

S.J. RES. 118

At the request of Mr. SCHUMER, his name was added as a cosponsor of S.J. Res. 118, a joint resolution to direct the removal of United States Armed Forces from hostilities within or against the Islamic Republic of Iran that have not been authorized by Congress.

S.J. RES. 172

At the request of Mr. SCHUMER, his name was added as a cosponsor of S.J. Res. 172, a joint resolution to direct the removal of United States Armed Forces from hostilities within or against the Islamic Republic of Iran that have not been authorized by Congress.

S.J. RES. 191

At the request of Mr. SCHUMER, his name was added as a cosponsor of S.J. Res. 191, a joint resolution to direct removal of United States Armed Forces from hostilities within or against the Islamic Republic of Iran that have not been authorized by Congress.

S.J. RES. 200

At the request of Mr. SCHUMER, his name was added as a cosponsor of S.J. Res. 200, a joint resolution to direct the removal of United States Armed Forces from hostilities within or against the Islamic Republic of Iran that have not been authorized by Congress.

S.J. RES. 211

At the request of Mr. SCHUMER, his name was added as a cosponsor of S.J. Res. 211, a joint resolution to direct the removal of United States Armed Forces from hostilities within or against the Islamic Republic of Iran that have not been authorized by Congress.

S. CON. RES. 6

At the request of Mr. CRAPO, the name of the Senator from Nebraska (Mrs. FISCHER) was added as a cosponsor of S. Con. Res. 6, a concurrent resolution expressing the sense of Congress that tax-exempt fraternal benefit societies have historically provided and continue to provide critical benefits to the people and communities of the United States.

AMENDMENT NO. 6828

At the request of Ms. BALDWIN, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 6828 intended to be proposed to S. 4668, a bill to protect the name, image, and likeness rights of, and provide protections for, student athletes and to promote fair competition among intercollegiate athletics, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN:

S. 5515. A bill to improve Federal efforts with respect to the prevention of maternal mortality, and for other purposes; to the Committee on Finance.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows

S. 5515

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

SECTION 1. SHORT TITLE.

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

SEC. 2. FINDINGS.

Congress finds the following:

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

(2) The maternal mortality rate is often used as a proxy to measure the overall health of a population. While the infant mortality rate in the United States has reached its lowest point, the risk of death for women in the United States during pregnancy, childbirth, or the postpartum period is higher than such risk in many other high-income countries. The estimated maternal mortality rate (deaths per 100,000 live births) for the 48 contiguous States and the District of Columbia, increased from 14.5 percent in 2000 to 32.0 in 2021. The United States is the only industrialized nation with a rising maternal mortality rate.

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

(4) It is estimated that more than 80 percent of maternal deaths in the United States are preventable.

(5) According to the Centers for Disease Control and Prevention, the maternal mortality rate varies drastically for women by race and ethnicity. There are about 26.6 deaths per 100,000 live births for White women, 69.9 deaths per 100,000 live births for non-Hispanic Black women, and 32.0 deaths per 100,000 live births for American Indian/Alaska Native women. While maternal mortality disparately impacts Black women, this urgent public health crisis traverses race, ethnicity, socioeconomic status, educational background, and geography.

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

(7) According to the National Center for Health Statistics of the Centers for Disease Control and Prevention, the maternal mortality rate heightens with age, as women 40 and older die at a rate of 138.5 per 100,000 births compared to 20.4 per 100,000 for women under 25. This translates to women over 40 being 6.8 times more likely to die compared to their counterparts under 25 years of age.

(8) The COVID-19 pandemic has exacerbated the maternal health crisis. A study of the Centers for Disease Control and Prevention suggested that pregnant women are at a significantly higher risk for severe outcomes, including death, from COVID-19 as compared to non-pregnant women. The COVID-19 pandemic also decreased access to prenatal and postpartum care. A study by the Government Accountability Office found that COVID-19 contributed to 25 percent of maternal deaths in 2020 and 2021.

(9) The findings described in paragraphs (1) through (8) are of major concern to researchers, academics, members of the business

community, and providers across the obstetric continuum represented by organizations such as—

(A) the American College of Nurse-Midwives;

(B) the American College of Obstetricians and Gynecologists;

(C) the American Medical Association;

(D) the Association of Women’s Health, Obstetric and Neonatal Nurses;

(E) the Black Mamas Matter Alliance;

(F) the Black Women’s Health Imperative;

(G) the California Maternal Quality Care Collaborative;

(H) EverThrive Illinois;

(I) the Illinois Perinatal Quality Collaborative;

(J) the March of Dimes;

(K) the National Association of Certified Professional Midwives;

(L) RH Impact: The Collaborative for Equity and Justice;

(M) the National Partnership for Women & Families;

(N) the National Polycystic Ovary Syndrome Association;

(O) the Preeclampsia Foundation;

(P) the Society for Maternal-Fetal Medicine;

(Q) the What To Expect Project;

(R) Tufts University School of Medicine Center for Black Maternal Health and Reproductive Justice;

(S) the Shades of Blue Project;

(T) the Maternal Mental Health Leadership Alliance;

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

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

(W) Physicians for Reproductive Health.

(10) Hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection or sepsis, embolism, mental health conditions (including substance use disorder), hypertensive disorders, stroke and cerebrovascular accidents, and anesthesia complications are the predominant medical causes of maternal-related deaths and complications. Most of these conditions are largely preventable or manageable. Even when these conditions are not preventable, mortality and morbidity may be prevented when conditions are diagnosed and treated in a timely manner.

(11) According to a study published by the Journal of Perinatal Education, doula-assisted mothers are 4 times less likely to have a low-birthweight baby, 2 times less likely to experience a birth complication involving themselves or their baby, and significantly more likely to initiate breastfeeding and human lactation. Doula care has also been shown to produce cost savings resulting in part from reduced rates of cesarean and preterm births.

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

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

unintentionally spread oral bacteria to their babies, putting their children at higher risk for tooth decay, prevention efforts should happen even before children are born, as a matter of pre-pregnancy health and prenatal care during pregnancy.

(14) In the United States, death reporting and analysis is a State function rather than a Federal process. States report all deaths—including maternal deaths—on a semi-voluntary basis, without standardization across States. While the Centers for Disease Control and Prevention has the capacity and system for collecting death-related data based on death certificates, these data are not sufficiently reported by States in an organized and standard format across States such that the Centers for Disease Control and Prevention is able to identify causes of maternal death and best practices for the prevention of such death.

(15) Vital statistics systems often underestimate maternal mortality and are insufficient data sources from which to derive a full scope of medical and social determinant factors contributing to maternal deaths, such as intimate partner violence. While the addition of pregnancy checkboxes on death certificates since 2003 have likely improved States' abilities to identify pregnancy-related deaths, they are not generally completed by obstetric providers or persons trained to recognize pregnancy-related mortality. Thus, these vital forms may be missing information or may capture inconsistent data. Due to varying maternal mortality-related analyses, lack of reliability, and granularity in data, current maternal mortality informatics do not fully encapsulate the myriad medical and socially determinant factors that contribute to such high maternal mortality rates within the United States compared to other developed nations. Lack of standardization of data and data sharing across States and between Federal entities, health networks, and research institutions keep the United States in the dark about ways to prevent maternal deaths.

