

117TH CONGRESS
1ST SESSION

H. R. 3407

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

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 2021

Ms. KELLY of Illinois (for herself, Mrs. BEATTY, Ms. MOORE of Wisconsin, Ms. DEGETTE, Mr. BLUMENAUER, Mr. SCHNEIDER, Mrs. LAWRENCE, Ms. CASTOR of Florida, Ms. DELBENE, Ms. SEWELL, Mr. DEFazio, Ms. DEAN, Mr. SWALWELL, Mr. MEEKS, Mr. BUTTERFIELD, Mr. CARSON, Mr. PAYNE, Ms. KUSTER, Ms. CLARKE of New York, Mr. GRIJALVA, Ms. BARRAGÁN, Ms. MENG, Mr. LOWENTHAL, Ms. LEE of California, Ms. WILSON of Florida, and Ms. BLUNT ROCHESTER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Mothers and Offspring
3 Mortality and Morbidity Awareness Act” or the “MOM-
4 MA’s Act”.

5 **SEC. 2. FINDINGS.**

6 Congress finds the following:

7 (1) Every year, across the United States, nearly
8 4,000,000 women give birth, about 700 women suf-
9 fer fatal complications during pregnancy, while giv-
10 ing birth or during the postpartum period, and
11 about 70,000 women suffer near-fatal, partum-re-
12 lated complications.

13 (2) The maternal mortality rate is often used as
14 a proxy to measure the overall health of a popu-
15 lation. While the infant mortality rate in the United
16 States has reached its lowest point, the risk of death
17 for women in the United States during pregnancy,
18 childbirth, or the postpartum period is higher than
19 such risk in many other high-income countries. The
20 estimated maternal mortality rate (deaths per
21 100,000 live births) for the 48 contiguous States
22 and Washington, DC, increased from 14.5 percent in
23 2000 to 17.3 in 2017. The United States is the only
24 industrialized nation with a rising maternal mor-
25 tality rate.

1 (3) The National Vital Statistics System of the
2 Centers for Disease Control and Prevention has
3 found that in 2018, there were 17.4 maternal deaths
4 for every 100,000 live births in the United States.
5 This ratio is more than double that of most other
6 high-income countries.

7 (4) It is estimated that more than 60 percent
8 of maternal deaths in the United States are prevent-
9 able.

10 (5) According to the Centers for Disease Con-
11 trol and Prevention, the maternal mortality rate var-
12 ies drastically for women by race and ethnicity.
13 There are about 13 deaths per 100,000 live births
14 for White women, 40.8 deaths per 100,000 live
15 births for non-Hispanic Black women, and 29.7
16 deaths per 100,000 live births for American Indian/
17 Alaskan Native women. While maternal mortality
18 disparately impacts Black women, this urgent public
19 health crisis traverses race, ethnicity, socioeconomic
20 status, educational background, and geography.

21 (6) In the United States, non-Hispanic Black
22 women are about 3 times more likely to die from
23 causes related to pregnancy and childbirth compared
24 to non-Hispanic White women, which is one of the
25 most disconcerting racial disparities in public health.

1 This disparity widens in certain cities and States
2 across the country.

3 (7) According to the National Center for Health
4 Statistics of the Centers for Disease Control and
5 Prevention, the maternal mortality rate heightens
6 with age, as women 40 and older die at a rate of
7 81.9 per 100,000 births compared to 10.6 per
8 100,000 for women under 25. This translates to
9 women over 40 being 7.7 times more likely to die
10 compared to their counterparts under 25 years of
11 age.

12 (8) The COVID–19 pandemic risks exacer-
13 bating the maternal health crisis. A recent study of
14 the Centers for Disease Control and Prevention sug-
15 gests that pregnant women are at a significantly
16 higher risk for severe outcomes, including death,
17 from COVID–19 as compared to non-pregnant
18 women. The COVID–19 pandemic has also de-
19 creased access to prenatal and postpartum care.

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

1 (A) the American College of Nurse-Mid-
2 wives;

3 (B) the American College of Obstetricians
4 and Gynecologists;

5 (C) the American Medical Association;

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

8 (E) the Black Mamas Matter Alliance;

9 (F) the Black Women’s Health Imperative;

10 (G) the California Maternal Quality Care
11 Collaborative;

12 (H) EverThrive Illinois;

13 (I) the Illinois Perinatal Quality Collabo-
14 rative;

15 (J) the March of Dimes;

16 (K) the National Association of Certified
17 Professional Midwives;

18 (L) the National Birth Equity Collabo-
19 rative;

20 (M) the National Partnership for Women
21 & Families;

22 (N) the National Polycystic Ovary Syn-
23 drome Association;

24 (O) the Preeclampsia Foundation;

1 (P) the Society for Maternal-Fetal Medi-
2 cine; and

3 (Q) the What To Expect Project.

