



THE BIRTH FREEDOM AND HEALTHCARE CHOICE ACT

A BILL

To expand the Right to Try Act to include complementary healthcare practices, protect birth freedom and choice in delivery methods, enable interstate telemedicine practice, and prevent state interference with life-giving healthcare and access to alternatives to standard healthcare.

SECTION 1. SHORT TITLE.

This Act may be cited as the “Birth Freedom and Healthcare Choice Act of 2025”.

SEC. 2. FINDINGS AND PURPOSE.

(1) FINDINGS.—Congress finds the following:

- (A) The Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017 (Public Law 115-176) established that patients facing life-threatening conditions should have access to investigational treatments without excessive federal interference.
- (B) The principles underlying the Right to Try Act—patient autonomy, informed consent, and freedom from government interference in healthcare decisions—apply with equal force to all healthcare choices, not merely those involving terminal illness.
- (C) Healthcare choice is a fundamental liberty interest protected by the Due Process Clause of the Fifth and Fourteenth Amendments and the Ninth Amendment's recognition of unenumerated rights retained by the people.
- (D) Childbirth is a natural physiological process, not a medical illness, and has been safely attended by midwives and other traditional birth attendants throughout human history and since before the founding of the United States.
- (E) The practice of midwifery has been part of the history and tradition of the United States since before its founding, and midwives continue to provide safe, quality care to families across the nation.
- (F) Peer-reviewed medical literature demonstrates that for low-risk pregnancies, planned out of hospital births attended by qualified midwives have outcomes comparable to or

- better than hospital births, with lower rates of medical intervention and no increased risk of adverse outcomes.
- (G) Approximately 26 states impose significant restrictions on or prohibit the practice of certified professional midwifery, creating healthcare deserts for families seeking evidence-based, physiologic birth care.
 - (H) The COVID-19 pandemic demonstrated that telemedicine and interstate healthcare practice can effectively expand access to care while maintaining quality and safety standards.
 - (I) Arbitrary state restrictions on lawful healthcare practices, including licensing barriers, certificate-of-need requirements, and unnecessary facility regulations, serve no compelling public health interest and instead restrict access to care, increase costs, and violate individual liberty.
 - (J) The Commerce Clause empowers Congress to regulate healthcare practitioners who serve patients across state lines and to prevent state laws that unduly burden interstate commerce in healthcare services.
 - (K) Occupational licensing restrictions, while sometimes justified by legitimate safety concerns, often serve primarily to protect incumbent providers from competition, raising costs, reducing incentives to innovate and offer quality services, and reducing access to care without corresponding public health benefits.
 - (L) Congress has previously recognized the importance of allowing healthcare providers to travel with those under their care across state lines. The Sports Medicine Licensure Clarity Act of 2018 (Pub. L. 115-254, codified at 15 U.S.C. § 8601) established that sports medicine professionals may travel with athletes and athletic teams to provide care in secondary states without violating licensure requirements, provided the secondary state has substantially similar licensure standards. This provision applies that same principle more broadly to protect patient access to their chosen healthcare providers.
 - (M) Women have a fundamental right to direct and choose their maternal healthcare, including the unqualified right to choose where, how, and with whom to give birth, and this right includes the right to decline any service, treatment, or intervention.
 - (N) State interference with the practice of complementary healthcare modalities—including midwifery, naturopathy, traditional Chinese medicine, and other evidence-based practices—violates the rights of both patients and providers without serving compelling governmental interests.

SEC. 3. PURPOSES.

The purposes of this Act are:

- (a) To expand the Right to Try framework to include access to complementary healthcare practices for all patients, not merely those with terminal illnesses.

