal expenditures made to address  
6 such needs.

7 (b) PERIOD COVERED.—The report under subsection  
8 (a) shall cover the period of 2000 through 2024.

9 (c) CONTENTS.—The report under subsection (a)  
10 shall include analysis of the following:

11 (1) How Federal funds provided to States for  
12 maternal health were distributed across regions,  
13 States, and localities or counties.

14 (2) Barriers to applying for and receiving Fed-  
15 eral funds for maternal health, including with re-  
16 spect to initial applications—

17 (A) requirements for submission in part-  
18 nership with other entities; and

19 (B) stringent network requirements.

20 (3) Why applicants did not receive funding, in-  
21 cluding limited availability of funds, the strength of  
22 the respective applications, and failure to adhere to  
23 requirements.

1 (d) DISAGGREGATION OF DATA.—The report under  
2 subsection (a) shall disaggregate data on mothers served  
3 by race, ethnicity, insurance status, and language spoken.

4 **SEC. 8. INCREASING EXCISE TAXES ON CIGARETTES AND**  
5 **ESTABLISHING EXCISE TAX EQUITY AMONG**  
6 **ALL TOBACCO PRODUCT TAX RATES.**

7 (a) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO.—  
8 Section 5701(g) of the Internal Revenue Code of 1986 is  
9 amended by striking “\$24.78” and inserting “\$49.56”.

10 (b) TAX PARITY FOR PIPE TOBACCO.—Section  
11 5701(f) of the Internal Revenue Code of 1986 is amended  
12 by striking “\$2.8311 cents” and inserting “\$49.56”.

13 (c) TAX PARITY FOR SMOKELESS TOBACCO.—

14 (1) Section 5701(e) of the Internal Revenue  
15 Code of 1986 is amended—

16 (A) in paragraph (1), by striking “\$1.51”  
17 and inserting “\$26.84”;

18 (B) in paragraph (2), by striking “50.33  
19 cents” and inserting “\$10.74”; and

20 (C) by adding at the end the following:

21 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE  
22 SINGLE-USE UNITS.—On discrete single-use units,  
23 \$100.66 per thousand.”.

24 (2) Section 5702(m) of such Code is amend-  
25 ed—

1 (A) in paragraph (1), by striking “or chew-  
2 ing tobacco” and inserting “, chewing tobacco,  
3 or discrete single-use unit”;

4 (B) in paragraphs (2) and (3), by inserting  
5 “that is not a discrete single-use unit” before  
6 the period in each such paragraph; and

7 (C) by adding at the end the following:

8 “(4) DISCRETE SINGLE-USE UNIT.—The term  
9 ‘discrete single-use unit’ means any product con-  
10 taining, made from, or derived from tobacco or nico-  
11 tine that—

12 “(A) is not intended to be smoked; and

13 “(B) is in the form of a lozenge, tablet,  
14 pill, pouch, dissolvable strip, or other discrete  
15 single-use or single-dose unit.”.

16 (d) TAX PARITY FOR SMALL CIGARS.—Paragraph  
17 (1) of section 5701(a) of the Internal Revenue Code of  
18 1986 is amended by striking “\$50.33” and inserting  
19 “\$100.66”.

20 (e) TAX PARITY FOR LARGE CIGARS.—

21 (1) IN GENERAL.—Paragraph (2) of section  
22 5701(a) of the Internal Revenue Code of 1986 is  
23 amended by striking “52.75 percent” and all that  
24 follows through the period and inserting the fol-  
25 lowing: “\$49.56 per pound and a proportionate tax

1 at the like rate on all fractional parts of a pound but  
2 not less than 10.066 cents per cigar.”.

3 (2) GUIDANCE.—The Secretary of the Treas-  
4 ury, or the Secretary’s delegate, may issue guidance  
5 regarding the appropriate method for determining  
6 the weight of large cigars for purposes of calculating  
7 the applicable tax under section 5701(a)(2) of the  
8 Internal Revenue Code of 1986.

9 (3) CONFORMING AMENDMENT.—Section 5702  
10 of such Code is amended by striking subsection (l).

11 (f) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO  
12 AND CERTAIN PROCESSED TOBACCO.—Subsection (o) of  
13 section 5702 of the Internal Revenue Code of 1986 is  
14 amended by inserting “, and includes processed tobacco  
15 that is removed for delivery or delivered to a person other  
16 than a person with a permit provided under section 5713,  
17 but does not include removals of processed tobacco for ex-  
18 portation” after “wrappers thereof”.

