

119TH CONGRESS
1ST SESSION

S. 1677

To provide health insurance benefits for outpatient and inpatient items and services related to the diagnosis and treatment of a congenital anomaly or birth defect.

IN THE SENATE OF THE UNITED STATES

MAY 8, 2025

Ms. BALDWIN (for herself, Ms. ERNST, Ms. KLOBUCHAR, Ms. MURKOWSKI, Mr. LUJÁN, Mr. TILLIS, Mr. KING, Mr. MARSHALL, Mr. REED, Mr. GRASSLEY, Mr. BLUMENTHAL, Mr. BOOKER, and Mr. MERKLEY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide health insurance benefits for outpatient and inpatient items and services related to the diagnosis and treatment of a congenital anomaly or birth defect.

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 “Ensuring Lasting
5 Smiles Act”.

1 **SEC. 2. COVERAGE OF CONGENITAL ANOMALY OR BIRTH**
 2 **DEFECT.**

3 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—
 4 Part D of title XXVII of the Public Health Service Act
 5 (42 U.S.C. 300gg–111 et seq.) is amended by adding at
 6 the end the following new section:

7 **“SEC. 2799A–11. COVERAGE OF CONGENITAL ANOMALY OR**
 8 **BIRTH DEFECT.**

9 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-
 10 TIVE TREATMENT.—

11 “(1) IN GENERAL.—A group health plan, and a
 12 health insurance issuer offering group or individual
 13 health insurance coverage, shall provide coverage for
 14 outpatient and inpatient items and services related
 15 to the diagnosis and treatment of a congenital
 16 anomaly or birth defect that primarily impacts the
 17 appearance or function of the eyes, ears, teeth,
 18 mouth, or jaw, consistent with paragraphs (2) and
 19 (3).

20 “(2) FINANCIAL REQUIREMENTS.—Any cov-
 21 erage provided under paragraph (1) under a group
 22 health plan or group or individual health insurance
 23 coverage may be subject to cost-sharing require-
 24 ments (such as coinsurance, copayments, and
 25 deductibles), as required by the plan or issuer offer-
 26 ing such coverage, that are no more restrictive than

the predominant cost-sharing requirements applied to substantially all other medical and surgical benefits covered by the plan or coverage.

“(3) APPLICABLE ITEMS AND SERVICES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the items and services required under paragraph (1) to be covered by a group health plan or group or individual health insurance coverage offered by a health insurance issuer include—

“(i) any item or service to improve, repair, or restore any body part to achieve normal body functioning or appearance, or performed to approximate a normal appearance, as determined medically necessary by the treating physician (as defined in section 1861(r) of the Social Security Act), on account of a congenital anomaly or birth defect that primarily impacts the appearance or function of the eyes, ears, teeth, mouth, or jaw; and

“(ii) any treatment or diagnostic service with respect to any and all missing or abnormal body parts (including teeth, the oral cavity, and their associated struc-

1 tures), as determined medically necessary
2 by the treating physician (as defined in
3 section 1861(r) of the Social Security Act),
4 including—

5 “(I) reconstructive services and
6 procedures, and items and services re-
7 lated to any complications arising
8 from such services and procedures;

9 “(II) adjunctive dental, ortho-
10 dontic, or prosthodontic support from
11 birth until the medical or surgical
12 treatment of the defect or anomaly
13 has been completed, including ongoing
14 or subsequent treatment required to
15 maintain function or approximate a
16 normal appearance, notwithstanding
17 any exclusions, limitations, or restric-
18 tions under the plan or health insur-
19 ance coverage on coverage of dental,
20 orthodontic, or prosthodontic items
21 and services arising from other inju-
22 ries or sicknesses; and

23 “(III) items and services related
24 to secondary conditions and follow-up
25 treatment associated with the under-

1 lying congenital anomaly or birth de-
2 fect.

3 “(B) EXCEPTION.—The items and services
4 required under this subsection to be covered by
5 a group health plan or health insurance issuer
6 offering group or individual health insurance
7 coverage shall not include cosmetic surgery per-
8 formed to reshape normal structures of the
9 body to improve appearance or self-esteem, if
10 such items and services are not furnished as a
11 result of a medical determination of a con-
12 genital anomaly or birth defect.