(16) Having reliable and valid State data aggregated at the Federal level are critical to the ability of the United States to quell surges in maternal death and imperative for researchers to identify long-lasting interventions.

(17) Leaders in maternal wellness highly recommend that maternal deaths and cases of maternal morbidity, including complications that result in chronic illness and future increased risk of death, be investigated at the State level first, and that standardized, streamlined, de-identified data regarding maternal deaths be sent annually to the Centers for Disease Control and Prevention. Such data standardization and collection would be similar in operation and effect to the National Program of Cancer Registries of the Centers for Disease Control and Prevention and akin to the Confidential Enquiry in Maternal Deaths Programme in the United Kingdom. Such a maternal mortalities and morbidities registry and surveillance system would help providers, academicians, lawmakers, and the public to address questions concerning the types of, causes of, and best practices to thwart, maternal mortality and morbidity.

(18) The United Nations' Millennium Development Goal 5a aimed to reduce by 75 percent, between 1990 and 2015, the maternal mortality rate, yet this metric has not been achieved. In fact, the maternal mortality rate in the United States has been estimated to have more than doubled between 2000 and 2014.

(19) The United States has no comparable, coordinated Federal process by which to review cases of maternal mortality, systems failures, or best practices. The majority of

States have active Maternal Mortality Review Committees (referred to in this section as "MMRC"), which help leverage work to impact maternal wellness. For example, the State of California has worked extensively with the California State health departments, health and hospital systems, and research collaborative organizations, including the California Maternal Quality Care Collaborative and the Alliance for Innovation on Maternal Health, to establish MMRCs, wherein such State has determined the most prevalent causes of maternal mortality and recorded and shared data with providers and researchers, who have developed and implemented safety bundles and care protocols related to preeclampsia, maternal hemorrhage, peripartum cardiomyopathy, and the like. In this way, the State of California has been able to leverage its maternal mortality review board system, generate data, and apply those data to effect changes in maternal care-related protocol.

(20) Hospitals and health systems across the United States lack standardization of emergency obstetric protocols before, during, and after delivery. Consequently, many providers are delayed in recognizing critical signs indicating maternal distress that quickly escalate into fatal or near-fatal incidences. Moreover, any attempt to address an obstetric emergency that does not consider both clinical and public health approaches falls woefully under the mark of excellent care delivery. State-based perinatal quality collaboratives, or entities participating in the Alliance for Innovation on Maternal Health (AIM), have formed obstetric protocols, tool kits, and other resources to improve system care and response as they relate to maternal complications and warning signs for such conditions as maternal hemorrhage, hypertension, and preeclampsia. These perinatal quality collaboratives serve an important role in providing infrastructure that supports quality improvement efforts addressing obstetric care and outcomes. State-based perinatal quality collaboratives partner with hospitals, physicians, nurses, midwives, patients, public health, and other stakeholders to provide opportunities for collaborative learning, rapid response data, and quality improvement science support to achieve systems-level change.

(21) The Centers for Disease Control and Prevention reports that 22 percent of deaths occurred during pregnancy, 25 percent occurred on the day of delivery or within 7 days after the day of delivery, and 53 percent occurred between 7 days and 1 year after the day of delivery. Yet, for women eligible for the Medicaid program on the basis of pregnancy in States without Medicaid postpartum extension, such Medicaid coverage lapses at the end of the month on which the 60th postpartum day lands.

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

(23) A growing body of evidence-based research has shown the correlation between the stress associated with systematic racism and one's birthing outcomes. The undue stress of sex and race discrimination paired with institutional racism has been demonstrated to contribute to a higher risk of maternal mortality, irrespective of one's gestational age, maternal age, socio-

economic status, educational level, geographic region, or individual-level health risk factors, including poverty, limited access to prenatal care, and poor physical and mental health (although these are not nominal factors). Black women remain the most at risk for pregnancy-associated or pregnancy-related causes of death. When it comes to preeclampsia, for example, for which obesity is a risk factor, Black women of normal weight remain at a higher at risk of dying during the perinatal period compared to non-Black obese women.

(24) The rising maternal mortality rate in the United States is driven predominantly by the disproportionately high rates of Black maternal mortality.

(25) Compared to women from other racial and ethnic demographics, Black women across the socioeconomic spectrum experience prolonged, unrelenting stress related to systematic racial and gender discrimination, contributing to higher rates of maternal mortality, giving birth to low-weight babies, and experiencing pre-term birth. Racism is a risk-factor for these aforementioned experiences. This cumulative stress, called weathering, often extends across the life course and is situated in everyday spaces where Black women establish livelihood. Systematic racism, structural barriers, lack of access to quality maternal health care, lack of access to nutritious food, and social determinants of health exacerbate Black women's likelihood to experience poor or fatal birthing outcomes, but do not fully account for the great disparity.

(26) Black women are twice as likely to experience postpartum depression, and disproportionately higher rates of preeclampsia compared to White women.

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

(28) Women are not the only people who can become pregnant or give birth. Non-binary, transgender, and gender-expansive people can also become pregnant. The terms "birthing people" or "birthing persons" are also used to describe pregnant or postpartum people in a way that is inclusive of individuals who experience gender beyond the binary.

(29) Substance misuse among pregnant women, including the use of substances that are illegal or criminalized, misuse of prescribed medications, and binge drinking, has increased year after year for the past decade. Pregnant people with Substance Use Disorder, particularly those with opioids, amphetamines, and cocaine use disorders, are at greater risk of severe maternal morbidity, including conditions such as eclampsia, heart attack or failure, and sepsis.

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

(a) FUNDING FOR STATE-BASED PERINATAL QUALITY COLLABORATIVES DEVELOPMENT AND SUSTAINABILITY.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this Act (other than section 8) as the "Secretary"), acting through the Division of Reproductive Health of the Centers

for Disease Control and Prevention, shall establish a grant program, to be known as the "State-Based Perinatal Quality Collaborative Grant Program", under which the Secretary shall award grants to eligible entities for the purpose of development and sustainability of perinatal quality collaboratives in each State, the District of Columbia, and eligible territories, in order to measurably improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants.

(2) GRANT AMOUNTS.—Grants awarded under this subsection shall be in amounts not to exceed \$250,000 per year, for the duration of the grant period.

(3) DEFINITION OF PERINATAL QUALITY COLLABORATIVE.—In this subsection, the term "perinatal quality collaborative" means a network of teams that—

(A) is multidisciplinary in nature and includes the full range of perinatal and maternity care providers;

(B) works to improve measurable outcomes 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.—There is authorized to be appropriated to carry out this subsection \$35,000,000 for each of fiscal years 2027 through 2031.