19 (g) CLARIFYING TAX RATE FOR OTHER TOBACCO  
20 PRODUCTS.—

21 (1) IN GENERAL.—Section 5701 of the Internal  
22 Revenue Code of 1986 is amended by adding at the  
23 end the following new subsection:

24 “(i) OTHER TOBACCO PRODUCTS.—Any product not  
25 otherwise described under this section that has been deter-

1 mined to be a tobacco product by the Food and Drug Ad-  
2 ministration through its authorities under the Family  
3 Smoking Prevention and Tobacco Control Act shall be  
4 taxed at a level of tax equivalent to the tax rate for ciga-  
5 rettes on an estimated per use basis as determined by the  
6 Secretary.”.

7           (2) ESTABLISHING PER USE BASIS.—For pur-  
8 poses of section 5701(i) of the Internal Revenue  
9 Code of 1986, not later than 12 months after the  
10 later of the date of the enactment of this Act or the  
11 date that a product has been determined to be a to-  
12 bacco product by the Food and Drug Administra-  
13 tion, the Secretary of the Treasury (or the Secretary  
14 of the Treasury’s delegate) shall issue final regula-  
15 tions establishing the level of tax for such product  
16 that is equivalent to the tax rate for cigarettes on  
17 an estimated per use basis.

18           (h) CLARIFYING DEFINITION OF TOBACCO PROD-  
19 UCTS.—

20           (1) IN GENERAL.—Subsection (c) of section  
21 5702 of the Internal Revenue Code of 1986 is  
22 amended to read as follows:

23           “(c) TOBACCO PRODUCTS.—The term ‘tobacco prod-  
24 ucts’ means—

1           “(1) cigars, cigarettes, smokeless tobacco, pipe  
2 tobacco, and roll-your-own tobacco, and

3           “(2) any other product subject to tax pursuant  
4 to section 5701(i).”.

5           (2) CONFORMING AMENDMENTS.—Subsection  
6 (d) of section 5702 of such Code is amended by  
7 striking “cigars, cigarettes, smokeless tobacco, pipe  
8 tobacco, or roll-your-own tobacco” each place it ap-  
9 pears and inserting “tobacco products”.

10          (i) INCREASING TAX ON CIGARETTES.—

11           (1) SMALL CIGARETTES.—Section 5701(b)(1)  
12 of such Code is amended by striking “\$50.33” and  
13 inserting “\$100.66”.

14           (2) LARGE CIGARETTES.—Section 5701(b)(2)  
15 of such Code is amended by striking “\$105.69” and  
16 inserting “\$211.38”.

17          (j) TAX RATES ADJUSTED FOR INFLATION.—Section  
18 5701 of such Code, as amended by subsection (g), is  
19 amended by adding at the end the following new sub-  
20 section:

21           “(j) INFLATION ADJUSTMENT.—

22           “(1) IN GENERAL.—In the case of any calendar  
23 year beginning after 2025, the dollar amounts pro-  
24 vided under this chapter shall each be increased by  
25 an amount equal to—

1 “(A) such dollar amount, multiplied by

2 “(B) the cost-of-living adjustment deter-  
3 mined under section 1(f)(3) for the calendar  
4 year, determined by substituting ‘calendar year  
5 2024’ for ‘calendar year 2016’ in subparagraph  
6 (A)(ii) thereof.

7 “(2) ROUNDING.—If any amount as adjusted  
8 under paragraph (1) is not a multiple of \$0.01, such  
9 amount shall be rounded to the next highest multiple  
10 of \$0.01.”.

11 (k) FLOOR STOCKS TAXES.—

12 (1) IMPOSITION OF TAX.—On tobacco products  
13 manufactured in or imported into the United States  
14 which are removed before any tax increase date and  
15 held on such date for sale by any person, there is  
16 hereby imposed a tax in an amount equal to the ex-  
17 cess of—

18 (A) the tax which would be imposed under  
19 section 5701 of the Internal Revenue Code of  
20 1986 on the article if the article had been re-  
21 moved on such date, over

22 (B) the prior tax (if any) imposed under  
23 section 5701 of such Code on such article.