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

16 (11) According to a study published by the
17 Journal of Perinatal Education, doula-assisted
18 mothers are 4 times less likely to have a low-birth-
19 weight baby, 2 times less likely to experience a birth
20 complication involving themselves or their baby, and
21 significantly more likely to initiate breastfeeding.
22 Doula care has also been shown to produce cost sav-
23 ings resulting in part from reduced rates of cesarean
24 and pre-term births.

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

9 (13) Oral health is an important part of
10 perinatal health. Reducing bacteria in a woman’s
11 mouth during pregnancy can significantly reduce her
12 risk of developing oral diseases and spreading decay-
13 causing bacteria to her baby. Moreover, some evi-
14 dence suggests that women with periodontal disease
15 during pregnancy could be at greater risk for poor
16 birth outcomes, such as preeclampsia, pre-term
17 birth, and low-birth weight. Furthermore, a woman’s
18 oral health during pregnancy is a good predictor of
19 her newborn’s oral health, and since mothers can
20 unintentionally spread oral bacteria to their babies,
21 putting their children at higher risk for tooth decay,
22 prevention efforts should happen even before chil-
23 dren are born, as a matter of pre-pregnancy health
24 and prenatal care during pregnancy.

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

14 (15) Vital statistics systems often underesti-
15 mate maternal mortality and are insufficient data
16 sources from which to derive a full scope of medical
17 and social determinant factors contributing to ma-
18 ternal deaths, such as intimate partner violence.
19 While the addition of pregnancy checkboxes on death
20 certificates since 2003 have likely improved States’
21 abilities to identify pregnancy-related deaths, they
22 are not generally completed by obstetric providers or
23 persons trained to recognize pregnancy-related mor-
24 tality. Thus, these vital forms may be missing infor-
25 mation or may capture inconsistent data. Due to

1 varying maternal mortality-related analyses, lack of
2 reliability, and granularity in data, current maternal
3 mortality informatics do not fully encapsulate the
4 myriad medical and socially determinant factors that
5 contribute to such high maternal mortality rates
6 within the United States compared to other devel-
7 oped nations. Lack of standardization of data and
8 data sharing across States and between Federal en-
9 tities, health networks, and research institutions
10 keep the Nation in the dark about ways to prevent
11 maternal deaths.

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

17 (17) Leaders in maternal wellness highly rec-
18 ommend that maternal deaths and cases of maternal
19 morbidity, including complications that result in
20 chronic illness and future increased risk of death, be
21 investigated at the State level first, and that stand-
22 ardized, streamlined, de-identified data regarding
23 maternal deaths be sent annually to the Centers for
24 Disease Control and Prevention. Such data stand-
25 ardization and collection would be similar in oper-

1 ation and effect to the National Program of Cancer
2 Registries of the Centers for Disease Control and
3 Prevention and akin to the Confidential Enquiry in
4 Maternal Deaths Programme in the United King-
5 dom. Such a maternal mortalities and morbidities
6 registry and surveillance system would help pro-
7 viders, academicians, lawmakers, and the public to
8 address questions concerning the types of, causes of,
9 and best practices to thwart, maternal mortality and
10 morbidity.

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

18 (19) Many States have struggled to establish or
19 maintain Maternal Mortality Review Committees
20 (referred to in this section as "MMRC"). On the
21 State level, MMRCs have lagged because States have
22 not had the resources to mount local reviews. State-
23 level reviews are necessary as only the State depart-
24 ments of health have the authority to request med-

1 ical records, autopsy reports, and police reports crit-
2 ical to the function of the MMRC.

3 (20) The United States has no comparable, co-
4 ordinated Federal process by which to review cases
5 of maternal mortality, systems failures, or best prac-
6 tices. Many States have active MMRCs and leverage
7 their work to impact maternal wellness. For exam-
8 ple, the State of California has worked extensively
9 with their State health departments, health and hos-
10 pital systems, and research collaborative organiza-
11 tions, including the California Maternal Quality Care
12 Collaborative and the Alliance for Innovation on Ma-
13 ternal Health, to establish MMRCs, wherein such
14 State has determined the most prevalent causes of
15 maternal mortality and recorded and shared data
16 with providers and researchers, who have developed
17 and implemented safety bundles and care protocols
18 related to preeclampsia, maternal hemorrhage,
19 peripartum cardiomyopathy, and the like. In this
20 way, the State of California has been able to lever-
21 age its maternal mortality review board system, gen-
22 erate data, and apply those data to effect changes
23 in maternal care-related protocol. To date, the State
24 of California has reduced its maternal mortality

1 rate, which is now comparable to the low rates of the
2 United Kingdom.

