

117TH CONGRESS
2D SESSION

H. R. 1916

IN THE SENATE OF THE UNITED STATES

APRIL 5, 2022

Received; read twice and referred to the Committee on Health, Education,
Labor, and Pensions

AN ACT

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,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Ensuring Lasting
3 Smiles Act”.

4 **SEC. 2. COVERAGE OF CONGENITAL ANOMALY OR BIRTH**
5 **DEFECT.**

6 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—
7 Part D of title XXVII of the Public Health Service Act
8 (42 U.S.C. 300gg–111 et seq.) is amended by adding at
9 the end the following new section:

10 **“SEC. 2799A–11. STANDARDS RELATING TO BENEFITS FOR**
11 **CONGENITAL ANOMALY OR BIRTH DEFECT.**

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

14 “(1) IN GENERAL.—A group health plan, and a
15 health insurance issuer offering group or individual
16 health insurance coverage, shall provide coverage for
17 outpatient and inpatient items and services related
18 to the diagnosis and treatment of a congenital
19 anomaly or birth defect.

20 “(2) REQUIREMENTS.—

21 “(A) IN GENERAL.—Coverage provided
22 under paragraph (1) shall include any medically
23 necessary item or service to functionally im-
24 prove, repair, or restore any body part to
25 achieve normal body functioning or appearance,
26 as determined by the treating physician (as de-

1 fined in section 1861(r) of the Social Security
2 Act), due to congenital anomaly or birth defect.

3 “(B) FINANCIAL REQUIREMENTS AND
4 TREATMENT REQUIREMENTS.—Any coverage
5 provided under paragraph (1) under a group
6 health plan or individual or group health insur-
7 ance coverage offered by a health insurance
8 issuer may be subject to coverage limits (such
9 as medical necessity, pre-authorization, or pre-
10 certification) and cost-sharing requirements
11 (such as coinsurance, copayments, and
12 deductibles), as required by the plan or issuer,
13 that are no more restrictive than the predomi-
14 nant coverage limits and cost-sharing require-
15 ments, respectively, applied to substantially all
16 medical and surgical benefits covered by the
17 plan (or coverage).

18 “(3) TREATMENT DEFINED.—In this section:

19 “(A) IN GENERAL.—Except as provided in
20 subparagraph (B), the term ‘treatment’ in-
21 cludes, with respect to a group health plan or
22 group or individual health insurance coverage
23 offered by a health insurance issuer, inpatient
24 and outpatient items and services performed to
25 improve, repair, or restore bodily function (or

1 performed to approximate a normal appear-
2 ance), due to a congenital anomaly or birth de-
3 fect, and includes treatment to any and all
4 missing or abnormal body parts (including
5 teeth, the oral cavity, and their associated
6 structures) that would otherwise be provided
7 under the plan or coverage for any other injury
8 or sickness, including—

9 “(i) any items or services, including
10 inpatient and outpatient care, reconstruc-
11 tive services and procedures, and complica-
12 tions thereof;

13 “(ii) adjunctive dental, orthodontic, or
14 prosthodontic support from birth until the
15 medical or surgical treatment of the defect
16 or anomaly has been completed, including
17 ongoing or subsequent treatment required
18 to maintain function or approximate a nor-
19 mal appearance;

20 “(iii) procedures that materially im-
21 prove, repair, or restore bodily function;
22 and

23 “(iv) procedures for secondary condi-
24 tions and follow-up treatment associated

1 with the underlying congenital anomaly or
2 birth defect.

3 “(B) EXCEPTION.—The term ‘treatment’
4 shall not include cosmetic surgery performed to
5 reshape normal structures of the body to im-
6 prove appearance or self-esteem.

7 “(b) NOTICE.—Not later than one year after the date
8 of the enactment of this section and annually thereafter,
9 a group health plan, and a health insurance issuer offering
10 group or individual health insurance coverage, shall, in ac-
11 cordance with regulations or guidance issued by the Sec-
12 retary, provide to each enrollee under such plan or cov-
13 erage a written description of the terms of this section.
14 Such description shall be in language which is understand-
15 able to the typical enrollee.”.