- (b) To protect the fundamental right of women to direct and choose their prenatal, labor and delivery, and postpartum care, including the right to choose where and with whom to give birth.
- (c) To remove impediments to the practice of midwifery and other complementary healthcare modalities that provide safe, effective care.
- (d) To ensure that all healthcare providers can practice to the full extent of their training and expertise without arbitrary state restrictions.
- (e) To enable healthcare providers licensed in any state to provide telemedicine services and to travel with patients across state lines without facing criminal prosecution or licensure barriers.
- (f) To increase access to prenatal, labor and delivery, and postpartum care by removing unreasonable regulatory burdens on birth centers and other out-of-hospital birth settings.
- (g) To establish a uniform federal standard that preempts state laws unduly burdening healthcare freedom while preserving state authority to regulate for genuine public health and safety purposes.
- (h) To create robust enforcement mechanisms protecting both patients' rights to access care and providers' rights to practice their professions.

SEC. 4. DEFINITIONS.

For purposes of this Act:

- (a) ELIGIBLE PATIENT.—The term “eligible patient” means any individual who:
 - (1) Has legal capacity to provide informed consent to healthcare, or has a legal guardian, healthcare proxy, or designated representative authorized to provide consent on their behalf.
 - (2) Has been provided with complete written and verbal disclosure of all relevant risks, benefits, alternatives, and the provider's qualifications; and
 - (3) Has documented their voluntary choice to pursue the healthcare service in question through written informed consent executed without coercion.
- (b) ELIGIBLE PROVIDER.—The term “eligible provider” means any healthcare practitioner who:
 - (1) Holds a valid license, certification, credential, or registration recognized by at least one State, territory, or the District of Columbia for the practice in question.
 - (2) Carries professional liability insurance where commercially available and reasonably obtainable, or provides written disclosure if such insurance is unavailable.

(3) Provides written disclosure to patients of qualifications, state of licensure, training, scope of practice, and any limitations on practice.

(4) Practices within the generally accepted scope of practice for their profession as recognized by their credentialing body or professional association.

(c) COMPLIMENTARY HEALTHCARE PRACTICE.

(1) The term includes, but is not limited to:

(A) Midwifery services, including services provided by:

(i) certified professional midwives (CPM).

(ii) certified nurse-midwives (CNM).

(iii) certified midwives (CM).

(iv) licensed midwives (LM).

(v) direct-entry midwives with documented training.

(vi) traditional birth attendants serving specific cultural or religious communities.

(B) Home birth services.

(C) Birth center services.

(D) Alternative birthing methods, including water birth, physiologic birth, and other low-intervention approaches.

(E) Naturopathic medicine.

(F) Traditional Chinese medicine, including acupuncture and herbal medicine.

(G) Ayurvedic medicine.

(H) Chiropractic care.

(I) Massage therapy and bodywork.

(J) Herbal medicine and botanical therapies.

(K) Homeopathy.

(L) Functional and integrative medicine.

(M) Traditional healing practices of indigenous peoples.

(N) Doula services and other birth support services.

(O) Any other healthcare modality lawfully practiced in at least one State, territory, or the District of Columbia.

(2) Complementary healthcare practice must also meet the definition of “Healthcare” in Section (J).

(d) BIRTH CENTER.—The term means a facility, other than a hospital or private residence, where mothers receive prenatal care, give birth, and receive postpartum care, and where newborns receive care, all within the scope of practice of qualified providers. Birth centers may provide additional services including well-person reproductive healthcare, family planning services, and lactation support.

(e) TELEMEDICINE.—The term means the delivery of healthcare services using telecommunications technology, including:

- (1) Synchronous (real-time) audio-video consultation.
- (2) Synchronous audio-only consultation, including phone calls and voice-over-internet protocol (VoIP) communications.
- (3) Asynchronous (store-and-forward) transmission of medical information.
- (4) Remote patient monitoring.
- (5) Mobile health applications; and
- (6) Electronic communications, including electronic mail (email), text messages (SMS/MMS), and secure messaging platforms.

(f) IMMINENT HARM.—The term means a substantial probability of death or serious permanent physical injury that is immediate, not speculative, and based on objective medical evidence, not merely theoretical risk.