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

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

(A) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in subsection (a)(4)—

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

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

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

(IV) by striking the semicolon at the end and inserting “; and (G) oral health services for pregnant and postpartum women (as defined in subsection (1))”;

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

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

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

“(2) COVERAGE REQUIREMENTS.—To satisfy the requirement to provide oral health serv-

ices for pregnant and postpartum women, a State shall, at a minimum, provide coverage for preventive, diagnostic, periodontal, and restorative care consistent with recommendations for perinatal oral health care and dental care during pregnancy from the American Academy of Pediatric Dentistry and the American College of Obstetricians and Gynecologists.”.

(B) CHIP.—Section 2103(c)(6) of the Social Security Act (42 U.S.C. 1397cc(c)(6)) is amended—

(i) in subparagraph (A)—

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

(II) by inserting “, and, in the case of a targeted low-income child who is pregnant or a targeted low-income pregnant woman, satisfies the coverage requirements specified in section 1905(11)” after “emergency conditions”; and

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

(2) REQUIRING 12-MONTH CONTINUOUS COVERAGE OF FULL BENEFITS FOR PREGNANT AND POSTPARTUM INDIVIDUALS UNDER MEDICAID AND CHIP.—

(A) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(i) in subsection (a)—

(ii) in paragraph (89), by striking “and” at the end;

(iii) in paragraph (90)(C), by striking the period at the end and inserting “; and”; and

(iv) by inserting after paragraph (90)(C) the following new paragraph:

“(91) provide that the State plan is in compliance with subsection (e)(16).”; and

(v) in subsection (e)(16)—

(I) in subparagraph (A), by striking “At the option of the State, the State plan (or waiver of such State plan) may provide” and inserting “A State plan (or waiver of such State plan) shall provide”; and

(II) in subparagraph (B), in the matter preceding clause (i), by striking “by a State making an election under this paragraph” and inserting “under a State plan (or a waiver of such State plan)”; and

(III) by striking subparagraph (C).

(B) CHIP.—

(i) IN GENERAL.—Section 2107(e)(1)(K) of the Social Security Act (42 U.S.C. 1397gg(e)(1)(K)) is amended to read as follows:

“(K) Paragraphs (5) and (16) of section 1902(e) (relating to the requirement to provide medical assistance under the State plan or waiver consisting of full benefits during pregnancy and throughout the 12-month postpartum period under title XIX).”.

(ii) CONFORMING AMENDMENT.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 139711(d)(2)(A)) is amended by striking “the month in which the 60-day period” and all that follows through “pursuant to section 2107(e)(1).”.

(3) MAINTENANCE OF EFFORT.—

(A) MEDICAID.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

“(5) During the period that begins on the date of enactment of this paragraph and ends on the date that is 5 years after such date of enactment, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect, with respect to women who are eligible for medical assistance under the State plan or under a waiver of such plan on the basis of being

pregnant or having been pregnant, eligibility standards, methodologies, or procedures under the State plan or waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver that are in effect on the date of enactment of this paragraph.”.

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

“(4) ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT WOMEN.—During the period that begins on the date of enactment of this paragraph and ends on the date that is 5 years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide assistance to women on the basis of being pregnant (including pregnancy-related assistance provided to targeted low-income pregnant women (as defined in section 2112(d)), pregnancy-related assistance provided to women who are eligible for such assistance through application of section 1903(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the State child health plan (or a waiver of such plan) which is provided to women on the basis of being pregnant) shall not have in effect, with respect to such women, eligibility standards, methodologies, or procedures under such plan (or waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.”.

(4) INFORMATION ON BENEFITS.—The Secretary shall make publicly available on the internet website of the Department of Health and Human Services information regarding benefits available to pregnant and postpartum women and under the Medicaid program and the Children’s Health Insurance Program, including information on—

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

(B) optional benefits that States may provide to pregnant and postpartum women under such programs; and

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

(5) FEDERAL FUNDING FOR COST OF EXTENDED MEDICAID AND CHIP COVERAGE FOR POSTPARTUM WOMEN.—

(A) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by paragraph (1), is further amended by adding at the end the following:

“(mm) INCREASED FMAP FOR EXTENDED MEDICAL ASSISTANCE FOR POSTPARTUM INDIVIDUALS.—

“(1) IN GENERAL.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State, with respect to amounts expended by such State for medical assistance for an individual who is eligible for such assistance on the basis of being pregnant or having been pregnant that is provided during the 305-day period that begins on the 60th 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 plan (or a waiver of such plan) for assistance provided under the plan (or waiver) to a woman who is eligible for such assistance on the basis of being pregnant (including pregnancy-related assistance provided to a targeted low-income pregnant woman (as defined in section 2112(d)), pregnancy-related assistance provided to a woman who is eligible for such assistance through application of section 1903(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the plan (or waiver) provided to a woman who is eligible for such assistance on the basis of being pregnant) during the 305-day period that begins on the 60th day after the last day of her 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.”.

(6) GUIDANCE ON STATE OPTIONS FOR MEDICAID COVERAGE OF DOULA SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall issue guidance for the States concerning options for Medicaid coverage and payment for support services provided by doulas.

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

(A) in subsection (b), by striking “and (ii)” and inserting “(ii), (mm), and (nn)”;

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

“(nn) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR OBSTETRIC AND GYNECOLOGICAL SERVICES FURNISHED AT RURAL HOSPITALS.—

“(1) IN GENERAL.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State, with respect to amounts expended by such State for medical assistance for obstetric or gynecological services that are furnished in a hospital that is located in a rural area (as defined for purposes of section 1886) shall be equal to 90 percent for each calendar quarter beginning with the first calendar quarter during which this subsection is in effect.

“(2) EXCLUSION FROM TERRITORIAL CAPS.—Any payment made to a territory for expenditures for medical assistance 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.”.

(8) EFFECTIVE DATES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C)—

(1) the amendments made by paragraphs (1), (2), and (5) shall take effect on the first day of the first calendar quarter that begins

on or after the date that is 1 year after the date of enactment of this Act;

(ii) the amendments made by paragraph (3) shall take effect on the date of enactment of this Act; and

(iii) the amendments made by paragraph (7) shall take effect on the first day of the first calendar quarter that begins on or after the date of enactment of this Act.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act that the Secretary determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(C) STATE OPTION FOR EARLIER EFFECTIVE DATE.—A State may elect to have subsection (e)(16) of section 1902 of the Social Security Act (42 U.S.C. 1396a) and subparagraph (K) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by paragraph (2), and subsection (mm) of section 1905 of the Social Security Act (42 U.S.C. 1396d) and paragraph (13) of section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)), as added by paragraph (5), take effect with respect to the State on the first day of any fiscal quarter that begins before the date described in subparagraph (A) and apply to amounts payable to the State for expenditures for medical assistance, child health assistance, or pregnancy-related assistance to pregnant or postpartum individuals furnished on or after such day.

