

119TH CONGRESS
1ST SESSION

H. R. 6303

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

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

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

evidence-informed clinical practices using quality improvement principles;

(C) works with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, including patients and families, to spread best practices and optimize resources to improve perinatal care and outcomes;

(D) employs strategies that include the use of the collaborative learning model to provide opportunities for hospitals and clinical teams to collaborate on improvement strategies, rapid-response data to provide timely feedback to hospital and other clinical teams to track progress, and quality improvement science to provide support and coaching to hospital and clinical teams;

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

(F) has the goal of improving outcomes of all birthing people, through the coordination, integration, and collaboration across birth settings.

(4) AUTHORIZATION OF APPROPRIATIONS.—For 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(c)(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

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

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

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

“(2) EXCLUSION FROM TERRITORIAL CAPS.—

Any payment made to a territory for expenditures for medical assistance for an individual described in paragraph (1) that is subject to the Federal medical assistance percentage specified under paragraph (1) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108.”.

(B) CHIP.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

“(13) ENHANCED PAYMENT FOR EXTENDED ASSISTANCE PROVIDED TO PREGNANT WOMEN.— Notwithstanding subsection (b), the enhanced FMAP, with respect to payments under subsection (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 EFPEC-
24 TIVE DATE.—A State may elect to have sub-
25 section (e)(16) of section 1902 of the Social Se-

1 security 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 vere maternal morbidity, including racial and ethnic
2 minority groups, into programs described in para-
3 graphs (1) and (2).

4 (c) FUNDING.—In addition to amounts otherwise
5 available, there is appropriated to the Secretary for fiscal
6 year 2026, out of any money in the Treasury not otherwise
7 appropriated, \$50,000,000, to remain available until ex-
8 pended, for carrying out this section.

9 **SEC. 5. GRANTS FOR RURAL OBSTETRIC MOBILE HEALTH**
10 **UNITS.**

11 Part B of title III of the Public Health Service Act
12 (42 U.S.C. 243 et seq.) is amended by adding at the end
13 the following:

14 **“SEC. 320C. GRANTS FOR RURAL OBSTETRIC MOBILE**
15 **HEALTH UNITS.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Administrator of the Health Resources and Services
18 Administration (referred to in this section as the ‘Sec-
19 retary’), shall establish a pilot program under which the
20 Secretary shall make grants to States—

21 “(1) to purchase and equip rural mobile health
22 units for the purpose of providing pre-conception,
23 pregnancy, postpartum, and obstetric emergency
24 services in rural and underserved communities;

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 appropriate;
5

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

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 (I) 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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