

119TH CONGRESS
1ST SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

Ms. BALDWIN introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Ensuring Lasting
5 Smiles Act”.

6 **SEC. 2. COVERAGE OF CONGENITAL ANOMALY OR BIRTH**
7 **DEFECT.**

8 (a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—
9 Part D of title XXVII of the Public Health Service Act

1 (42 U.S.C. 300gg–111 et seq.) is amended by adding at
2 the end the following new section:

3 **“SEC. 2799A–11. COVERAGE OF CONGENITAL ANOMALY OR**
4 **BIRTH DEFECT.**

5 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-
6 TIVE TREATMENT.—

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

16 “(2) FINANCIAL REQUIREMENTS.—Any cov-
17 erage provided under paragraph (1) under a group
18 health plan or group or individual health insurance
19 coverage may be subject to cost-sharing require-
20 ments (such as coinsurance, copayments, and
21 deductibles), as required by the plan or issuer offer-
22 ing such coverage, that are no more restrictive than
23 the predominant cost-sharing requirements applied
24 to substantially all other medical and surgical bene-
25 fits covered by the plan or coverage.

1 “(3) APPLICABLE ITEMS AND SERVICES.—

2 “(A) IN GENERAL.—Except as provided in
3 subparagraph (B), the items and services re-
4 quired under paragraph (1) to be covered by a
5 group health plan or group or individual health
6 insurance coverage offered by a health insur-
7 ance issuer include—

8 “(i) any item or service to improve,
9 repair, or restore any body part to achieve
10 normal body functioning or appearance, or
11 performed to approximate a normal ap-
12 pearance, as determined medically nec-
13 essary by the treating physician (as de-
14 fined in section 1861(r) of the Social Secu-
15 rity Act), on account of a congenital anom-
16 ally or birth defect that primarily impacts
17 the appearance or function of the eyes,
18 ears, teeth, mouth, or jaw; and

19 “(ii) any treatment or diagnostic serv-
20 ice with respect to any and all missing or
21 abnormal body parts (including teeth, the
22 oral cavity, and their associated struc-
23 tures), as determined medically necessary
24 by the treating physician (as defined in

1 section 1861(r) of the Social Security Act),
2 including—

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

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

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

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

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

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

23 “(1) be caused by genetic or chromosomal dis-
24 orders, embryotoxic or teratogenic environmental

1 factors, nutrient deficiency, multifactorial inherit-
2 ance, or be of an unknown cause;

3 “(2) manifest as abnormal anatomical struc-
4 tures;

5 “(3) manifest as physical, sensory, or cognitive
6 functional disabilities;

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

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

11 (b) ERISA AMENDMENTS.—

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

16 **“SEC. 726. COVERAGE OF CONGENITAL ANOMALY OR BIRTH**
17 **DEFECT.**

18 “(a) REQUIREMENTS FOR CARE AND RECONSTRUC-
19 TIVE TREATMENT.—

20 “(1) IN GENERAL.—A group health plan, and a
21 health insurance issuer offering group health insur-
22 ance coverage, shall provide coverage for outpatient
23 and inpatient items and services related to the diag-
24 nosis and treatment of a congenital anomaly or birth
25 defect that primarily impacts the appearance or

1 function of the eyes, ears, teeth, mouth, or jaw, con-
2 sistent with paragraphs (2) and (3).

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

14 “(3) APPLICABLE ITEMS AND SERVICES.—

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

21 “(i) any item or service to improve,
22 repair, or restore any body part to achieve
23 normal body functioning or appearance, or
24 performed to approximate a normal ap-
25 pearance, as determined medically nec-

1 essary by the treating physician (as de-
2 fined in section 1861(r) of the Social Secu-
3 rity Act), on account of a congenital anom-
4 aly or birth defect that primarily impacts
5 the appearance or function of the eyes,
6 ears, teeth, mouth, or jaw; and

7 “(ii) any treatment or diagnostic serv-
8 ice with respect to any and all missing or
9 abnormal body parts (including teeth, the
10 oral cavity, and their associated struc-
11 tures), as determined medically necessary
12 by the treating physician (as defined in
13 section 1861(r) of the Social Security Act),
14 including—

15 “(I) reconstructive services and
16 procedures, and items and services re-
17 lated to any complications arising
18 from such services and procedures;

19 “(II) adjunctive dental, ortho-
20 dontic, or prosthodontic support from
21 birth until the medical or surgical
22 treatment of the defect or anomaly
23 has been completed, including ongoing
24 or subsequent treatment required to
25 maintain function or approximate a

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

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

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

23 “(b) NOTICE.—Beginning not later than January 1,
24 2026, a group health plan or health insurance offer-
25 ing group health insurance coverage shall provide notice

1 to each participant and beneficiary under such plan or cov-
2 erage regarding the coverage required by this section, in
3 any documents describing services, in accordance with any
4 regulations promulgated by the Secretary.

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

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

14 “(2) manifest as abnormal anatomical struc-
15 tures;

16 “(3) manifest as physical, sensory, or cognitive
17 functional disabilities;

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

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

22 (2) TECHNICAL AMENDMENTS.—

23 (A) Section 732(a) of such Act (29 U.S.C.
24 1191a(a)) is amended by striking “section 711”
25 and inserting “sections 711 and 726”.

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

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

4 (c) INTERNAL REVENUE CODE AMENDMENTS.—

5 (1) IN GENERAL.—Subchapter B of chapter
6 100 of the Internal Revenue Code of 1986 is amend-
7 ed by adding at the end the following:

8 **“SEC. 9826. COVERAGE OF CONGENITAL ANOMALY OR**
9 **BIRTH DEFECT.**

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

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

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

1 requirements applied to substantially all other med-
2 ical and surgical benefits covered by the plan.

3 “(3) APPLICABLE ITEMS AND SERVICES.—

4 “(A) IN GENERAL.—Except as provided in
5 subparagraph (B), the items and services re-
6 quired under paragraph (1) to be covered by a
7 group health plan include—

8 “(i) any item or service to improve,
9 repair, or restore any body part to achieve
10 normal body functioning or appearance, or
11 performed to approximate a normal ap-
12 pearance, as determined medically nec-
13 essary by the treating physician (as de-
14 fined in section 1861(r) of the Social Secu-
15 rity Act), on account of a congenital anom-
16 ally or birth defect that primarily impacts
17 the appearance or function of the eyes,
18 ears, teeth, mouth, or jaw; and

19 “(ii) any treatment or diagnostic serv-
20 ice with respect to any and all missing or
21 abnormal body parts (including teeth, the
22 oral cavity, and their associated struc-
23 tures), as determined medically necessary
24 by the treating physician (as defined in

1 section 1861(r) of the Social Security Act),
2 including—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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