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

“SEC. 399V.—**8. REGIONAL CENTERS OF EXCELLENCE ADDRESSING IMPLICIT BIAS AND CULTURAL COMPETENCY IN PATIENT-PROVIDER INTERACTIONS EDUCATION.**

“(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall enter into cooperative agreements with eligible entities for the establishment or support of regional centers of excellence that address implicit bias, cultural competency, and respectful care practices in patient-provider interactions education for the purpose of enhancing and improving how health care professionals are educated in implicit bias and delivering culturally competent health care.

“(b) ELIGIBILITY.—To be eligible to enter into a cooperative agreement under subsection (a), an entity shall—

“(1) be a public or other (as specified by the Secretary) nonprofit entity that provides educational and training opportunities for students and health care professionals, including a health system, teaching hospital, community health center, medical school, school of public health, school of nursing, dental school, social work school, school of professional psychology, or any other health professional school or program at an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) focused on the prevention, treatment, or re-

covery of health conditions that contribute to maternal mortality and the prevention of maternal mortality and severe maternal morbidity;

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

“(3) demonstrate engagement with groups engaged in the implementation of health care professional training in implicit bias and delivering culturally competent care, such as departments of public health, perinatal quality collaboratives, hospital systems, and health care professional groups, in order to obtain input on resources needed for effective implementation strategies; and

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

“(c) DIVERSITY.—In selecting eligible entities with which to enter into a cooperative agreement under subsection (a), the Secretary shall take into account any regional differences among eligible entities and make an effort to ensure geographic diversity among award recipients.

“(d) DISSEMINATION OF INFORMATION.—

“(1) PUBLIC AVAILABILITY.—The Secretary shall make publicly available on the internet website of the Department of Health and Human Services information submitted to the Secretary under subsection (b)(4).

“(2) EVALUATION.—The Secretary shall evaluate each regional center of excellence established or supported pursuant to subsection (a) and disseminate the findings resulting from each such evaluation to the appropriate public and private entities.

“(3) DISTRIBUTION.—The Secretary shall share the evaluations and overall findings described in paragraph (2) with State departments of health and other relevant State level offices to inform State and local best practices.

“(e) DEFINITION OF MATERNAL MORTALITY.—In this section, the term ‘maternal mortality’ means death of a woman that occurs during pregnancy or within the 1-year period following the end of such pregnancy.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$5,000,000 for each of fiscal years 2027 through 2031.”.

(d) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN.—Section 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

(1) by striking the clause designation and heading and all that follows through “A State” and inserting the following:

“(ii) WOMEN.—

“(I) BREASTFEEDING WOMEN.—A State”;

(2) in subclause (I) (as so designated), by striking “1 year” and all that follows through “earlier” and inserting “2 years postpartum”; and

(3) by adding at the end the following:

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

SEC. 4. FULL-SPECTRUM DOULA WORKFORCE.

(a) IN GENERAL.—The Secretary shall establish and implement a program to award grants to, or enter into contracts with, eligible entities to establish or expand programs to grow and diversify the doula workforce, including through improving the capacity and supply of health care providers.

(b) ELIGIBILITY.—To be eligible to receive a grant or enter into a contract under subsection (a), an entity shall be—

(1) a health professions school;

(2) a school of public health;

(3) an academic health center;

- (4) a State or local government;
- (5) a territory;
- (6) an Indian Tribe, Tribal organization, urban Indian organization, or Native Hawaiian organization;
- (7) a community-based organization; or
- (8) another appropriate public or private nonprofit entity or a consortium of public or private nonprofit entities, including entities that promote multidisciplinary approaches.

(c) **USE OF FUNDS.**—An eligible entity that receives a grant or enters into a contract under subsection (a) shall use the funds received pursuant to such grant or contract for 1 or more of the following activities:

(1) Establishing programs that provide education and training to individuals seeking appropriate training or certification as a full-spectrum doula.

(2) Expanding the capacity of existing programs that provide education and training to individuals seeking appropriate training or certification as a full-spectrum doula for the purpose of increasing the number of students enrolled in such programs, including by awarding scholarships for students who agree to work in underserved communities after receiving such education and training.

(3) Developing and implementing strategies to recruit and retain students from underserved communities, particularly from demographic groups experiencing high rates of maternal mortality and severe maternal morbidity, including racial and ethnic minority groups, into programs described in paragraphs (1) and (2).

(d) **FUNDING.**—In addition to amounts otherwise available, there is authorized to be appropriated to the Secretary to carry out this section, and there is appropriated, out of any money in the Treasury not otherwise appropriated, \$50,000,000 for fiscal year 2027, to remain available until expended.

SEC. 5. GRANTS FOR RURAL OBSTETRIC MOBILE HEALTH UNITS.

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

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

“(a) **IN GENERAL.**—The Secretary, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the ‘Secretary’), shall establish a 5-year pilot program under which the Secretary shall make grants to States—

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

“(2) to train providers, including obstetrician-gynecologists, certified nurse-midwives, nurse practitioners, nurses, and midwives, to operate and provide obstetric services, including training and planning for obstetric emergencies, in such mobile health units; and

“(3) to address access issues, including social determinants of health and wrap-around clinical and community services, including nutrition, housing, lactation services, and transportation support and referrals.

“(b) **NO SHARING OF DATA WITH LAW ENFORCEMENT.**—As a condition of receiving a grant under this section, a State shall submit to the Secretary an assurance that the State will not make available to Federal or State law enforcement any personally identifiable information regarding any pregnant or postpartum individual collected pursuant to such grant.

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

“(d) **REPORTING REQUIREMENTS.**—

“(1) **IN GENERAL.**—Not later than 3 years after the date on which a State receives a grant under this section, and not later than 6 years after such date, such State shall submit to the Secretary a report that describes the results of the activities carried out pursuant to the grant, including—

“(A) relevant information and relevant quantitative indicators of the success of such activities in improving the standard of care and maternal health outcomes for individuals in rural and underserved communities who are seen for pre-conception, pregnancy, or postpartum visits in the rural mobile health units, stratified by the categories of data described in paragraph (2);

“(B) relevant qualitative evaluations from individuals receiving pre-conception, pregnant, or postpartum care from rural mobile health units provided through the grant, including measures of patient-reported experience of care and measures of patient-reported issues with access to care without such rural mobile health unit; and

“(C) strategies to sustain such activities beyond the duration of the grant and expand such activities to other rural and underserved communities.

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

“(A) Race, ethnicity, sex, gender, gender identity, primary language, age, geography, disability status, and insurance status.

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

“(C) Number of repeat visits provided for pre-conception, prenatal, or postpartum care.

“(D) Number of screenings or tests provided for smoking, substance use, hypertension, sexually transmitted diseases, diabetes, HIV, depression, intimate partner violence, Pap smears, and pregnancy.

“(3) **DATA PRIVACY PROTECTION.**—The reports required under paragraph (1) shall not contain any personally identifiable information regarding any pregnant or postpartum individual.