16 (b) ERISA AMENDMENTS.—

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

21 **“SEC. 726. STANDARDS RELATING TO BENEFITS FOR CON-**
22 **GENITAL ANOMALY OR BIRTH DEFECT.**

23 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-
24 TIVE TREATMENT.—

1 “(1) IN GENERAL.—A group health plan, and a
2 health insurance issuer offering group health insur-
3 ance coverage, shall provide coverage for outpatient
4 and inpatient items and services related to the diag-
5 nosis and treatment of a congenital anomaly or birth
6 defect.

7 “(2) REQUIREMENTS.—

8 “(A) IN GENERAL.—Coverage provided
9 under paragraph (1) shall include any medically
10 necessary item or service to functionally im-
11 prove, repair, or restore any body part to
12 achieve normal body functioning or appearance,
13 as determined by the treating physician (as de-
14 fined in section 1861(r) of the Social Security
15 Act), due to congenital anomaly or birth defect.

16 “(B) FINANCIAL REQUIREMENTS AND
17 TREATMENT REQUIREMENTS.—Any coverage
18 provided under paragraph (1) under a group
19 health plan or group health insurance coverage
20 offered by a health insurance issuer may be
21 subject to coverage limits (such as medical ne-
22 cessity, pre-authorization, or pre-certification)
23 and cost-sharing requirements (such as coinsur-
24 ance, copayments, and deductibles), as required
25 by the plan or issuer, that are no more restric-

1 tive than the predominant coverage limits and
2 cost-sharing requirements, respectively, applied
3 to substantially all medical and surgical benefits
4 covered by the plan (or coverage).

5 “(3) TREATMENT DEFINED.—In this section:

6 “(A) IN GENERAL.—Except as provided in
7 subparagraph (B), the term ‘treatment’ in-
8 cludes, with respect to a group health plan or
9 group health insurance coverage offered by a
10 health insurance issuer, inpatient and out-
11 patient items and services performed to im-
12 prove, repair, or restore bodily function (or per-
13 formed to approximate a normal appearance),
14 due to a congenital anomaly or birth defect, and
15 includes treatment to any and all missing or ab-
16 normal body parts (including teeth, the oral
17 cavity, and their associated structures) that
18 would otherwise be provided under the plan or
19 coverage for any other injury or sickness, in-
20 cluding—

21 “(i) any items or services, including
22 inpatient and outpatient care, reconstruc-
23 tive services and procedures, and complica-
24 tions thereof;

1 “(ii) adjunctive dental, orthodontic, or
2 prosthodontic support from birth until the
3 medical or surgical treatment of the defect
4 or anomaly has been completed, including
5 ongoing or subsequent treatment required
6 to maintain function or approximate a nor-
7 mal appearance;

8 “(iii) procedures that materially im-
9 prove, repair, or restore bodily function;
10 and

11 “(iv) procedures for secondary condi-
12 tions and follow-up treatment associated
13 with the underlying congenital anomaly or
14 birth defect.

15 “(B) EXCEPTION.—The term ‘treatment’
16 shall not include cosmetic surgery performed to
17 reshape normal structures of the body to im-
18 prove appearance or self-esteem.

19 “(b) NOTICE.—Not later than one year after the date
20 of the enactment of this section and annually thereafter,
21 a group health plan, and a health insurance issuer offering
22 group health insurance coverage, shall, in accordance with
23 regulations or guidance issued by the Secretary, provide
24 to each participant or beneficiary under such plan or cov-
25 erage a written description of the terms of this section.

1 Such description shall be in language which is understand-
2 able to the typical participant or beneficiary.”.

3 (2) TECHNICAL AMENDMENT.—The table of
4 contents in section 1 of such Act is amended by in-
5 serting after the item relating to section 725 the fol-
6 lowing new item:

“Sec. 726. Standards relating to benefits for congenital anomaly or birth de-
fect.”.

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. STANDARDS RELATING TO BENEFITS FOR CON-**
12 **GENITAL ANOMALY OR 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.