(g) CLEAR AND CONVINCING EVIDENCE.—The term means evidence that produces in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, a higher standard than preponderance of the evidence but less than beyond a reasonable doubt.

(h) LEAST RESTRICTIVE MEANS.—The term means the regulatory approach that achieves the stated governmental interest while imposing the minimal burden on individual liberty, including consideration of alternatives such as disclosure requirements, informed consent protocols, voluntary certification, insurance requirements, and targeted enforcement against actual misconduct rather than categorical prohibitions.

(i) STATE.—The term includes any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(j) HEALTHCARE.

(1) IN GENERAL. The term “healthcare” means medical services, treatment, and procedures provided to diagnose, treat, prevent, or cure physical or mental conditions, injuries, or diseases.

(2) EXCLUSIONS. The term “healthcare” does not include:

(A) Abortion services or procedures intended to terminate the life of an unborn child.

(B) Abortion-inducing drugs, including mifepristone, misoprostol, or any other drug or combination of drugs intended to terminate a pregnancy.

(C) Referrals for abortion services or provision of information with the intent to facilitate access to abortion services.

(3) CLARIFICATIONS. For purposes of this subsection:

(A) The term “abortion” does not include:

(i) treatment for ectopic pregnancy, including surgical or medical intervention to remove an ectopic pregnancy.

(ii) procedures to remove a deceased unborn child following a miscarriage or stillbirth.

(iii) medical treatment provided when necessary to preserve the life of the mother when, in reasonable medical judgment, continuation of the pregnancy would result in the mother’s death.

(B) The term “unborn child” means a human offspring at any stage of development from fertilization until birth.

(k) ADVANCED PRACTICE REGISTERED NURSE (“APRN”).—The term means an individual with knowledge and skills acquired in basic nursing education; licensure as a registered nurse (“RN”); and graduation from or completion of a graduate-level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN role and at least (1) population focus. “APRN” includes certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, or clinical nurse specialists.

(l) COLLABORATIVE PRACTICE AGREEMENT.—The term means a legally binding contract between an APRN and a licensed physician outlining the parameters of the health professional’s practice and the physician’s role.

SEC.5. EXPANSION OF RIGHT TO TRY.

(a) **GENERAL EXPANSION.**—The provisions of the Trickett Wendler, Frank Mongiello, Jordan McLinn, and Matthew Bellina Right to Try Act of 2017 (Public Law 115-176) are hereby expanded to include access to complementary healthcare practices.

(b) **BROAD INTERPRETATION OF ELIGIBLE TREATMENTS.**—The terms “eligible investigational drug” and “eligible investigational device” as defined in Public Law 115-176 shall be interpreted to include:

- (1) Non-hospital birthing methods, procedures, and healthcare services.
- (2) Services provided by complementary practitioners as defined in Section 4(c).
- (3) Any healthcare service or practice that is lawfully provided in at least one State.
- (4) Healthcare services that are under investigation or evaluation in a manner analogous to investigational drugs or devices, including services studied in peer-reviewed research, clinical trials, or systematic quality improvement programs.

(c) **FEDERAL NON-INTERFERENCE.**—No federal agency shall prohibit or restrict an eligible patient's access to, or an eligible provider's provision of, healthcare services covered under this Act, except:

- (1) The Food and Drug Administration may continue to regulate drugs, devices, and biologics as authorized by statute, but shall not use its regulatory authority to prohibit complementary healthcare practices that do not primarily rely on FDA-regulated products.
- (2) Federal agencies may establish voluntary quality standards, best practices guidelines, and data collection protocols, but shall not condition healthcare practice on compliance with such voluntary standards.