“(e) **EVALUATION.**—Not later than December 31, 2032, the Secretary shall conduct an evaluation of the pilot program under this section to determine the impact of the pilot program with respect to—

“(1) the effectiveness of the grants awarded under this section to improve maternal health outcomes in rural and underserved communities, with data stratified by race, ethnicity, primary language, socioeconomic status, geography, insurance type, and such other factors as the Secretary determines appropriate;

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

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

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

“(f) **REPORT.**—Not later than 1 year after the completion of the pilot program under this section, the Secretary shall submit to Congress, and make publicly available, a report that contains—

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

“(2) recommendations regarding whether the pilot program should be continued and expanded on a national basis.

“(g) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to the Secretary to carry out this section \$10,000,000 for each of fiscal years 2027 through 2031.”

SEC. 6. REQUIRING NOTIFICATION OF IMPENDING HOSPITAL OBSTETRIC UNIT CLOSURE.

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

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

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

(3) by inserting after subparagraph (Y) the following new subparagraph:

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

“(i) a report analyzing the impact the closure will have on the community;

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

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

SEC. 7. REPORT ON MATERNAL HEALTH NEEDS.

(a) **IN GENERAL.**—Not later than 2 years after the date of enactment of this Act, the Secretary shall prepare, and submit to Congress, a report on—

(1) where the maternal health needs are greatest in the United States; and

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

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

(c) **CONTENTS.**—The report under subsection (a) shall include an analysis of each of the following:

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

(2) Barriers to applying for and receiving Federal funds for maternal health, including with respect to initial applications—

(A) requirements for submission in partnership with other entities; and

(B) stringent network requirements.

(3) Why applicants did not receive funding, including limited availability of funds, the strength of the respective applications, and failure to adhere to requirements.

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

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

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

(b) **TAX PARITY FOR PIPE TOBACCO.**—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking “\$2.831 cents” and inserting “\$49.56”.

(c) **TAX PARITY FOR SMOKELESS TOBACCO.**—(1) Section 5701(e) of the Internal Revenue Code of 1986 is amended—

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

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

(C) by adding at the end the following:

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

(2) Section 5702(m) of such Code is amended—

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

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

(C) by adding at the end the following:

“(4) **DISCRETE SINGLE-USE UNIT.**—The term ‘discrete single-use unit’ means any product containing, made from, or derived from tobacco or nicotine that—

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

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

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

(e) TAX PARITY FOR LARGE CIGARS.—

(1) IN GENERAL.—Paragraph (2) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking “52.75 percent” and all that follows through the period and inserting the following: “\$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.066 cents per cigar.”.

(2) GUIDANCE.—The Secretary of the Treasury, or the Secretary’s delegate, may issue guidance regarding the appropriate method for determining the weight of large cigars for purposes of calculating the applicable tax under section 5701(a)(2) of the Internal Revenue Code of 1986.

(3) CONFORMING AMENDMENT.—Section 5702 of such Code is amended by striking subsection (1).

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

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

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

“(i) OTHER TOBACCO PRODUCTS.—Any product not otherwise described under this section that has been determined to be a tobacco product by the Food and Drug Administration through its authorities under the Family Smoking Prevention and Tobacco Control Act shall be taxed at a level of tax equivalent to the tax rate for cigarettes on an estimated per use basis as determined by the Secretary.”.

(2) ESTABLISHING PER USE BASIS.—For purposes of section 5701(i) of the Internal Revenue Code of 1986, not later than 12 months after the later of the date of the enactment of this Act or the date that a product has been determined to be a tobacco product by the Food and Drug Administration, the Secretary of the Treasury (or the Secretary of the Treasury’s delegate) shall issue final regulations establishing the level of tax for such product that is equivalent to the tax rate for cigarettes on an estimated per use basis.

(h) CLARIFYING DEFINITION OF TOBACCO PRODUCTS.—

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

“(c) TOBACCO PRODUCTS.—The term ‘tobacco products’ means—

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

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

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

(i) INCREASING TAX ON CIGARETTES.—

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

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

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

“(j) INFLATION ADJUSTMENT.—

“(1) IN GENERAL.—In the case of any calendar year beginning after 2026, the dollar amounts provided under this chapter shall each be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2025’ for ‘calendar year 2016’ in subparagraph (A)(ii) thereof.

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

(k) FLOOR STOCKS TAXES.—

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

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

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

(2) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to the lesser of \$1,000 or the amount of such taxes. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 person for purposes of this paragraph.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products on any tax increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the first proviso of section 3(a) of such Act, or

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

(5) DEFINITIONS.—For purposes of this subsection—

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

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

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

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

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

(1) EFFECTIVE DATES.—

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

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

(3) OTHER TOBACCO PRODUCTS.—The amendments made by subsection (g)(1) shall apply to products removed after the last day of the month which includes the date that the Secretary of the Treasury (or the Secretary of the Treasury’s delegate) issues final regulations establishing the level of tax for such product.

By Mr. REED (for himself, Mr.

VAN HOLLEN, and Mr. WYDEN):

S. 5549. A bill to support educators; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, it is time for a national investment in building a strong and resilient educator workforce to ensure that all schools have the diverse, profession-ready teachers, principals, librarians, counselors, and other specialized instructional support personnel they need to support student development and academic achievement. Today, along with Senators VAN HOLLEN and WYDEN, I am introducing the Quality Educator Partnership Act to invest in a national strategy to support the educator workforce now and into the future. I am pleased that Representative ALMA ADAMS is introducing a companion bill in the other body with Representatives JAHANA HAYES and SUZANNE BONAMICI.

We are facing a national crisis in the education profession. A 2024 report from the Annenberg Institute at Brown University found that across multiple measures, regard for the teaching profession is at its lowest levels in 50 years—from prestige to interest in the field to job satisfaction. Since 2010, the decline has accelerate, with perceptions of teacher prestige falling between 20 percent and 47 percent and interest in teaching careers among high school seniors and college freshman declining nearly 50 percent. Between 2006 and 2021, the number of prospective

teachers earning licenses has fallen by over 100,000. We cannot afford to neglect the educator workforce any longer.

History shows that the Nation can rise to this challenge. Following the launch of Sputnik in 1957, Congress enacted the National Defense Education Act of 1958 that invested in math, science, and foreign language instruction and the teaching workforce to deliver it. With the rise of new technologies and artificial intelligence, we need that kind of effort today to ensure American students have professional educators that can teach the skills students will need to thrive in a changing environment. In February, a coalition of education organizations came together with a call to action to change the trajectory of the education profession through Federal leadership and systemic accountability, investing in innovation and sustainability, making the education profession an affordable career path, and advancing research and evidence to guide the future of learning.

The Quality Educator Partnership Act is the legislative plan to answer the call to action. Our legislation calls for a comprehensive national strategy to recruit, prepare, retain, and advance high-quality educators from early childhood through secondary education led by a dedicated Office of Educator Workforce at the U.S. Department of Education. It calls for \$500 million annual investment in partnerships between school districts and educator preparation programs to address local workforce needs. It includes \$500 million for grants to States to design and implement educator workforce strategies. Our bill creates a new National Educator Service Corps that will cover the cost of tuition and living expenses for prospective teachers who agree to teach in high-need areas. Additionally, the Quality Educator Partnership Act calls for new investments in data collection and accountability to track the state of the educator workforce and equitable access to profession-ready educators. It also calls for new investments in research and development to prepare for the future of teaching.

