119TH CONGRESS
2D SESSION

H. R. 8807

To authorize appropriations for data collection, surveillance, and research on maternal health outcomes during public health emergencies, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 14, 2026

Ms. UNDERWOOD (for herself, Mrs. MCIVER, Ms. TLAIB, Ms. NORTON, Ms. MOORE of Wisconsin, Mrs. WATSON COLEMAN, Ms. KAMLAGER-DOVE, Mr. JOHNSON of Georgia, Ms. PRESSLEY, Mr. IVEY, Mr. KRISHNAMOORTHI, Mr. MENEFEE, Mr. BELL, Mr. MOULTON, Ms. CLARKE of New York, Ms. DELBENE, Mr. GARAMENDI, Mr. COHEN, Ms. STANSBURY, Mrs. DINGELL, Ms. SCANLON, Ms. JACOBS, Mr. FIGURES, Mr. HORSFORD, Mr. GARCÍA of Illinois, Mr. VEASEY, Mrs. BEATTY, Mr. SMITH of Washington, Ms. SEWELL, Ms. WILSON of Florida, Mr. JACKSON of Illinois, Mr. CONAWAY, Mr. SCOTT of Virginia, Mrs. HAYES, Mr. QUIGLEY, Ms. CRAIG, Mr. MCGARVEY, Mrs. GRIJALVA, Mr. CARSON, Mr. TAKANO, Mrs. MCBATH, Mr. LATIMER, Ms. JOHNSON of Texas, Mr. SOTO, Ms. ADAMS, Mr. GOTTHEIMER, Ms. POU, Mrs. FOUSHEE, Mrs. SYKES, Mr. LIEU, Mr. VARGAS, Ms. DEAN of Pennsylvania, Mr. MULLIN, Ms. MENG, Ms. SALINAS, Ms. SCHRIER, Ms. STRICKLAND, Ms. MCCOLLUM, Mr. NADLER, Ms. SCHOLTEN, Mr. CARBAJAL, Mr. MEEKS, Mr. LYNCH, Ms. BARRAGÁN, Ms. WILLIAMS of Georgia, Mr. TONKO, Mrs. TORRES of California, and Mr. MFUME) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To authorize appropriations for data collection, surveillance, and research on maternal health outcomes during public health emergencies, 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,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Maternal Health Pan-
5 demic Response Act".

6 **SEC. 2. FUNDING FOR DATA COLLECTION, SURVEILLANCE,**
7 **AND RESEARCH ON MATERNAL HEALTH OUT-**
8 **COMES DURING PUBLIC HEALTH EMER-**
9 **GENCIES.**

10 To conduct or support data collection, surveillance,
11 and research on maternal health as a result of public
12 health emergencies and infectious diseases that pose a risk
13 to maternal and infant health, including support to assist
14 in the capacity building for State, Tribal, territorial, and
15 local public health departments to collect and transmit ra-
16 cial, ethnic, and other demographic data related to mater-
17 nal health, there are authorized to be appropriated—

18 (1) $100,000,000 for the Surveillance for
19 Emerging Threats to Mothers and Babies program
20 of the Centers for Disease Control and Prevention,
21 to support the Centers for Disease Control and Pre-
22 vention in its efforts to—

23 (A) work with public health, clinical, and
24 community-based organizations to provide time-
25 ly, continually updated guidance to families and

1 health care providers on ways to reduce risk to
2 pregnant and postpartum individuals and their
3 newborns and tailor interventions to improve
4 their long-term health;
5 (B) partner with more State, Tribal, terri-
6 torial, and local public health programs in the
7 collection and analysis of clinical data on the
8 impact of public health emergencies and infec-
9 tious diseases that pose a risk to maternal and
10 infant health on pregnant and postpartum pa-
11 tients and their newborns, particularly among
12 patients from racial and ethnic minority groups;
13 and
14 (C) establish regionally based centers of
15 excellence to offer medical, public health, and
16 other knowledge to ensure communities can
17 help pregnant and postpartum individuals and
18 newborns get the care and support they need,
19 particularly in areas with large populations of
20 individuals from demographic groups with ele-
21 vated rates of maternal mortality, severe mater-
22 nal morbidity, maternal health disparities, or
23 other adverse perinatal or childbirth outcomes;
24 (2) $30,000,000 for the Enhancing Reviews
25 and Surveillance to Eliminate Maternal Mortality