24 (2) CREDIT AGAINST TAX.—Each person shall  
25 be allowed as a credit against the taxes imposed by

1 paragraph (1) an amount equal to the lesser of  
2 \$1,000 or the amount of such taxes. For purposes  
3 of the preceding sentence, all persons treated as a  
4 single employer under subsection (b), (c), (m), or (o)  
5 of section 414 of the Internal Revenue Code of 1986  
6 shall be treated as 1 person for purposes of this  
7 paragraph.

8 (3) LIABILITY FOR TAX AND METHOD OF PAY-  
9 MENT.—

10 (A) LIABILITY FOR TAX.—A person hold-  
11 ing tobacco products on any tax increase date  
12 to which any tax imposed by paragraph (1) ap-  
13 plies shall be liable for such tax.

14 (B) METHOD OF PAYMENT.—The tax im-  
15 posed by paragraph (1) shall be paid in such  
16 manner as the Secretary shall prescribe by reg-  
17 ulations.

18 (C) TIME FOR PAYMENT.—The tax im-  
19 posed by paragraph (1) shall be paid on or be-  
20 fore the date that is 120 days after the effective  
21 date of the tax rate increase.

22 (4) ARTICLES IN FOREIGN TRADE ZONES.—  
23 Notwithstanding the Act of June 18, 1934 (com-  
24 monly known as the Foreign Trade Zone Act, 48  
25 Stat. 998, 19 U.S.C. 81a et seq.), or any other pro-

1 vision of law, any article which is located in a for-  
2 eign trade zone on any tax increase date shall be  
3 subject to the tax imposed by paragraph (1) if—

4 (A) internal revenue taxes have been deter-  
5 mined, or customs duties liquidated, with re-  
6 spect to such article before such date pursuant  
7 to a request made under the first proviso of  
8 section 3(a) of such Act, or

9 (B) such article is held on such date under  
10 the supervision of an officer of the United  
11 States Customs and Border Protection of the  
12 Department of Homeland Security pursuant to  
13 the second proviso of such section 3(a).

14 (5) DEFINITIONS.—For purposes of this sub-  
15 section—

16 (A) IN GENERAL.—Any term used in this  
17 subsection which is also used in section 5702 of  
18 such Code shall have the same meaning as such  
19 term has in such section.

20 (B) TAX INCREASE DATE.—The term “tax  
21 increase date” means the effective date of any  
22 increase in any tobacco product excise tax rate  
23 pursuant to the amendments made by this sec-  
24 tion (other than subsection (j) thereof).

1           (C) SECRETARY.—The term “Secretary”  
2           means the Secretary of the Treasury or the  
3           Secretary’s delegate.

4           (6) CONTROLLED GROUPS.—Rules similar to  
5           the rules of section 5061(e)(3) of such Code shall  
6           apply for purposes of this subsection.

7           (7) OTHER LAWS APPLICABLE.—All provisions  
8           of law, including penalties, applicable with respect to  
9           the taxes imposed by section 5701 of such Code  
10          shall, insofar as applicable and not inconsistent with  
11          the provisions of this subsection, apply to the floor  
12          stocks taxes imposed by paragraph (1), to the same  
13          extent as if such taxes were imposed by such section  
14          5701. The Secretary may treat any person who bore  
15          the ultimate burden of the tax imposed by para-  
16          graph (1) as the person to whom a credit or refund  
17          under such provisions may be allowed or made.

18          (1) EFFECTIVE DATES.—

19               (1) IN GENERAL.—Except as provided in para-  
20               graphs (2) and (3), the amendments made by this  
21               section shall apply to articles removed (as defined in  
22               section 5702(j) of the Internal Revenue Code of  
23               1986) after the last day of the month which includes  
24               the date of the enactment of this Act.

1           (2) DISCRETE SINGLE-USE UNITS, LARGE CI-  
2 GARS, AND PROCESSED TOBACCO.—The amendments  
3 made by subsections (c)(1)(C), (c)(2), (e), and (f)  
4 shall apply to articles removed (as defined in section  
5 5702(j) of the Internal Revenue Code of 1986) after  
6 the date that is 6 months after the date of the en-  
7 actment of this Act.

8           (3) OTHER TOBACCO PRODUCTS.—The amend-  
9 ments made by subsection (g)(1) shall apply to prod-  
10 ucts removed after the last day of the month which  
11 includes the date that the Secretary of the Treasury  
12 (or the Secretary of the Treasury’s delegate) issues  
13 final regulations establishing the level of tax for  
14 such product.

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