The Quality Educator Partnership Act reflects input from stakeholders across the field about what is needed to recruit, prepare, and support educators. To date, more than two dozen organizations have endorsed it, including the American Association of Colleges for Teacher Education, American Federation of Teachers, National Education Association, City Teaching Alliance, Center for Reaching and Teaching the Whole Child, International Society for Transforming Education, National Association for School-University Partnerships, National Center for Teacher Residencies, InnovateEDU, National Principals Association, Council for Academic Deans of Research Education Institutions, National Association for Family, School and Community Engagement, Deans for Impact,

National Association of Community College Teacher Education Programs, 1890 Universities Foundation, ETS, Thurgood Marshall College Fund, Teacher Education Council of State Colleges and Universities, National Association for Music Education, ACTFL, National Center for Learning Disabilities, AILACTE, AMLE, National Association of Elementary School Principals, National Council of Teachers of English, UNCF, Teach Plus, and American Library Association.

The Nation's outlook for the future is tied to the strength of the education profession. Our economic prosperity, the health of our democracy and civic society, and our ability to meet the challenges of climate change and the information age depend on our students having access to well-prepared and supported educators who reflect the diversity of the students they serve.

Today, the profession is in crisis. It is time to act. I urge my colleagues to cosponsor the Quality Educator Partnership Act and work with me to see that it is enacted into law.

By Mr. PADILLA (for himself, Mr. TILLIS, and Mr. MERKLEY):

S. 5558. A bill to direct the Secretary of Transportation to establish a grant program to facilitate the installation of evidence-based suicide deterrents, including suicide prevention nets and barriers, on certain infrastructure, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. PADILLA. Mr. President, I rise to introduce the bipartisan Barriers to Suicide Act. This legislation would establish competitive grants to help State and local governments fund nets and barriers that have been shown to reduce suicide on bridges and other high-risk infrastructure.

This bipartisan bill would establish a grant program for States and localities to apply for Federal funding under the National Highway Performance Program to install nets, barriers, and other evidence-based suicide deterrents on bridges, buildings, parking garages, highway-rail grade crossings, and at rail stations.

This bill would also authorize a study to identify the types of structures most commonly used for suicide attempts, types of barriers that are most effective in prevention, and additional strategies to reduce jumping deaths.

The CDC estimated that about 12.8 million people seriously thought about suicide, 3.7 million made a plan, and 1.5 million attempted suicide in 2023. There were over 49,000 deaths from suicide in 2023 and between 2010 and 2020, 11,154 Americans lost their lives through suicide-by-jumping.

Research shows that physical barriers on bridges and high structures can reduce suicide deaths at those sites by up to 90 percent.

States and localities should have access to a grant program that allows

them to proactively prevent suicide-by-jumping by building safety nets and barriers on bridges, buildings, parking garages, and at rail stations and highway-rail grade rail crossings, with the goal of preventing suicides.

I would like to thank Senator TILLIS for introducing this important legislation with me, and I look forward to working with my colleagues to enact the Barriers to Suicide Act as soon as possible.

By Mr. PADILLA (for himself, Ms. WARREN, Mr. BLUMENTHAL, Mr. BOOKER, Ms. HIRONO, and Mr. VAN HOLLEN):

S. 5559. A bill to provide for the basic needs of students at institutions of higher education; to the Committee on Health, Education, Labor, and Pensions.

Mr. PADILLA. Mr. President, I rise to speak in support of the Basic Assistance for Students in College Act or the BASIC Act, which I introduced today.

I know how important it is to help students cover the full cost of attending college, including tuition and fees, housing, food, transportation, books, childcare, healthcare, supplies, and more.

According to the Hope Center for Student Basic Needs, three in five college students experience food and housing insecurity. We also know that rates of basic needs insecurity are much higher for historically marginalized students, including Black, Latino, and indigenous students; parenting students; LGBTQIA+ students; first-generation students; Pell Grant recipients; former foster youth; and justice-involved students.

Our Nation's college students shouldn't have to worry about going hungry or having a roof over their heads. Yet far too many do, and basic needs will be out of reach for millions more students due to the One Big Beautiful Act, which cut food assistance, healthcare coverage, and access to financial aid.

The evidence is clear that addressing students' basic needs prevents students from having to sacrifice their health and well-being in order to succeed in higher education.

That is why I am proud to introduce this bill to authorize \$1 billion for a new grant program to help institutions of higher education meet students' basic needs. This funding represents an essential aspect of building more equitable paths to higher education, and it represents an investment in our students, our institutions, and our future. The legislation also helps coordinate assistance across Federal Agency lines.

I want to thank Senator WARREN and Representative TORRES for introducing this bill with me, and I hope our colleagues will join us in support of this bill that ensures no student is forced to choose between their education and their basic needs.

By Mr. DURBIN (for himself, Mr. PADILLA, Mr. KING, Ms. HIRONO,

Mr. KAINE, Mr. BLUMENTHAL, and Mrs. MURRAY):

S. 5560. A bill to improve fairness and accountability with respect to the arrest and detention of noncitizens; to the Committee on the Judiciary.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 5560

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Immigration Warrants Reform Act of 2026".

SEC. 2. INSPECTION OF NONCITIZENS.

Section 235(b)(2)(A) of the Immigration and Nationality Act (8 U.S.C. 1225(b)(2)(A)) is amended—

(1) by striking "an alien" each place such term appears and inserting "a noncitizen";

(2) by striking "the alien" and inserting "a noncitizen"; and

(3) by inserting "at the border (and who is not or was not paroled)" after "applicant for admission".

SEC. 3. ARREST, DETENTION, AND RELEASE OF NONCITIZENS.

Section 236 of the Immigration and Nationality Act (8 U.S.C. 1226) is amended—

(1) in the section heading, by striking "ALIENS" and inserting "NONCITIZENS"; and

(2) by striking subsections (a) and (b) and inserting the following:

"(a) ARREST, DETENTION, AND RELEASE.—

"(1) IN GENERAL.—Upon the issuance of an administrative warrant described in paragraph (4), a noncitizen may be arrested and detained pending a decision on whether the noncitizen will be removed from the United States.

"(2) RELEASE.—Except as provided in subsection (c), the Department of Homeland Security may release a detained noncitizen on his or her own recognizance or subject to such conditions as may be necessary to facilitate the noncitizen's attendance with future proceedings and to prevent any danger to the community.

"(3) PERIODIC REVIEW.—

"(A) IN GENERAL.—A detained noncitizen is entitled to seek a custody review every 60 days from an immigration judge or an appropriate district court of the United States that may release the noncitizen on his or her own recognizance or subject to such conditions as may be necessary to facilitate the noncitizen's attendance with future proceedings and to prevent any danger to the community.