1 program (commonly known as the ‘‘ERASE MM
2 program’’) of the Centers for Disease Control and
3 Prevention, to support the Centers for Disease Con-
4 trol and Prevention in expanding its partnerships
5 with States and Indian Tribes and provide technical
6 assistance to existing Maternal Mortality Review
7 Committees;
8 (3) $45,000,000 for the Pregnancy Risk As-
9 sessment Monitoring System (commonly known as
10 the ‘‘PRAMS’’) of the Centers for Disease Control
11 and Prevention, to support the Centers for Disease
12 Control and Prevention in its efforts to—
13 (A) create a supplement to its PRAMS
14 survey related to public health emergencies and
15 infectious diseases that pose a risk to maternal
16 and infant health;
17 (B) add questions around experiences of
18 respectful maternity care in prenatal,
19 intrapartum, and postpartum care; and
20 (C) work to transition such PRAMS survey
21 to an electronic platform and expand such
22 PRAMS survey to a larger population, with a
23 special focus on reaching underrepresented
24 communities, and other program improvements;
25 and

1 (4) $15,000,000 for the National Institute of
2 Child Health and Human Development, to conduct
3 or support research for interventions to mitigate the
4 effects of public health emergencies and infectious
5 diseases that pose a risk to maternal and infant
6 health, with a particular focus on individuals from
7 demographic groups with elevated rates of maternal
8 mortality, severe maternal morbidity, maternal
9 health disparities, or other adverse perinatal or
10 childbirth outcomes.

11 **SEC. 3. PUBLIC HEALTH EMERGENCY MATERNAL HEALTH**
12 **DATA COLLECTION AND DISCLOSURE.**

13 (a) AVAILABILITY OF COLLECTED DATA.—The Sec-
14 retary, acting through the Director of the Centers for Dis-
15 ease Control and Prevention and the Administrator of the
16 Centers for Medicare & Medicaid Services, shall make pub-
17 licly available on the website of the Centers for Disease
18 Control and Prevention data described in subsection (b).

19 (b) DATA DESCRIBED.—The data described in this
20 subsection are data collected through Federal surveillance
21 systems under the Centers for Disease Control and Pre-
22 vention with respect to public health emergencies and indi-
23 viduals who are pregnant or in a postpartum period. Such
24 data shall include the following:

1 (1) Diagnostic testing, confirmed cases, hos-
2 pitalizations, deaths, and other health outcomes re-
3 lated to an infectious disease outbreak among preg-
4 nant and postpartum individuals.
5 (2) Maternal and infant health outcomes among
6 individuals who test positive for an infectious disease
7 during or after pregnancy.
8 (c) AMERICAN INDIAN AND ALASKA NATIVE HEALTH
9 OUTCOMES.—In carrying out subsection (a), the Secretary
10 shall consult with Indian Tribes and confer with Urban
11 Indian organizations.
12 (d) DISAGGREGATED INFORMATION.—In carrying
13 out subsection (a), the Secretary shall disaggregate data
14 by race, ethnicity, gender, primary language, geography,
15 socioeconomic status, and other relevant factors.
16 (e) UPDATE.—During public health emergencies, the
17 Secretary shall update the data made available under this
18 section—
19 (1) at least on a monthly basis; and
20 (2) not less than one month after the end of
21 such public health emergency.
22 (f) PRIVACY.—In carrying out subsection (a), the
23 Secretary shall—
24 (1) take steps to protect the privacy of individ-
25 uals pursuant to regulations promulgated under sec-

1 tion 264(c) of the Health Insurance Portability and
2 Accountability Act of 1996 (42 U.S.C. 1320d–2
3 note); and
4 (2) ensure that—
5 (A) all data collected is deidentified;
6 (B) at a minimum, there is no disclosure
7 of any individually identifying or potentially
8 identifying information regarding a patient or a
9 patient's health care provider; and
10 (C) all data is collected in a manner that
11 is consistent with applicable Federal and State
12 privacy law.
13 (g) GUIDANCE.—
14 (1) IN GENERAL.—Not later than 30 days after
15 the declaration of a public health emergency, the
16 Secretary shall issue guidance to States and local
17 public health departments to ensure that—
18 (A) laboratories that test specimens for an
19 infectious disease receive all relevant demo-
20 graphic data on race, ethnicity, pregnancy sta-
21 tus, and other demographic data as determined
22 by the Secretary; and
23 (B) data described in subsection (b) are
24 disaggregated by race, ethnicity, gender, pri-

mary language, geography, socioeconomic status, and other relevant factors.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall consult with Indian Tribes—

(A) to ensure that such guidance includes tribally developed best practices; and

(B) to reduce misclassification of American Indians and Alaska Natives.

SEC. 4. PUBLIC HEALTH COMMUNICATION REGARDING MATERNAL CARE DURING PUBLIC HEALTH EMERGENCIES.

The Director of the Centers for Disease Control and Prevention shall conduct public health education campaigns during public health emergencies to ensure that pregnant and postpartum individuals, their employers, and their health care providers have accurate, evidence-based information on maternal and infant health risks during the public health emergency, with a particular focus on reaching pregnant and postpartum individuals in underserved communities.