3 (21) Hospitals and health systems across the
4 United States lack standardization of emergency ob-
5 stetric protocols before, during, and after delivery.
6 Consequently, many providers are delayed in recog-
7 nizing critical signs indicating maternal distress that
8 quickly escalate into fatal or near-fatal incidences.
9 Moreover, any attempt to address an obstetric emer-
10 gency that does not consider both clinical and public
11 health approaches falls woefully under the mark of
12 excellent care delivery. State-based perinatal quality
13 collaboratives, or entities participating in the Alli-
14 ance for Innovation on Maternal Health (AIM), have
15 formed obstetric protocols, tool kits, and other re-
16 sources to improve system care and response as they
17 relate to maternal complications and warning signs
18 for such conditions as maternal hemorrhage, hyper-
19 tension, and preeclampsia. These perinatal quality
20 collaboratives serve an important role in providing
21 infrastructure that supports quality improvement ef-
22 forts addressing obstetric care and outcomes. State-
23 based perinatal quality collaboratives partner with
24 hospitals, physicians, nurses, patients, public health,
25 and other stakeholders to provide opportunities for

1 collaborative learning, rapid response data, and qual-
2 ity improvement science support to achieve systems-
3 level change.

4 (22) The Centers for Disease Control and Pre-
5 vention reports that nearly half of all maternal
6 deaths occur in the immediate postpartum period—
7 the 42 days following a pregnancy—whereas more
8 than one-third of maternal deaths occur while a per-
9 son is still pregnant. Further, 21 percent of mater-
10 nal deaths occur between 1 and 6 weeks postpartum,
11 and 12 percent of maternal deaths occur during the
12 remaining portion of the postpartum year. Yet, for
13 women eligible for the Medicaid program on the
14 basis of pregnancy, such Medicaid coverage lapses at
15 the end of the month on which the 60th postpartum
16 day lands.

17 (23) The experience of serious traumatic
18 events, such as being exposed to domestic violence,
19 substance use disorder, or pervasive and systematic
20 racism, can over-activate the body's stress-response
21 system. Known as toxic stress, the repetition of
22 high-doses of cortisol to the brain, can harm healthy
23 neurological development and other body systems,
24 which can have cascading physical and mental health
25 consequences, as documented in the Adverse Child-

1 hood Experiences study of the Centers for Disease
2 Control and Prevention.

3 (24) A growing body of evidence-based research
4 has shown the correlation between the stress associ-
5 ated with systematic racism and one's birthing out-
6 comes. The undue stress of sex and race discrimina-
7 tion paired with institutional racism has been dem-
8 onstrated to contribute to a higher risk of maternal
9 mortality, irrespective of one's gestational age, ma-
10 ternal age, socioeconomic status, educational level,
11 or individual-level health risk factors, including pov-
12 erty, limited access to prenatal care, and poor phys-
13 ical and mental health (although these are not nomi-
14 nal factors). Black women remain the most at risk
15 for pregnancy-associated or pregnancy-related causes
16 of death. When it comes to preeclampsia, for exam-
17 ple, for which obesity is a risk factor, Black women
18 of normal weight remain at a higher at risk of dying
19 during the perinatal period compared to non-Black
20 obese women.

21 (25) The rising maternal mortality rate in the
22 United States is driven predominantly by the dis-
23 proportionately high rates of Black maternal mor-
24 tality.

1 (26) Compared to women from other racial and
2 ethnic demographics, Black women across the socio-
3 economic spectrum experience prolonged, unrelenting
4 stress related to systematic racial and gender dis-
5 crimination, contributing to higher rates of maternal
6 mortality, giving birth to low-weight babies, and ex-
7 perencing pre-term birth. Racism is a risk-factor for
8 these aforementioned experiences. This cumulative
9 stress, called weathering, often extends across the
10 life course and is situated in everyday spaces where
11 Black women establish livelihood. Systematic racism,
12 structural barriers, lack of access to care, lack of ac-
13 cess to nutritious food, and social determinants of
14 health exacerbate Black women’s likelihood to expe-
15 rience poor or fatal birthing outcomes, but do not
16 fully account for the great disparity.

17 (27) Black women are twice as likely to experi-
18 ence postpartum depression, and disproportionately
19 higher rates of preeclampsia compared to White
20 women.

21 (28) Racism is deeply ingrained in United
22 States systems, including in health care delivery sys-
23 tems between patients and providers, often resulting
24 in disparate treatment for pain, irreverence for cul-
25 tural norms with respect to health, and dismissive-

1 ness. However, the provider pool is not primed with
2 many people of color, nor are providers (whether
3 maternity care clinicians or maternity care support
4 personnel) consistently required to undergo implicit
5 bias, cultural competency, respectful care practices,
6 or empathy training on a consistent, on-going basis.

7 (29) Not all people who have been pregnant or
8 given birth identify as being a “woman”. The terms
9 “birthing people” or “birthing persons” are also
10 used to describe pregnant and postpartum people.