"(B) BURDEN OF PROOF.—In any proceeding under subparagraph (A), the burden of proof shall be on the Secretary of Homeland Security to establish, by clear and convincing evidence, that the noncitizen is a flight risk from attending future proceedings or a danger to the community.

"(4) REQUIREMENTS FOR ADMINISTRATIVE WARRANT.—All administrative warrants for the arrest of a noncitizen shall—

"(A) accurately document individualized probable cause of the noncitizen's removability under section 212 or section 237;

"(B) be signed by a supervising officer of the Department of Homeland Security at least 24 hours in advance of its execution;

"(C) be issued concurrently with, or based on, a previously existing notice to appear pursuant to section 239(a); and

"(D) be served on the noncitizen with such notice to appear at the time of arrest.

"(b) REVOCATION OF RELEASE.—The Secretary of Homeland Security may, at any time, upon an individualized determination that there is probable cause to find that a noncitizen presents a danger to the community—

"(1) revoke a release authorized under subsection (a)(2);

"(2) rearrest the noncitizen pursuant to a warrant described in subsection (a)(4); and

"(3) detain the noncitizen.".

SEC. 4. POWERS OF IMMIGRATION OFFICERS AND EMPLOYEES WITHOUT A WARRANT.

Section 287(a) of the Immigration and Nationality Act (8 U.S.C. 1357(a)) is amended—

(1) by striking the matter preceding paragraph (1) and all that follows through the end of paragraph (2) and inserting the following:

"(1) UNAUTHORIZED ENTRY.—Any officer or employee of the Department of Homeland Security authorized under regulations prescribed by the Secretary of Homeland Security shall have power, without a warrant, to arrest any noncitizen who, in the presence or view of the officer or employee, is entering or attempting to enter the United States at any time or place other than as designated by the Department of Homeland Security or an immigration officer.

"(2) INTERIOR ARRESTS.—

"(A) IN GENERAL.—Any officer or employee of the Department of Homeland Security authorized under regulations prescribed by the Secretary of Homeland Security shall have power, without a warrant, to arrest any noncitizen who is physically present in the United States if the officer or employee has probable cause to believe such individual—

"(i) is a noncitizen;

"(ii) is subject to removal under section 212 or section 237;

"(iii) presents an imminent danger to the community, which requires immediate arrest; and

"(iv) is likely to escape before a warrant can be obtained for such arrest.

"(B) DOCUMENTATION.—Not later than 12 hours after each arrest carried out pursuant to subparagraph (A), the officer or employee making the arrest shall submit a sworn, written statement, under penalty of perjury, to a supervisory immigration officer or employee that includes an individualized assessment of probable cause regarding the factors described in clauses (i) through (iv) of subparagraph (A) that are required for such warrantless arrest.

"(C) JUDICIAL REVIEW.—Not later than 24 hours after each arrest carried out pursuant to subparagraph (A), an immigration judge or an appropriate district court of the United States shall—

"(i) examine whether such arrest met the requirements under subparagraph (A) based on available evidence, including—

"(I) the sworn statement submitted pursuant to subparagraph (B); and

"(II) in-person testimony from the individual who was arrested;

"(ii) make individualized findings of whether the arresting officer or employee has established probable cause as to the factors described in clauses (i) through (iv) of subparagraph (A) that are required to make a warrantless arrest; and

"(iii) if the judge or court determines that the Department has not established such probable cause and the individual arrested does not present an imminent danger to the community, the judge or the court shall order the prompt release of the individual.";

(2) in paragraph (3), by striking "(3) within a reasonable distance" and inserting the following:

"(3) OTHER POWERS.—Any officer or employee of the Department of Homeland Security

authorized under regulations prescribed by the Secretary of Homeland Security shall have power, without a warrant—

"(A) within a reasonable distance".

SEC. 5. CONFORMING AMENDMENTS.

Section 287(a) of the Immigration and Nationality Act (8 U.S.C. 1357(a)) is further amended—

(1) in paragraph (5), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and by moving such clauses 2 ems to the right;

(2) by redesignating paragraphs (4) and (5) as subparagraphs (B) and (C), respectively, and by moving such subparagraphs 2 ems to the right;

(3) in paragraph (3), as redesignated—

(A) by striking "aliens" each place such term appears and inserting "noncitizens"; and

(B) in subparagraph (C)(ii), by striking "reasonable grounds to believe" and inserting "probable cause"; and

(4) in the undesignated matter following paragraph (3)(C)(ii), as redesignated—

(A) by striking "under paragraph (5)(B)" each place it appears and inserting "under paragraph (3)(C)(ii)";

(B) by inserting "or the Secretary of Homeland Security" after "Attorney General"; and

(C) by striking "Service" each place such term appears and inserting "Department of Homeland Security".

By Mr. PADILLA:

S. 5563. A bill to direct the Administrator of the National Oceanic and Atmospheric Administration to study the impacts of the dumping of certain waste in the San Pedro Basin, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. PADILLA. Mr. President, I rise today to introduce the Ocean Protection and DDT Reduction Act. This bill would direct NOAA, in consultation with EPA and DOD, to study and address the impacts of historical toxic waste dumping, especially dichlorodiphenyltrichloroethane, DDT, and other industrial and military wastes, in the San Pedro Basin off the coast of California.

Dumping of industrial, chemical, and military waste off the Southern California coast occurred from the 1930s until it was banned in 1972 by the Ocean Dumping Act. This included the dumping of DDT, radioactive materials, alkaline and oil waste, and unexploded ordnance and munitions across 14 sites along the coastline from San Diego to Santa Monica.

In addition to the dumping of chemical waste barrels, millions of pounds of DDT and PCBs were discharged through sewer outfall pipes. Roughly 110 tons of DDT ended up in the sediments of the Palos Verdes Shelf, and in 1996, EPA added this 17 square-mile underwater site as a Superfund site.

Recent studies have found tens of thousands of degrading and leaking barrels of DDT and hazardous waste on the ocean floor at a depth of 3,000 ft deep and 8 to 24 miles from the coast of Southern California, posing potential risks to marine life, fisheries, and public health.

New images from 2020 that showed corroded metal barrels with mysterious

“halos” in the deep ocean off Los Angeles prompted a Scripps study supported by NOAA, which found that these barrels were leaking caustic alkaline waste.

This bill would support important research and coordination on the scope and impacts of the dumped covered waste in the San Pedro Basin and the potential of bioremediation, as well as require a report to Congress after 3 years. The bill would also establish a grant program for academic and research institutions to study the mapping, movement, breakdown, and bioaccumulation of contaminants.