(d) **INFORMED CONSENT REQUIREMENTS.**—Prior to receiving services under this Act, eligible patients must:

- (1) Receive complete written disclosure, in plain language understandable to a layperson, of:
 - (A) All material risks and benefits of the proposed treatment or service.
 - (B) Available alternatives, including conventional medical options.
 - (C) The provider's qualifications, training, credentials, and experience.
 - (D) Any limitations on the provider's scope of practice.
 - (E) The provider's professional liability insurance status.
 - (F) The patient's right to decline treatment or to seek second opinions.

- (2) Receive verbal explanation of the written disclosure in language the patient understands, with qualified interpreter services if necessary.
- (3) Have the opportunity to ask questions and receive answers.
- (4) Provide voluntary, documented written consent free from coercion.
- (5) Be advised that consent may be withdrawn at any time.

(e) **RECORD-KEEPING.**—Providers shall maintain documentation of informed consent for a minimum of seven years and shall provide copies to patients upon request.

(f) **NO LIABILITY FOR FEDERAL GOVERNMENT.**—Nothing in this Act shall be construed to create any right to or basis for liability against the United States, its agencies, officers, or employees for any adverse outcome resulting from healthcare services provided under this Act.

SEC. 6. PROHIBITION ON STATE INTERFERENCE.

(a) **GENERAL PROHIBITION.**—No State shall prohibit, criminalize, or unduly burden an eligible patient's access to, or an eligible provider's provision of, complementary healthcare practices covered under Section 5, except as provided in subsection (b).

(b) **LIMITED EXCEPTION.**—A State may restrict access only if the State demonstrates by clear and convincing evidence in a judicial proceeding that:

- (1) The restriction is necessary to prevent direct, substantial, and imminent harm to the patient or to identifiable third parties.
- (2) The harm is not speculative but based on reliable, objective, peer-reviewed evidence.
- (3) The restriction is the least restrictive means available to prevent such harm.
- (4) Less restrictive alternatives—including enhanced disclosure requirements, informed consent protocols, voluntary certification programs, insurance requirements, quality assurance programs, and enforcement actions against individual practitioners who cause actual harm—would be insufficient to achieve the State's interest.

(c) **BURDEN OF PROOF.**—In any legal challenge to a State restriction on healthcare practices covered by this Act:

- (1) The State bears the burden of proof by clear and convincing evidence.
- (2) The State must present objective evidence, including peer-reviewed research, epidemiological data, and expert testimony.
- (3) The State may not rely solely on theoretical risks, speculative harms, or the mere assertion that conventional medical practice is superior.
- (4) Courts shall apply intermediate scrutiny and shall not defer to legislative or administrative judgments without independent review of the evidence.

(5) Courts shall resolve any ambiguity in favor of individual liberty and healthcare freedom.

(d) SPECIFICALLY PROHIBITED STATE RESTRICTIONS.—Notwithstanding any state law to the contrary, no State may:

- (1) **Hospital Admitting Privileges**—Require complementary healthcare providers, including midwives and birth center practitioners, to maintain hospital admitting privileges as a condition of practice, licensure, or facility operation.
- (2) **Physician Supervision or Collaboration**—Mandate that complementary healthcare providers practice under physician supervision, maintain collaborative practice agreements, or obtain physician approval for their services, except where necessary for prescriptive authority or where the provider's own professional standards require consultation.
- (3) **Facility Location Requirements**—Require birth centers or other healthcare facilities to be located within a specific distance or travel time from hospitals or neonatal intensive care units.
- (4) **Discriminatory Facility Standards**—Impose facility requirements on birth centers, home births, or other complementary healthcare settings that are more stringent than those applied to medical offices, ambulatory surgical centers, or other comparable healthcare facilities providing services with similar risk profiles.
- (5) **Criminal Penalties for Licensed Practice**—Criminalize the practice of midwifery, naturopathy, or other complementary healthcare when practiced by eligible providers who hold credentials recognized in at least one State.
- (6) **Transfer Agreement Requirements**—Require birth centers or providers to obtain signed transfer agreements, letters of support, or backup agreements from hospitals, physicians, or ambulance services as a condition of licensure or operation, though voluntary transfer protocols are encouraged.
- (7) **Certificate of Need**—Require any provider or facility to obtain a certificate of need, certificate of public advantage, or similar approval to:
 - (A) Open or operate a birth center.
 - (B) Provide obstetric, gynecological, or perinatal services.
 - (C) Offer or expand neonatal intensive care.
 - (D) Provide midwifery services; or
 - (E) Offer any complementary healthcare services.
- (8) **Discriminatory Insurance Practices**—Permit insurance companies or healthcare facilities to:

- (A) Deny coverage for complementary healthcare services solely because they are provided outside traditional medical settings.
 - (B) Reimburse complementary providers at rates substantially lower than conventional providers for comparable services.
 - (C) Discriminate against patients who choose complementary healthcare; or
 - (D) Report patients to child protective services solely based on their choice of lawful birth setting, provider, or healthcare modality.
- (9) **Prohibition on Telemedicine**—Prohibit healthcare providers licensed in another State from providing telemedicine services to residents when:
- (A) The standard of care does not require in-person examination; or
 - (B) The provider is consulting on their area of specialty and actual treatment, if any, will occur, or has occurred, in person in a state where the provider is licensed.
- (10) **Out-of-State Provider Travel Restrictions**—Prohibit healthcare providers licensed in another State from traveling with patients to provide in-person care within the State.
- (11) **Licensing of Traditional Practices**—Require occupational licenses for traditional birth attendants, doulas, or other traditional practitioners who: (A) Serve only members of their own cultural or religious community; (B) Have cultural or religious traditions that include attendance at births or provision of traditional healing practices; and (C) Do not hold themselves out as licensed medical professionals.
- (12) **Title Restrictions**—Prohibit individuals from using titles that accurately reflect their training, credentials, and expertise (such as "midwife," "naturopath," "herbalist," or similar titles) merely because they are not licensed in that State, provided they do not falsely claim to hold licenses they do not possess.
- (13) **Practice Scope Limitations Beyond Training**—Restrict providers from practicing to the full extent of their training and the scope of practice recognized by their credentialing body or by at least one State.
- (14) **Restrictions on Voluntary Licensure**—Prevent complementary healthcare providers from obtaining voluntary licenses for purposes of insurance reimbursement, facility privileges, or professional recognition.
- (e) **PERMITTED STATE REGULATIONS.**—Nothing in this Act prohibits States from:
- (1) Establishing voluntary certification or licensure programs that provide benefits such as insurance reimbursement, facility privileges, or use of protected titles, provided that failure to obtain such voluntary credentials does not prohibit practice.
 - (2) Requiring providers to carry professional liability insurance where commercially available and reasonably obtainable.

- (3) Establishing reasonable facility safety standards substantially related to fire safety, sanitation, infection control, and emergency preparedness, provided such standards are not more burdensome than those applied to similar facilities.
- (4) Promulgating voluntary best practice guidelines and quality standards.
- (5) Investigating and taking disciplinary action against individual providers who cause actual harm through negligence, fraud, or practice beyond their scope of expertise.
- (6) Prosecuting unlicensed individuals who falsely represent themselves as holding medical licenses they do not possess.
- (7) Enforcing generally applicable criminal laws against assault, battery, fraud, or other misconduct.
- (8) Requiring reasonable emergency transfer protocols for birth centers, provided such protocols do not require signed agreements from receiving facilities.

SEC. 7. BIRTH FREEDOM PROTECTIONS.

(a) **FUNDAMENTAL RIGHT TO CHOOSE BIRTH SETTING.**—Women have a fundamental right to choose the setting for childbirth, and no State shall prohibit or substantially burden this right. Protected choices include:

- (1) Home birth attended by a qualified midwife or other attendant selected by the woman giving birth.
- (2) Birth center attended by qualified practitioners.
- (3) Hospital birth.
- (4) Birth in any other location chosen by the woman; or
- (5) Unassisted birth (freebirth), following documented informed refusal of attendant care.