13 “(b) NOTICE.—Beginning not later January 1, 2026,
14 a group health plan or health insurance issuer offering
15 group or individual health insurance coverage shall provide
16 notice to each participant and beneficiary under such plan
17 or coverage regarding the coverage required by this section
18 in any documents describing services, in accordance with
19 any regulations promulgated by the Secretary.

20 “(c) DEFINITION.—In this section, the term ‘con-
21 genital anomaly or birth defect’ means a structural or
22 functional anomaly that occurs during intrauterine life,
23 develops prenatally, and may be identified before birth, at
24 birth, or later in life, and which may—

1 “(1) be caused by genetic or chromosomal dis-
 2 orders, embryotoxic or teratogenic environmental
 3 factors, nutrient deficiency, multifactorial inherit-
 4 ance, or be of an unknown cause;

5 “(2) manifest as abnormal anatomical struc-
 6 tures;

7 “(3) manifest as physical, sensory, or cognitive
 8 functional disabilities;

9 “(4) manifest as syndromes, diseases, or other
 10 health problems; and

11 “(5) manifest as singular anomalies or in com-
 12 bination prenatally, at birth, or later in life.”.

13 (b) ERISA AMENDMENTS.—

14 (1) IN GENERAL.—Subpart B of part 7 of sub-
 15 title B of title I of the Employee Retirement Income
 16 Security Act of 1974 is amended by adding at the
 17 end the following:

18 **“SEC. 726. COVERAGE OF CONGENITAL ANOMALY OR BIRTH**
 19 **DEFECT.**

20 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-
 21 TIVE TREATMENT.—

22 “(1) IN GENERAL.—A group health plan, and a
 23 health insurance issuer offering group health insur-
 24 ance coverage, shall provide coverage for outpatient
 25 and inpatient items and services related to the diag-

1 nosis and treatment of a congenital anomaly or birth
 2 defect that primarily impacts the appearance or
 3 function of the eyes, ears, teeth, mouth, or jaw, con-
 4 sistent with paragraphs (2) and (3).

5 “(2) FINANCIAL REQUIREMENTS.—Any cov-
 6 erage provided under paragraph (1) under a group
 7 health plan or group health insurance coverage of-
 8 fered by a health insurance issuer may be subject to
 9 cost-sharing requirements (such as coinsurance, co-
 10 payments, and deductibles), as required by the plan
 11 or issuer offering such coverage, that are no more
 12 restrictive than the predominant cost-sharing re-
 13 quirements applied to substantially all other medical
 14 and surgical benefits covered by the plan or cov-
 15 erage.

16 “(3) APPLICABLE ITEMS AND SERVICES.—

17 “(A) IN GENERAL.—Except as provided in
 18 subparagraph (B), the items and services re-
 19 quired under paragraph (1) to be covered by a
 20 group health plan or group health insurance
 21 coverage offered by a health insurance issuer
 22 include—

23 “(i) any item or service to improve,
 24 repair, or restore any body part to achieve
 25 normal body functioning or appearance, or

performed to approximate a normal appearance, as determined medically necessary by the treating physician (as defined in section 1861(r) of the Social Security Act), on account of a congenital anomaly or birth defect that primarily impacts the appearance or function of the eyes, ears, teeth, mouth, or jaw; and

“(ii) any treatment or diagnostic service with respect to any and all missing or abnormal body parts (including teeth, the oral cavity, and their associated structures), as determined medically necessary by the treating physician (as defined in section 1861(r) of the Social Security Act), including—

“(I) reconstructive services and procedures, and items and services related to any complications arising from such services and procedures;

“(II) adjunctive dental, orthodontic, or prosthodontic support from birth until the medical or surgical treatment of the defect or anomaly has been completed, including ongoing

1 or subsequent treatment required to
2 maintain function or approximate a
3 normal appearance, notwithstanding
4 any exclusions, limitations, or restric-
5 tions under the plan or health insur-
6 ance coverage on coverage of dental,
7 orthodontic, or prosthodontic items
8 and services arising from other inju-
9 ries or sicknesses; and

10 “(III) items and services related
11 to secondary conditions and follow-up
12 treatment associated with the under-
13 lying congenital anomaly or birth de-
14 fect.