Due to slow degradation, DDT is an ongoing hazard to humans and wildlife, with bioaccumulation found in sea lions, dolphins, bottom-feeding fish, and condors. Supporting further research is crucial to addressing the impacts of the toxic waste dumping.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 898—EXPRESSING THE SENSE OF THE SENATE THAT THE ADDITIONAL TARIFFS IMPOSED ON CANADIAN GOODS UNDER SECTION 338 OF THE TARIFF ACT OF 1930 AND THE RHETORIC SURROUNDING THE BILATERAL RELATIONSHIP BETWEEN CANADA AND THE UNITED STATES HARM UNITED STATES CONSUMERS AND BUSINESSES AND THE TARIFFS SHOULD BE RESCINDED

Ms. ROSEN submitted the following resolution; which was referred to the Committee on Finance:

S. RES. 898

Whereas Canada is one of the strongest allies of the United States, among the largest trading partners of the United States, and the leading source of foreign visitors to many travel destinations in the United States;

Whereas Canada was the top source of international visitors to the United States in 2024, with 20,400,000 visits generating \$20,500,000,000 in spending and supporting 140,000 United States jobs, according to the United States Travel Association;

Whereas President Donald J. Trump has used increasingly hostile rhetoric toward Canada, disrespecting the neighbor of the United States to the north by claiming it will become the “51st State” and calling its Prime Minister “Governor”;

Whereas, as a result of President Trump’s hostility toward Canada, travel by citizens of Canada to the United States dropped 25 percent from 2024 to 2025;

Whereas President Trump has further inflamed tensions by attempting to rename Lake Ontario as Lake America;

Whereas, on July 20, 2026, President Trump announced that he would impose tariffs of 50 percent ad valorem on certain Canadian goods under section 338 of the Tariff Act of 1930 (19 U.S.C. 1338), the first time a president has expressly cited that statute to impose tariffs;

Whereas the cost-raising tariffs went into effect on August 22, 2026;

Whereas the Government of Canada imposed retaliatory tariffs on United States goods worth \$27,600,000,000 in Canadian dollars, starting on September 8, 2026;

Whereas rising costs from the tariffs imposed under section 338 of the Tariff Act of 1930 compound existing affordability pressures facing United States families in housing, transportation, and everyday goods; and

Whereas United States businesses that rely on Canadian imports or cross-border supply chains face increased costs, disrupted planning, and reduced competitiveness as a result of President Trump’s tariffs: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) the additional tariffs imposed on Canadian goods under section 338 of the Tariff Act of 1930 (19 U.S.C. 1338), and the rhetoric surrounding the bilateral relationship between the United States and Canada, harm United States consumers and businesses;

(2) the President should rescind the imposition of the tariffs on Canadian goods; and

(3) the President should immediately stop inflaming tensions with Canada and refrain from needlessly harming the bilateral relationship with a close ally of the United States, including by ceasing reference to Canada as the “51st State” and attempting to rename Lake Ontario.

SENATE RESOLUTION 899—RECOGNIZING SUICIDE AS A SERIOUS PUBLIC HEALTH PROBLEM AND EXPRESSING SUPPORT FOR THE DESIGNATION OF SEPTEMBER AS “NATIONAL SUICIDE PREVENTION MONTH”

Mr. MURPHY (for himself, Mr. TILLIS, Mr. REED, Mr. PETERS, Mrs. CAPITO, and Mr. JUSTICE) submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 899

Whereas suicide is the 10th leading cause of death in the United States and the second leading cause of death among individuals between 10 and 34 years of age;

Whereas, according to the Centers for Disease Control and Prevention (referred to in this preamble as the “CDC”), 1 individual in the United States dies by suicide every 11 minutes, resulting in around 49,000 deaths each year in the United States;

Whereas, according to the Department of Veterans Affairs, 6,400 veterans die by suicide annually, the equivalent of nearly 18 veteran suicides per day;

Whereas, between 2001 and 2024, the suicide rate in the United States increased by 28 percent from 10.7 suicides for every 100,000 individuals to 13.7 suicides for every 100,000 individuals;

Whereas it is estimated that there are approximately 2,200,000 suicide attempts each year in the United States;

Whereas more than half of individuals who die by suicide did not have a known mental health condition;

Whereas, according to the CDC, many factors contribute to suicide among individuals with and without known mental health conditions, including challenges related to relationships, substance use, physical health, and stress regarding work, money, legal problems, or housing;

Whereas, according to the CDC, suicide results in an estimated \$500,000,000,000 each year in combined medical costs, the impact of lives cut short, lost work, and quality of life costs in the United States; and

Whereas the stigma associated with mental health conditions and suicidality hinders suicide prevention by discouraging at-risk individuals from seeking life-saving help and

can further traumatize survivors of suicide loss and individuals with lived experience of suicide: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes suicide as a serious and preventable public health problem of the United States and each State;

(2) supports the designation of September as “National Suicide Prevention Month”;

(3) declares suicide prevention as a priority;

(4) acknowledges that no single suicide prevention program or effort will be appropriate for all populations or communities;

(5) promotes awareness that there is no single cause of suicide; and

(6) supports strategies to increase access to high-quality mental health and suicide prevention services and substance-use disorder treatments.

SENATE RESOLUTION 900—EXPRESSING SUPPORT FOR THE DESIGNATION OF THE SECOND MONDAY IN OCTOBER 2026 AS “INDIGENOUS PEOPLES’ DAY” TO CELEBRATE AND HONOR INDIGENOUS PEOPLES AND THEIR SHARED HISTORY AND CULTURE

Mr. HEINRICH (for himself, Mr. LUJÁN, Mr. KING, Mr. SANDERS, Ms. WARREN, Mr. SCHATZ, Ms. SMITH, Mr. GALLEGOS, Mr. HICKENLOOPER, Mr. KAINE, Ms. HIRONO, Mr. MERKLEY, Mr. SCHIFF, Mr. PADILLA, and Mr. BOOKER) submitted the following resolution; which was referred to the Committee on Indian Affairs:

S. RES. 900

Whereas currently over 200 municipalities, 17 States, and the District of Columbia celebrate or recognize “Indigenous Peoples’ Day” on the second Monday of October;

Whereas Columbus Day is a Federal holiday, established by Congress in 1968 (by the Act entitled “An Act to provide for uniform annual observances of certain legal public holidays on Mondays, and for other purposes”, approved June 28, 1968 (82 Stat. 250)), and is officially recognized by some cities and States around the United States on the second Monday of October;

Whereas Columbus Day does not currently provide an opportunity to reflect on the stories and perseverance of the Indigenous Peoples of the lands that are now part of the United States;

Whereas, prior to Western contact, Indigenous Peoples lived and flourished in the lands that are now part of the United States for thousands of years;

Whereas Western contact with the lands that are now part of the United States led to the suppression, forced assimilation, and genocide of Indigenous Peoples and their cultures;

Whereas the Senate recognizes and values the vast contributions made to the United States by Indigenous Peoples’ knowledge, science, philosophy, arts, and culture;

Whereas the Senate recognizes its responsibility to honor the history, traditions, and cultural contributions of the Indigenous Peoples of the United States; and

Whereas the second Monday in October 2026 would be an appropriate date to designate as “Indigenous Peoples’ Day”: Now, therefore, be it

Resolved, That the Senate—

(1) honors and recognizes the unique contributions Indigenous Peoples have made to the United States of America;

(2) encourages the people of the United States to observe “Indigenous Peoples’ Day”