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

13 (a) TECHNICAL ASSISTANCE FOR STATES WITH RE-
14 SPECT TO REPORTING MATERNAL MORTALITY.—Not
15 later than one year after the date of enactment of this
16 Act, the Director of the Centers for Disease Control and
17 Prevention (referred to in this section as the “Director”),
18 in consultation with the Administrator of the Health Re-
19 sources and Services Administration, shall provide tech-
20 nical assistance to States that elect to report comprehen-
21 sive data on maternal mortality and factors relating to
22 such mortality (including oral and mental health), inti-
23 mate partner violence, and breastfeeding health informa-
24 tion, for the purpose of encouraging uniformity in the re-

1 porting of such data and to encourage the sharing of such
2 data among the respective States.

3 (b) BEST PRACTICES RELATING TO PREVENTION OF
4 MATERNAL MORTALITY.—

5 (1) IN GENERAL.—Not later than one year
6 after the date of enactment of this Act—

7 (A) the Director, in consultation with rel-
8 evant patient and provider groups, shall issue
9 best practices to State maternal mortality re-
10 view committees on how best to identify and re-
11 view maternal mortality cases, taking into ac-
12 count any data made available by States relat-
13 ing to maternal mortality, including data on
14 oral, mental, and breastfeeding health, and uti-
15 lization of any emergency services; and

16 (B) the Director, working in collaboration
17 with the Health Resources and Services Admin-
18 istration, shall issue best practices to hospitals,
19 State professional society groups, and perinatal
20 quality collaboratives on how best to prevent
21 maternal mortality.

22 (2) AUTHORIZATION OF APPROPRIATIONS.—For
23 purposes of carrying out this subsection, there is au-
24 thorized to be appropriated \$5,000,000 for each of
25 fiscal years 2021 through 2025.

1 (c) ALLIANCE FOR INNOVATION ON MATERNAL
2 HEALTH GRANT PROGRAM.—

3 (1) IN GENERAL.—Not later than one year
4 after the date of enactment of this Act, the Sec-
5 retary of Health and Human Services (referred to in
6 this subsection as the “Secretary”), acting through
7 the Associate Administrator of the Maternal and
8 Child Health Bureau of the Health Resources and
9 Services Administration, shall establish a grant pro-
10 gram to be known as the Alliance for Innovation on
11 Maternal Health Grant Program (referred to in this
12 subsection as “AIM”) under which the Secretary
13 shall award grants to eligible entities for the purpose
14 of—

15 (A) directing widespread adoption and im-
16 plementation of maternal safety bundles
17 through collaborative State-based teams; and

18 (B) collecting and analyzing process, struc-
19 ture, and outcome data to drive continuous im-
20 provement in the implementation of such safety
21 bundles by such State-based teams with the ul-
22 timate goal of eliminating preventable maternal
23 mortality and severe maternal morbidity in the
24 United States.

1 (2) ELIGIBLE ENTITIES.—In order to be eligi-
2 ble for a grant under paragraph (1), an entity
3 shall—

4 (A) submit to the Secretary an application
5 at such time, in such manner, and containing
6 such information as the Secretary may require;
7 and

8 (B) demonstrate in such application that
9 the entity is an interdisciplinary, multi-stake-
10 holder, national organization with a national
11 data-driven maternal safety and quality im-
12 provement initiative based on implementation
13 approaches that have been proven to improve
14 maternal safety and outcomes in the United
15 States.

16 (3) USE OF FUNDS.—An eligible entity that re-
17 ceives a grant under paragraph (1) shall use such
18 grant funds—

19 (A) to develop and implement, through a
20 robust, multi-stakeholder process, maternal
21 safety bundles to assist States, perinatal quality
22 collaboratives, and health care systems in align-
23 ing national, State, and hospital-level quality
24 improvement efforts to improve maternal health

1 outcomes, specifically the reduction of maternal
2 mortality and severe maternal morbidity;

3 (B) to ensure, in developing and imple-
4 menting maternal safety bundles under sub-
5 paragraph (A), that such maternal safety bun-
6 dles—

7 (i) satisfy the quality improvement
8 needs of a State, perinatal quality collabo-
9 rative, or health care system by factoring
10 in the results and findings of relevant data
11 reviews, such as reviews conducted by a
12 State maternal mortality review committee;
13 and

14 (ii) address topics which may in-
15 clude—

16 (I) information on evidence-based
17 practices to improve the quality and
18 safety of maternal health care in hos-
19 pitals and other health care settings
20 of a State or health care system, in-
21 cluding by addressing topics com-
22 monly associated with health com-
23 plications or risks related to prenatal
24 care, labor care, birthing, and post-
25 partum care;