1 **SEC. 5. TASK FORCE ON BIRTHING EXPERIENCE AND SAFE,**
2 **RESPECTFUL, RESPONSIVE, AND EMPOW-**
3 **ERING MATERNITY CARE DURING PUBLIC**
4 **HEALTH EMERGENCIES.**

5 (a) ESTABLISHMENT.—The Secretary, in consulta-
6 tion with the Director of the Centers for Disease Control
7 and Prevention and the Administrator of the Health Re-
8 sources and Services Administration, shall convene a task
9 force (in this subsection referred to as the ''Task Force'')
10 to develop Federal recommendations regarding respectful,
11 responsive, and empowering maternity care, including safe
12 birth care and postpartum care, during public health
13 emergencies.

14 (b) DUTIES.—The Task Force shall develop, publicly
15 post, and update Federal recommendations in multiple
16 languages to ensure high-quality, nondiscriminatory ma-
17 ternity care, promote positive birthing experiences, and
18 improve maternal health outcomes during public health
19 emergencies, with a particular focus on outcomes for indi-
20 viduals from demographic groups with elevated rates of
21 maternal mortality, severe maternal morbidity, maternal
22 health disparities, or other adverse perinatal or childbirth
23 outcomes. Such recommendations shall—

24 (1) address, with particular attention to ensur-
25 ing equitable treatment on the basis of race and eth-
26 nicity—

1 (A) measures to facilitate respectful, re-
2 sponsive, and empowering maternity care;
3 (B) measures to facilitate telehealth mater-
4 nity care for pregnant individuals who cannot
5 regularly access in-person care;
6 (C) strategies to increase access to special-
7 ized care for those with high-risk pregnancies
8 or pregnant individuals with elevated risk fac-
9 tors;
10 (D) diagnostic testing for pregnant and la-
11 boring patients;
12 (E) birthing without one's chosen compan-
13 ions, with one's chosen companions, and with
14 smartphone or other telehealth connection to
15 one's chosen companions;
16 (F) newborn separation after birth in rela-
17 tion to maternal infection status;
18 (G) breast milk feeding in relation to ma-
19 ternal infection status;
20 (H) licensure, training, scope of practice,
21 and Medicaid and other insurance reimburse-
22 ment for certified midwives, certified nurse-mid-
23 wives, and certified professional midwives, who
24 meet, at a minimum, the international defini-
25 tion of a midwife and global standards for mid-

1 wifery education, as established by the Inter-
2 national Confederation of Midwives, in a man-
3 ner that facilitates inclusion of midwives of
4 color and midwives from underserved commu-
5 nities;
6 (I) financial support and training for
7 perinatal health workers who provide nonclinical
8 support to individuals from pregnancy through
9 the postpartum period in a manner that facili-
10 tates inclusion from underserved communities;
11 (J) strategies to ensure and expand doula
12 coverage under State Medicaid programs;
13 (K) how to identify, address, and treat
14 prenatal and postpartum mental and behavioral
15 health conditions, such as anxiety, substance
16 use disorder, and depression, during public
17 health emergencies;
18 (L) how to identify and address instances
19 of intimate partner violence during pregnancy
20 which may arise or intensify during public
21 health emergencies;
22 (M) strategies to address hospital capacity
23 concerns in communities with a surge in infec-
24 tious disease cases and to provide childbearing
25 individuals with options that reduce the poten-

1 tial for cross-contamination and increase the
2 ability to implement their care preferences while
3 maintaining safety and quality, such as the use
4 of freestanding birth centers;
5 (N) provision of child care services during
6 prenatal and postpartum appointments for
7 mothers whose children are unable to attend as
8 a result of restrictions relating to the public
9 health emergencies;
10 (O) how to identify and address racism,
11 bias, and discrimination in the delivery of ma-
12 ternity care services to pregnant and
13 postpartum individuals, including evaluating the
14 value of training for hospital staff on implicit
15 bias and racism, respectful, responsive, and em-
16 powering maternity care, and demographic data
17 collection;
18 (P) how to address the needs of undocu-
19 mented pregnant individuals and new mothers
20 who may be afraid or unable to seek needed
21 care during the COVID–19 public health emer-
22 gency;
23 (Q) how to address the needs of uninsured
24 and underinsured pregnant individuals who

1 have historically relied on emergency depart-
2 ments for care;
3 (R) how to identify pregnant and
4 postpartum individuals at risk for depression,
5 anxiety disorder, psychosis, obsessive-compul-
6 sive disorder, and other maternal mood dis-
7 orders before, during, and after pregnancy, and
8 how to treat those diagnosed with a prenatal or
9 postpartum mood disorder;
10 (S) how to effectively and compassionately
11 screen for substance use disorder during preg-
12 nancy and postpartum and help pregnant and
13 postpartum individuals find support and effec-
14 tive treatment;
15 (T) how to ensure access to infant nutri-
16 tion during public health emergencies; and
17 (U) such other matters as the Task Force
18 determines appropriate;
19 (2) identify barriers to the implementation of
20 the recommendations;
21 (3) take into consideration existing State and
22 other programs that have demonstrated effectiveness
23 in addressing pregnancy, birth, and postpartum care
24 during public health emergencies; and

1 (4) identify policies specific to public health
2 emergencies that should be discontinued when safely
3 possible and those that should be continued as the
4 public health emergency abates.