15 “(B) EXCEPTION.—The items and services
16 required under this subsection to be covered by
17 a group health plan or health insurance issuer
18 offering group health insurance coverage shall
19 not include cosmetic surgery performed to re-
20 shape normal structures of the body to improve
21 appearance or self-esteem, if such items and
22 services are not furnished as a result of a med-
23 ical determination of a congenital anomaly or
24 birth defect.

1 “(b) NOTICE.—Beginning not later than January 1,
 2 2026, a group health plan or health insurance issuer offer-
 3 ing group health insurance coverage shall provide notice
 4 to each participant and beneficiary under such plan or cov-
 5 erage regarding the coverage required by this section, in
 6 any documents describing services, in accordance with any
 7 regulations promulgated by the Secretary.

8 “(c) DEFINITION.—In this section, the term ‘con-
 9 genital anomaly or birth defect’ means a structural or
 10 functional anomaly that occurs during intrauterine life,
 11 develops prenatally, and may be identified before birth, at
 12 birth, or later in life, and which may—

13 “(1) be caused by genetic or chromosomal dis-
 14 orders, embryotoxic or teratogenic environmental
 15 factors, nutrient deficiency, multifactorial inherit-
 16 ance, or be of an unknown cause;

17 “(2) manifest as abnormal anatomical struc-
 18 tures;

19 “(3) manifest as physical, sensory, or cognitive
 20 functional disabilities;

21 “(4) manifest as syndromes, diseases, or other
 22 health problems; and

23 “(5) manifest as singular anomalies or in com-
 24 bination prenatally, at birth, or later in life.”.

25 (2) TECHNICAL AMENDMENTS.—

1 (A) Section 732(a) of such Act (29 U.S.C.
 2 1191a(a)) is amended by striking “section 711”
 3 and inserting “sections 711 and 726”.

4 (B) The table of contents in section 1 of
 5 such Act is amended by inserting after the item
 6 relating to section 725 the following new item:

“Sec. 726. Coverage of congenital anomaly or birth defect.”.

7 (c) INTERNAL REVENUE CODE AMENDMENTS.—

8 (1) IN GENERAL.—Subchapter B of chapter
 9 100 of the Internal Revenue Code of 1986 is amend-
 10 ed by adding at the end the following:

11 **“SEC. 9826. COVERAGE OF CONGENITAL ANOMALY OR**
 12 **BIRTH DEFECT.**

13 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-
 14 TIVE TREATMENT.—

15 “(1) IN GENERAL.—A group health plan shall
 16 provide coverage for outpatient and inpatient items
 17 and services related to the diagnosis and treatment
 18 of a congenital anomaly or birth defect that pri-
 19 marily impacts the appearance or function of the
 20 eyes, ears, teeth, mouth, or jaw, consistent with
 21 paragraphs (2) and (3).

22 “(2) FINANCIAL REQUIREMENTS.—Any cov-
 23 erage provided under paragraph (1) under a group
 24 health plan may be subject to cost-sharing require-
 25 ments (such as coinsurance, copayments, and

deductibles), as required by the plan, that are no more restrictive than the predominant cost-sharing requirements applied to substantially all other medical and surgical benefits covered by the plan.