19 **“(2) REQUIREMENTS.—**

20 **“(A) IN GENERAL.—**Coverage provided
21 under paragraph (1) shall include any medically
22 necessary item or service to functionally im-
23 prove, repair, or restore any body part to
24 achieve normal body functioning or appearance,

1 as determined by the treating physician (as de-
2 fined in section 1861(r) of the Social Security
3 Act), due to congenital anomaly or birth defect.

4 “(B) FINANCIAL REQUIREMENTS AND
5 TREATMENT REQUIREMENTS.—Any coverage
6 provided under paragraph (1) under a group
7 health plan may be subject to coverage limits
8 (such as medical necessity, pre-authorization, or
9 pre-certification) and cost-sharing requirements
10 (such as coinsurance, copayments, and
11 deductibles), as required by the plan, that are
12 no more restrictive than the predominant cov-
13 erage limits and cost-sharing requirements, re-
14 spectively, applied to substantially all medical
15 and surgical benefits covered by the plan.

16 “(3) TREATMENT DEFINED.—In this section:

17 “(A) IN GENERAL.—Except as provided in
18 subparagraph (B), the term ‘treatment’ in-
19 cludes, with respect to a group health plan, in-
20 patient and outpatient items and services per-
21 formed to improve, repair, or restore bodily
22 function (or performed to approximate a normal
23 appearance), due to a congenital anomaly or
24 birth defect, and includes treatment to any and
25 all missing or abnormal body parts (including

1 teeth, the oral cavity, and their associated
2 structures) that would otherwise be provided
3 under the plan for any other injury or sickness,
4 including—

5 “(i) any items or services, including
6 inpatient and outpatient care, reconstruc-
7 tive services and procedures, and complica-
8 tions thereof;

9 “(ii) adjunctive dental, orthodontic, or
10 prosthodontic support from birth until the
11 medical or surgical treatment of the defect
12 or anomaly has been completed, including
13 ongoing or subsequent treatment required
14 to maintain function or approximate a nor-
15 mal appearance;

16 “(iii) procedures that materially im-
17 prove, repair, or restore bodily function;
18 and

19 “(iv) procedures for secondary condi-
20 tions and follow-up treatment associated
21 with the underlying congenital anomaly or
22 birth defect.

23 “(B) EXCEPTION.—The term ‘treatment’
24 shall not include cosmetic surgery performed to

1 reshape normal structures of the body to im-
2 prove appearance or self-esteem.

3 “(b) NOTICE.—Not later than one year after the date
4 of the enactment of this section and annually thereafter,
5 a group health plan shall, in accordance with regulations
6 or guidance issued by the Secretary, provide to each en-
7 rollee under such plan a written description of the terms
8 of this section. Such description shall be in language which
9 is understandable to the typical enrollee.”.

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

“Sec. 9826. Standards relating to benefits for congenital anomaly or birth de-
fect.”.

13 (d) RULE OF CONSTRUCTION.—A group health plan
14 or health insurance issuer shall provide the benefits de-
15 scribed in section 2799A–11 of the Public Health Service
16 Act (as added by subsection (a)), section 726 of the Em-
17 ployee Retirement Income Security Act of 1974 (as added
18 by subsection (b)), and section 9826 of the Internal Rev-
19 enue Code of 1986 (as added by subsection (c)) under the
20 terms of such plan or health insurance coverage offered
21 by such issuer.

22 (e) EFFECTIVE DATE.—The amendments made by
23 this section shall apply with respect to plan years begin-
24 ning on or after January 1, 2024.

1 **SEC. 3. DETERMINATION OF BUDGETARY EFFECTS.**

2 The budgetary effects of this Act, for the purpose of
3 complying with the Statutory Pay-As-You-Go Act of 2010,
4 shall be determined by reference to the latest statement
5 titled “Budgetary Effects of PAYGO Legislation” for this
6 Act, submitted for printing in the Congressional Record
7 by the Chairman of the House Budget Committee, pro-
8 vided that such statement has been submitted prior to the
9 vote on passage.

Passed the House of Representatives April 4, 2022.

Attest: CHERYL L. JOHNSON,
Clerk.