5 (c) MEMBERSHIP.—The Secretary shall appoint the
6 members of the Task Force. Such members shall be com-
7 prised of—

8 (1) representatives of the Department of Health
9 and Human Services, including representatives of—

10 (A) the Secretary;

11 (B) the Director of the Centers for Disease
12 Control and Prevention;

13 (C) the Administrator of the Health Re-
14 sources and Services Administration;

15 (D) the Administrator of the Centers for
16 Medicare & Medicaid Services;

17 (E) the Director of the Agency for
18 Healthcare Research and Quality;

19 (F) the Commissioner of Food and Drugs;

20 (G) the Assistant Secretary for Mental
21 Health and Substance Use; and

22 (H) the Director of the Indian Health
23 Service;

24 (2) at least 3 State, local, or territorial public
25 health officials representing departments of public

1 health, who shall represent jurisdictions from dif-
2 ferent regions of the United States with relatively
3 high concentrations of historically marginalized pop-
4 ulations;

5 (3) at least 1 Tribal public health official rep-
6 resenting departments of public health;

7 (4) 1 or more representatives of community-
8 based organizations that address adverse maternal
9 health outcomes with a specific focus on racial and
10 ethnic inequities in maternal health outcomes, with
11 special consideration given to representatives of such
12 organizations that are led by a person of color or
13 from communities with significant minority popu-
14 lations;

15 (5) a professionally diverse panel of maternity
16 care providers and perinatal health workers;

17 (6) 1 or more patients who were pregnant or
18 gave birth during the COVID–19 public health
19 emergency or a subsequent public health emergency;

20 (7) 1 or more patients who have received sup-
21 port from a perinatal health worker; and

22 (8) racially and ethnically diverse representa-
23 tion from at least 3 independent experts with knowl-
24 edge or field experience with racial and ethnic dis-

1 parities in public health, women's health, or mater-
2 nal mortality and severe maternal morbidity.

3 **SEC. 6. DEFINITIONS.**

4 In this Act:

5 (1) CULTURALLY AND LINGUISTICALLY CON-
6 GRUENT.—The term ''culturally and linguistically
7 congruent'', with respect to care or maternity care,
8 means care that is in agreement with the preferred
9 cultural values, beliefs, worldview, language, and
10 practices of the health care consumer and other
11 stakeholders.

12 (2) MATERNAL MORTALITY.—The term ''mater-
13 nal mortality'' means a death occurring during or
14 within a 1-year period after pregnancy, caused by
15 pregnancy-related or childbirth complications, in-
16 cluding a suicide, overdose, or other death resulting
17 from a mental health or substance use disorder at-
18 tributed to or aggravated by pregnancy-related or
19 childbirth complications.

20 (3) PERINATAL HEALTH WORKER.—The term
21 ''perinatal health worker'' means a nonclinical health
22 worker focused on maternal or perinatal health, such
23 as a doula, community health worker, peer sup-
24 porter, lactation educator or counselor, nutritionist
25 or dietitian, childbirth educator, social worker, home

1 visitor, patient navigator or coordinator, or language
2 interpreter.

3 (4) POSTPARTUM AND POSTPARTUM PERIOD.—
4 The terms ''postpartum'' and ''postpartum period''
5 refer to the 1-year period beginning on the last day
6 of the pregnancy of an individual.

7 (5) PUBLIC HEALTH EMERGENCY.—The term
8 ''public health emergency'' means a public health
9 emergency declared under section 319 of the Public
10 Health Service Act (42 U.S.C. 247d).

11 (6) RACIAL AND ETHNIC MINORITY GROUP.—
12 The term ''racial and ethnic minority group'' has the
13 meaning given such term in section 1707(g)(1) of
14 the Public Health Service Act (42 U.S.C. 300u–
15 6(g)(1)).

16 (7) RESPECTFUL MATERNITY CARE.—The term
17 ''respectful maternity care'' refers to care organized
18 for, and provided to, pregnant and postpartum indi-
19 viduals in a manner that—

20 (A) is culturally and linguistically con-
21 gruent;

22 (B) maintains their dignity, privacy, and
23 confidentiality;

24 (C) ensures freedom from harm and mis-
25 treatment; and

1 (D) enables informed choice and continuous support.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(9) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

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