“(3) APPLICABLE ITEMS AND SERVICES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the items and services required under paragraph (1) to be covered by a group health plan include—

“(i) any item or service to improve, repair, or restore any body part to achieve normal body functioning or appearance, or performed to approximate a normal appearance, as determined medically necessary by the treating physician (as defined in section 1861(r) of the Social Security Act), on account of a congenital anomaly or birth defect that primarily impacts the appearance or function of the eyes, ears, teeth, mouth, or jaw; and

“(ii) any treatment or diagnostic service with respect to any and all missing or abnormal body parts (including teeth, the oral cavity, and their associated structures), as determined medically necessary

1 by the treating physician (as defined in
2 section 1861(r) of the Social Security Act),
3 including—

4 “(I) reconstructive services and
5 procedures, and items and services re-
6 lated to any complications arising
7 from such services and procedures;

8 “(II) adjunctive dental, ortho-
9 dontic, or prosthodontic support from
10 birth until the medical or surgical
11 treatment of the defect or anomaly
12 has been completed, including ongoing
13 or subsequent treatment required to
14 maintain function or approximate a
15 normal appearance, notwithstanding
16 any exclusions, limitations, or restric-
17 tions under the plan on coverage of
18 dental, orthodontic, or prosthodontic
19 items and services arising from other
20 injuries or sicknesses; and

21 “(III) items and services related
22 to secondary conditions and follow-up
23 treatment associated with the under-
24 lying congenital anomaly or birth de-
25 fect.

1 “(B) EXCEPTION.—The items and services
 2 required under this subsection to be covered by
 3 a group health plan shall not include cosmetic
 4 surgery performed to reshape normal structures
 5 of the body to improve appearance or self-es-
 6 teem, if such items and services are not fur-
 7 nished as a result of a medical determination of
 8 a congenital anomaly or birth defect.

9 “(b) NOTICE.—Beginning not later January 1, 2026,
 10 a group health plan shall provide notice to each partici-
 11 pant and beneficiary under such plan or coverage regard-
 12 ing the coverage required by this section in any documents
 13 describing services, in accordance with any regulations
 14 promulgated by the Secretary.

15 “(c) DEFINITION.—In this section, the term ‘con-
 16 genital anomaly or birth defect’ means a structural or
 17 functional anomaly that occurs during intrauterine life,
 18 develops prenatally, and may be identified before birth, at
 19 birth, or later in life, and which may—

20 “(1) be caused by genetic or chromosomal dis-
 21 orders, embryotoxic or teratogenic environmental
 22 factors, nutrient deficiency, multifactorial inherit-
 23 ance, or be of an unknown cause;

24 “(2) manifest as abnormal anatomical struc-
 25 tures;

1 “(3) manifest as physical, sensory, or cognitive
2 functional disabilities;

3 “(4) manifest as syndromes, diseases, or other
4 health problems; and

5 “(5) manifest as singular anomalies or in com-
6 bination prenatally, at birth, or later in life.”.

7 (2) CLERICAL AMENDMENT.—The table of sec-
8 tions for such subchapter is amended by adding at
9 the end the following new item:

“Sec. 9826. Coverage of congenital anomaly or birth defect.”.

10 (d) STUDY AND REPORT ON NETWORK ADEQUACY.—
11 The Secretary of Health and Human Services shall con-
12 duct a study, and not later than December 31, 2027, sub-
13 mit a report to Congress, on the matters relating to access
14 of services for coverage of outpatient and inpatient items
15 and services related to the diagnosis and treatment of a
16 congenital anomaly or birth defect that primarily impacts
17 the appearance or function of the eyes, ears, teeth, mouth,
18 or jaw. Such study and report shall—

19 (1) evaluate the sufficiency and accessibility of
20 networks of providers that perform services related
21 to the diagnosis and treatment of such congenital
22 anomalies and birth defects under group health
23 plans and group and individual health insurance cov-
24 erage (as such terms are defined in section 2791 of

1 the Public Health Service Act (42 U.S.C. 300gg–
2 91)); and

3 (2) assess any change in out-of-pocket costs for
4 patients, by procedure type, resulting from the cov-
5 erage requirements under sections 2799A–11 of the
6 Public Health Service Act, 726 of the Employee Re-
7 tirement Income Security Act of 1974, and 9826 of
8 the Internal Revenue Code of 1986, as added by this
9 section, and any change in the overall procedure cost
10 for such services.

11 (e) EFFECTIVE DATE.—The amendments made by
12 subsections (a), (b), and (c) shall apply with respect to
13 plan years beginning on or after January 1, 2026.

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