- 1 (II) best practices for improving
2 maternal health care based on data
3 findings and reviews conducted by a
4 State maternal mortality review com-
5 mittee that address topics of relevance
6 to common complications or health
7 risks related to prenatal care, labor
8 care, birthing, and postpartum care;
- 9 (III) information on addressing
10 determinants of health that impact
11 maternal health outcomes for women
12 before, during, and after pregnancy;
- 13 (IV) obstetric hemorrhage;
- 14 (V) obstetric and postpartum
15 care for women with substance use
16 disorders, including opioid use dis-
17 order;
- 18 (VI) maternal cardiovascular sys-
19 tem;
- 20 (VII) maternal mental health;
- 21 (VIII) postpartum care basics for
22 maternal safety;
- 23 (IX) reduction of peripartum ra-
24 cial and ethnic disparities;

- 1 (X) reduction of primary cae-
2 sarean birth;
- 3 (XI) severe hypertension in preg-
4 nancy;
- 5 (XII) severe maternal morbidity
6 reviews;
- 7 (XIII) support after a severe ma-
8 ternal morbidity event;
- 9 (XIV) thromboembolism;
- 10 (XV) optimization of support for
11 breastfeeding;
- 12 (XVI) maternal oral health; and
- 13 (XVII) intimate partner violence;
- 14 and

15 (C) to provide ongoing technical assistance
16 at the national and State levels to support im-
17 plementation of maternal safety bundles under
18 subparagraph (A).

19 (4) MATERNAL SAFETY BUNDLE DEFINED.—
20 For purposes of this subsection, the term “maternal
21 safety bundle” means standardized, evidence-in-
22 formed processes for maternal health care.

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

1 thorized to be appropriated \$10,000,000 for each of
2 fiscal years 2021 through 2025.

3 (d) FUNDING FOR STATE-BASED PERINATAL QUAL-
4 ITY COLLABORATIVES DEVELOPMENT AND SUSTAIN-
5 ABILITY.—

6 (1) IN GENERAL.—Not later than one year
7 after the date of enactment of this Act, the Sec-
8 retary of Health and Human Services (referred to in
9 this subsection as the “Secretary”), acting through
10 the Division of Reproductive Health of the Centers
11 for Disease Control and Prevention, shall establish a
12 grant program to be known as the State-Based
13 Perinatal Quality Collaborative grant program under
14 which the Secretary awards grants to eligible entities
15 for the purpose of development and sustainability of
16 perinatal quality collaboratives in every State, the
17 District of Columbia, and eligible territories, in
18 order to measurably improve perinatal care and
19 perinatal health outcomes for pregnant and
20 postpartum women and their infants.

21 (2) GRANT AMOUNTS.—Grants awarded under
22 this subsection shall be in amounts not to exceed
23 \$250,000 per year, for the duration of the grant pe-
24 riod.

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

5 (A) is multidisciplinary in nature and in-
6 cludes the full range of perinatal and maternity
7 care providers;

8 (B) works to improve measurable outcomes
9 for maternal and infant health by advancing
10 evidence-informed clinical practices using qual-
11 ity improvement principles;

12 (C) works with hospital-based or out-
13 patient facility-based clinical teams, experts,
14 and stakeholders, including patients and fami-
15 lies, to spread best practices and optimize re-
16 sources to improve perinatal care and outcomes;

17 (D) employs strategies that include the use
18 of the collaborative learning model to provide
19 opportunities for hospitals and clinical teams to
20 collaborate on improvement strategies, rapid-re-
21 sponse data to provide timely feedback to hos-
22 pital and other clinical teams to track progress,
23 and quality improvement science to provide sup-
24 port and coaching to hospital and clinical
25 teams;

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

4 (F) has the goal of improving outcomes of
5 all birthing people, through the coordination,
6 integration, and collaboration across birth set-
7 tings.

8 (4) AUTHORIZATION OF APPROPRIATIONS.—For
9 purposes of carrying out this subsection, there is au-
10 thorized to be appropriated \$14,000,000 per year
11 for each of fiscal years 2021 through 2025.

12 (e) EXPANSION OF MEDICAID AND CHIP COVERAGE
13 FOR PREGNANT AND POSTPARTUM WOMEN.—

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

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

20 (i) in subsection (a)(4)—

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

23 (II) by inserting “; and (E) oral
24 health services for pregnant and
25 postpartum women (as defined in sub-

1 section (hh))” after “subsection
2 (bb))”; and
3 (ii) by adding at the end the following
4 new subsection:

5 “(hh) ORAL HEALTH SERVICES FOR PREGNANT AND
6 POSTPARTUM WOMEN.—

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

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

24 (B) CHIP.—Section 2103(c)(5)(A) of the
25 Social Security Act (42 U.S.C.

1 1397cc(c)(5)(A)) is amended by inserting “or a
2 targeted low-income pregnant woman” after
3 “targeted low-income child”.

