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118TH CONGRESS
1ST SESSION

# H. R. 5568

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

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IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 19, 2023

Ms. KELLY of Illinois (for herself, Ms. DEAN of Pennsylvania, Ms. SEWELL, Mr. VEASEY, Mr. JOHNSON of Georgia, Ms. PLASKETT, Mr. TRONE, Ms. CLARKE of New York, Ms. LEE of California, Ms. NORTON, Mrs. CHERFILUS-MCCORMICK, Mr. COHEN, Mr. JACKSON of Illinois, Mr. PAYNE, Mr. BISHOP of Georgia, Mrs. WATSON COLEMAN, Ms. SCHAKOWSKY, Ms. CROCKETT, Mr. GRIJALVA, Ms. JACKSON LEE, Mr. EVANS, Mr. DAVIS of North Carolina, Ms. MENG, Mr. VARGAS, Ms. MOORE of Wisconsin, and Mr. NADLER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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# A BILL

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

*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 Washington, DC, 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-birth-weight 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 pre-term 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 Nation 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 Nation's ability 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 their 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 op-

portunities 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, socioeconomic 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, ongoing basis.

(28) Women are not the only people who can become pregnant or give birth. Nonbinary, 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 one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection 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 awards grants to eligible entities for the purpose of development and sustainability of perinatal quality collaboratives in every 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) STATE-BASED PERINATAL QUALITY COLLABORATIVE DEFINED.—For purposes of this sub-

section, the term ''State-based 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.—For purposes of carrying out this subsection, there is authorized to be appropriated $35,000,000 per year for each of fiscal years 2024 through 2028.

(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)''; and

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

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

''(jj) 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 services 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, satisfy the coverage requirements specified in section 1905(jj)'' 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(jj))'' 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 (86), by striking ''and'' at the end;

(iii) in paragraph (87), by striking the period at the end and inserting ''; and''; and

(iv) by inserting after paragraph (87) the following new paragraph:

''(88) 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'';

(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)(J) of the Social Security Act (42 U.S.C. 1397gg(e)(1)(J)), as inserted by section 9822 of the American Rescue Plan Act of 2021 (Public Law 117–2), is amended to read as follows:

''(J) 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.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 1397ll(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) IN 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 1902(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 of Health and Human Services 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:

''(kk) 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 ap-

plying 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 1902(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 of Health and Human Services 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), (jj), (kk), and (ll)"; and

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

''(ll) 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)—

(i) 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 of Health and Human Services 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 be-

fore 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 (J) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by paragraph (2), and subsection (kk) 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 one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall award cooperative agreements for the establishment or support of regional centers of excellence addressing 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 receive a cooperative agreement under subsection (a), an entity shall—

''(1) be a public or other nonprofit entity specified by the Secretary that provides educational and training opportunities for students and health care

professionals, which may be 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 recovery 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 awarding 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)(3).

''(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 evaluations and overall findings with State departments of health and other relevant State level offices to inform State and local best practices.

''(e) MATERNAL MORTALITY DEFINED.—In this section, the term 'maternal mortality' means death of a

woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2024 through 2028.''.

(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.''.

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

**SEC. 4. FULL SPECTRUM DOULA WORKFORCE.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish and implement a program to award grants or contracts to health professions schools, schools of public health, academic health centers, State or local governments, territories, Indian Tribes and Tribal organizations, Urban Indian organizations, Native Hawaiian organizations, community-based organizations, or other appropriate public or private nonprofit entities (or consortia of any such entities, including entities promoting multidisciplinary approaches), to establish or expand programs to grow and diversify the doula workforce, including through improving the capacity and supply of health care providers.

(b) USE OF FUNDS.—Amounts made available by subsection (a) shall be used for the following activities:

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

(2) Expanding the capacity of existing programs described in paragraph (1), 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).

(c) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Secretary for fiscal year 2024, out of any money in the Treasury not otherwise appropriated, $50,000,000, to remain available until expended, for carrying out this section.

**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 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) IMPLEMENTING AND REPORTING.—

''(1) IN GENERAL.—States that receive pilot grants under this section shall be responsible for—

''(A) implementing the program funded by the pilot grants; and

''(B) not later than 3 years after the date of enactment of this Act, and 6 years after the date of enactment of this Act, submitting a report containing the results of such program to the Secretary, including—

''(i) relevant information and relevant quantitative indicators of the programs' success in improving the standard of care and maternal health outcomes for individuals in rural and underserved communities seen for pre-conception, pregnancy, or postpartum visits in the rural mobile health units, stratified by the categories of data specified in paragraph (2);

"(ii) relevant qualitative evaluations from individuals receiving pre-conception, pregnant, or postpartum care from rural mobile health units, including measures of patient-reported experience of care and measures of patient-reported issues with access to care without the rural mobile health unit pilot; and

"(iii) strategies to sustain such programs beyond the duration of the grant and expand such programs to other rural and underserved communities.

"(2) CATEGORIES OF DATA.—The categories of data specified 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 preconception, prenatal, or postpartum care.

"(C) Number of repeat visits provided for preconception, 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 referred to in paragraph (1)(B) shall not contain any personally identifiable information regarding any pregnant or postpartum individual.

''(e) EVALUATION.—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 other factors as the Secretary determines appropriate;

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

''(3) to the 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 one year after the completion of the pilot program under this section, the

Secretary shall submit to the Congress, and make publicly available, a report containing—

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

''(2) a recommendation regarding whether the pilot program should be continued after fiscal year 2028 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 2024 through 2028.''.

**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 24 months after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare, and submit to the 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 2022.

(c) CONTENTS.—The report under subsection (a) shall include analysis 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 ''$2.8311 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 (l).

(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 2023, 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 2022' 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 para-

graph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(l) 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.

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