4 (2) EXTENDING MEDICAID COVERAGE FOR
5 PREGNANT AND POSTPARTUM WOMEN.—Section
6 1902 of the Social Security Act (42 U.S.C. 1396a)
7 is amended—

8 (A) in subsection (e)—

9 (i) in paragraph (5)—

10 (I) by inserting “(including oral
11 health services for pregnant and
12 postpartum women (as defined in sec-
13 tion 1905(hh)))” after “postpartum
14 medical assistance under the plan”;
15 and

16 (II) by striking “60-day” and in-
17 serting “1-year”; and

18 (ii) in paragraph (6), by striking “60-
19 day” and inserting “1-year”; and

20 (B) in subsection (l)(1)(A), by striking
21 “60-day” and inserting “1-year”.

22 (3) EXTENDING MEDICAID COVERAGE FOR
23 LAWFUL RESIDENTS.—Section 1903(v)(4)(A)(i) of
24 the Social Security Act (42 U.S.C.

1 1396b(v)(4)(A)(i)) is amended by striking “60-day”
2 and inserting “1-year”.

3 (4) EXTENDING CHIP COVERAGE FOR PREG-
4 NANT AND POSTPARTUM WOMEN.—Section
5 2112(d)(2)(A) of the Social Security Act (42 U.S.C.
6 1397ll(d)(2)(A)) is amended by striking “60-day”
7 and inserting “1-year”.

8 (5) MAINTENANCE OF EFFORT.—

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

13 “(5) During the period that begins on the date of
14 enactment of this paragraph and ends on the date that
15 is five years after such date of enactment, as a condition
16 for receiving any Federal payments under section 1903(a)
17 for calendar quarters occurring during such period, a
18 State shall not have in effect, with respect to women who
19 are eligible for medical assistance under the State plan
20 or under a waiver of such plan on the basis of being preg-
21 nant or having been pregnant, eligibility standards, meth-
22 odologies, or procedures under the State plan or waiver
23 that are more restrictive than the eligibility standards,
24 methodologies, or procedures, respectively, under such

1 plan or waiver that are in effect on the date of enactment
2 of this paragraph.”.

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

7 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
8 GETED LOW-INCOME PREGNANT WOMEN.—During
9 the period that begins on the date of enactment of
10 this paragraph and ends on the date that is five
11 years after such date of enactment, as a condition
12 of receiving payments under subsection (a) and sec-
13 tion 1903(a), a State that elects to provide assist-
14 ance to women on the basis of being pregnant (in-
15 cluding pregnancy-related assistance provided to tar-
16 geted low-income pregnant women (as defined in
17 section 2112(d)), pregnancy-related assistance pro-
18 vided to women who are eligible for such assistance
19 through application of section 1902(v)(4)(A)(i)
20 under section 2107(e)(1), or any other assistance
21 under the State child health plan (or a waiver of
22 such plan) which is provided to women on the basis
23 of being pregnant) shall not have in effect, with re-
24 spect to such women, eligibility standards, meth-
25 odologies, or procedures under such plan (or waiver)

1 that are more restrictive than the eligibility stand-
2 ards, methodologies, or procedures, respectively,
3 under such plan (or waiver) that are in effect on the
4 date of enactment of this paragraph.”.

5 (6) INFORMATION ON BENEFITS.—The Sec-
6 retary of Health and Human Services shall make
7 publicly available on the internet website of the De-
8 partment of Health and Human Services, informa-
9 tion regarding benefits available to pregnant and
10 postpartum women and under the Medicaid program
11 and the Children’s Health Insurance Program, in-
12 cluding information on—

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

16 (B) optional benefits that States may pro-
17 vide to pregnant and postpartum women under
18 such programs; and

19 (C) the availability of different kinds of
20 benefits for pregnant and postpartum women,
21 including oral health and mental health bene-
22 fits, under such programs.

23 (7) FEDERAL FUNDING FOR COST OF EX-
24 TENDED MEDICAID AND CHIP COVERAGE FOR
25 POSTPARTUM WOMEN.—

1 (A) MEDICAID.—Section 1905 of the So-
2 cial Security Act (42 U.S.C. 1396d), as amend-
3 ed by paragraph (1), is further amended—

4 (i) in subsection (b), by striking “and
5 (ff)” and inserting “(aa), and (ii)”; and

6 (ii) by adding at the end the fol-
7 lowing:

8 “(b) INCREASED FMAP FOR EXTENDED MEDICAL
9 ASSISTANCE FOR POSTPARTUM WOMEN.—Notwith-
10 standing subsection (b), the Federal medical assistance
11 percentage for a State, with respect to amounts expended
12 by such State for medical assistance for a woman who is
13 eligible for such assistance on the basis of being pregnant
14 or having been pregnant that is provided during the 305-
15 day period that begins on the 60th day after the last day
16 of her pregnancy (including any such assistance provided
17 during the month in which such period ends), shall be
18 equal to—

19 “(1) 100 percent for the first 20 calendar quar-
20 ters during which this subsection is in effect; and

21 “(2) 90 percent for calendar quarters there-
22 after.”.

23 (B) CHIP.—Section 2105(c) of the Social
24 Security Act (42 U.S.C. 1397ee(c)) is amended

1 by adding at the end the following new para-
2 graph:

3 “(12) ENHANCED PAYMENT FOR EXTENDED
4 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—
5 Notwithstanding subsection (b), the enhanced
6 FMAP, with respect to payments under subsection
7 (a) for expenditures under the State child health
8 plan (or a waiver of such plan) for assistance pro-
9 vided under the plan (or waiver) to a woman who is
10 eligible for such assistance on the basis of being
11 pregnant (including pregnancy-related assistance
12 provided to a targeted low-income pregnant woman
13 (as defined in section 2112(d)), pregnancy-related
14 assistance provided to a woman who is eligible for
15 such assistance through application of section
16 1902(v)(4)(A)(i) under section 2107(e)(1), or any
17 other assistance under the plan (or waiver) provided
18 to a woman who is eligible for such assistance on the
19 basis of being pregnant) during the 305-day period
20 that begins on the 60th day after the last day of her
21 pregnancy (including any such assistance provided
22 during the month in which such period ends), shall
23 be equal to—

1 “(A) 100 percent for the first 20 calendar
2 quarters during which this paragraph is in ef-
3 fect; and

4 “(B) 90 percent for calendar quarters
5 thereafter.”.

6 (8) GUIDANCE ON STATE OPTIONS FOR MED-
7 ICAID COVERAGE OF DOULA SERVICES.—Not later
8 than 1 year after the date of the enactment of this
9 Act, the Secretary of Health and Human Services,
10 acting through the Administrator of the Centers for
11 Medicare & Medicaid Services, shall issue guidance
12 for the States concerning options for Medicaid cov-
13 erage and payment for support services provided by
14 doulas.

15 (9) EFFECTIVE DATE.—

16 (A) IN GENERAL.—Subject to subpara-
17 graph (B), the amendments made by this sub-
18 section shall take effect on the first day of the
19 first calendar quarter that begins on or after
20 the date that is one year after the date of en-
21 actment of this Act.

22 (B) EXCEPTION FOR STATE LEGISLA-
23 TION.—In the case of a State plan under title
24 XIX of the Social Security Act or a State child
25 health plan under title XXI of such Act that

1 the Secretary of Health and Human Services
2 determines requires State legislation in order
3 for the respective plan to meet any requirement
4 imposed by amendments made by this sub-
5 section, the respective plan shall not be re-
6 garded as failing to comply with the require-
7 ments of such title solely on the basis of its fail-
8 ure to meet such an additional requirement be-
9 fore the first day of the first calendar quarter
10 beginning after the close of the first regular
11 session of the State legislature that begins after
12 the date of enactment of this Act. For purposes
13 of the previous sentence, in the case of a State
14 that has a 2-year legislative session, each year
15 of the session shall be considered to be a sepa-
16 rate regular session of the State legislature.

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

1 **“SEC. 399V-7. REGIONAL CENTERS OF EXCELLENCE AD-**
2 **DRESSING IMPLICIT BIAS AND CULTURAL**
3 **COMPETENCY IN PATIENT-PROVIDER INTER-**
4 **ACTIONS EDUCATION.**

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

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

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

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

5 “(2) demonstrate community engagement and
6 participation, such as through partnerships with
7 home visiting and case management programs;

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

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

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

24 “(d) DISSEMINATION OF INFORMATION.—

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

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

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

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

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
20 purposes of carrying out this section, there is authorized
21 to be appropriated \$5,000,000 for each of fiscal years
22 2021 through 2025.”.

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

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

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

6 “(ii) WOMEN.—

7 “(I) BREASTFEEDING WOMEN.—

8 A State”;

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

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

13 “(II) POSTPARTUM WOMEN.—A

14 State may elect to certify a postpar-

15 tum woman for a period of 2 years.”.

16 (h) DEFINITIONS.—In this section:

17 (1) MATERNAL MORTALITY.—The term “mater-
18 nal mortality” means death of a woman that occurs
19 during pregnancy or within the one-year period fol-
20 lowing the end of such pregnancy.

21 (2) PREGNANCY RELATED DEATH.—The term
22 “pregnancy related death” includes the death of a
23 woman during pregnancy or within one year of the
24 end of pregnancy from a pregnancy complication, a
25 chain of events initiated by pregnancy, or the aggra-

1 vation of an unrelated condition by the physiologic
2 effects of pregnancy.

3 (3) SEVERE MATERNAL MORBIDITY.—The term
4 “severe maternal morbidity” includes unexpected
5 outcomes of labor and delivery that result in signifi-
6 cant short-term or long-term consequences to a
7 woman’s health.

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

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

14 (b) TAX PARITY FOR PIPE TOBACCO.—Section
15 5701(f) of the Internal Revenue Code of 1986 is amended
16 by striking “\$2.8311 cents” and inserting “\$49.56”.

17 (c) TAX PARITY FOR SMOKELESS TOBACCO.—

18 (1) Section 5701(e) of the Internal Revenue
19 Code of 1986 is amended—

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

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

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

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

4 (2) Section 5702(m) of such Code is amend-
5 ed—

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

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

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

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

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

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

21 (d) TAX PARITY FOR SMALL CIGARS.—Paragraph
22 (1) of section 5701(a) of the Internal Revenue Code of
23 1986 is amended by striking “\$50.33” and inserting
24 “\$100.66”.

25 (e) TAX PARITY FOR LARGE CIGARS.—

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

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

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

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

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

4 “(i) OTHER TOBACCO PRODUCTS.—Any product not
5 otherwise described under this section that has been deter-
6 mined to be a tobacco product by the Food and Drug Ad-
7 ministration through its authorities under the Family
8 Smoking Prevention and Tobacco Control Act shall be
9 taxed at a level of tax equivalent to the tax rate for ciga-
10 rettes on an estimated per use basis as determined by the
11 Secretary.”.

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

23 (h) CLARIFYING DEFINITION OF TOBACCO PROD-
24 UCTS.—

1 (1) IN GENERAL.—Subsection (c) of section
2 5702 of the Internal Revenue Code of 1986 is
3 amended to read as follows:

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

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

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

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

15 (i) INCREASING TAX ON CIGARETTES.—

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

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

22 (j) TAX RATES ADJUSTED FOR INFLATION.—Section
23 5701 of such Code, as amended by subsection (g), is
24 amended by adding at the end the following new sub-
25 section:

1 “(j) INFLATION ADJUSTMENT.—

2 “(1) IN GENERAL.—In the case of any calendar
3 year beginning after 2021, the dollar amounts pro-
4 vided under this chapter shall each be increased by
5 an amount equal to—

6 “(A) such dollar amount, multiplied by

7 “(B) the cost-of-living adjustment deter-
8 mined under section 1(f)(3) for the calendar
9 year, determined by substituting ‘calendar year
10 2020’ for ‘calendar year 2016’ in subparagraph
11 (A)(ii) thereof.

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

16 (k) FLOOR STOCKS TAXES.—

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

23 (A) the tax which would be imposed under
24 section 5701 of the Internal Revenue Code of

1 1986 on the article if the article had been re-
2 moved on such date, over

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

5 (2) CREDIT AGAINST TAX.—Each person shall
6 be allowed as a credit against the taxes imposed by
7 paragraph (1) an amount equal to \$500. Such credit
8 shall not exceed the amount of taxes imposed by
9 paragraph (1) on such date for which such person
10 is liable.

11 (3) LIABILITY FOR TAX AND METHOD OF PAY-
12 MENT.—

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

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

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

1 (4) ARTICLES IN FOREIGN TRADE ZONES.—
2 Notwithstanding the Act of June 18, 1934 (com-
3 monly known as the Foreign Trade Zone Act, 48
4 Stat. 998, 19 U.S.C. 81a et seq.), or any other pro-
5 vision of law, any article which is located in a for-
6 eign trade zone on any tax increase date shall be
7 subject to the tax imposed by paragraph (1) if—

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

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

18 (5) DEFINITIONS.—For purposes of this sub-
19 section—

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

24 (B) TAX INCREASE DATE.—The term “tax
25 increase date” means the effective date of any

1 increase in any tobacco product excise tax rate
2 pursuant to the amendments made by this sec-
3 tion (other than subsection (j) thereof).

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

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

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

21 (1) EFFECTIVE DATES.—

22 (1) IN GENERAL.—Except as provided in para-
23 graphs (2) through (4), the amendments made by
24 this section shall apply to articles removed (as de-
25 fined in section 5702(j) of the Internal Revenue

1 Code of 1986) after the last day of the month which
2 includes the date of the enactment of this Act.

3 (2) DISCRETE SINGLE-USE UNITS AND PROC-
4 ESSED TOBACCO.—The amendments made by sub-
5 sections (c)(1)(C), (c)(2), and (f) shall apply to arti-
6 cles removed (as defined in section 5702(j) of the
7 Internal Revenue Code of 1986) after the date that
8 is 6 months after the date of the enactment of this
9 Act.

10 (3) LARGE CIGARS.—The amendments made by
11 subsection (e) shall apply to articles removed after
12 December 31, 2021.

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

○