(b) **RIGHT TO CHOOSE BIRTH ATTENDANT.**—Women have an unqualified right to select their birth attendant, and no State shall prohibit or restrict this choice. Protected choices include:

- (1) Certified or licensed midwives of any category.
- (2) Physicians or physician assistants.
- (3) Nurses or nurse practitioners.
- (4) Doulas or birth support professionals.
- (5) Family members or other support persons.
- (6) Traditional birth attendants; or
- (7) No attendant (unassisted birth).

(c) RIGHT TO DECLINE INTERVENTION.—Women have the fundamental right to decline any medical intervention, treatment, procedure, or test during pregnancy, labor, delivery, or the postpartum period, and no State shall:

- (1) Permit providers to perform interventions over a woman's or her healthcare proxy's objection.
- (2) Permit courts to order medical interventions against a woman's will.
- (3) Permit child protective services to investigate, remove children from custody, or initiate dependency proceedings based solely on a woman's refusal of medical interventions during pregnancy or birth; or
- (4) Permit hospitals or providers to condition admission, continuing care, or facility access on acceptance of any particular intervention.

(d) RIGHT TO INFORMED CONSENT AND REFUSAL.

- (1) All pregnant and birthing women must receive complete information about proposed interventions, including:
 - (A) The purpose and potential benefits of the intervention.
 - (B) Material risks and potential complications.
 - (C) Available alternatives, including the option to decline.
 - (D) Anticipated consequences of declining the intervention.
 - (E) The patient's right to accept or refuse.
 - (F) The patient's right to revoke consent at any time.
- (2) Consent obtained through coercion, threats, misrepresentation, or during active labor without sufficient opportunity for deliberation is invalid.
- (3) Providers must respect refusal of interventions and may not abandon patients who exercise this right; and
- (4) Women may designate agents or advocates to support their decision-making and ensure their wishes are respected.

(e) PROTECTION FROM DISCRIMINATION.

- (1) Healthcare facilities and providers shall not:
 - (A) Discriminate against patients who choose non-hospital birth options, including denying subsequent care or reporting to child protective services.
 - (B) Require women who had previous out-of-hospital births to accept specific interventions in subsequent pregnancies.

- (C) Refuse to provide care to women planning out-of-hospital births.
- (D) Refuse to accept transfers from home births or birth centers; or
- (E) Retaliate against women for filing complaints or asserting their rights under this Act.

(2) Child protective services agencies shall not:

- (A) Investigate families solely based on choice of birth setting or provider.
- (B) Use choice of home birth, birth center, midwife care, or refusal of interventions as evidence of neglect or unfitness.
- (C) Remove children from custody absent evidence of actual abuse or neglect independent of healthcare choices; or
- (D) Coerce parents into accepting medical interventions through threats of investigation or custody removal; and

(3) Insurance companies shall not:

- (A) Deny coverage for births attended by licensed or certified midwives.
- (B) Require prior authorization for midwifery care when such authorization is not required for physician-attended births.
- (C) Impose higher deductibles or copayments for out-of-hospital births.
- (D) Exclude birth centers from provider networks; or
- (E) Discriminate in coverage or reimbursement based on birth setting or provider type.

(f) PROVIDER OBLIGATIONS.

- (1) Providers must respect women's healthcare choices and decisions regarding birth.
- (2) Providers must practice within their scope of competence and refer appropriately when conditions exceed their expertise.
- (3) Providers may not abandon patients who decline recommended interventions.
- (4) Providers must maintain appropriate standards for informed consent and documentation; and
- (5) Nothing in this Act requires providers to perform services contrary to their clinical judgment, ethical principles, or scope of practice.

(g) CONSCIENTIOUS OBJECTION.—Nothing in this Act requires any healthcare provider or facility to provide services that violate their sincerely held religious or moral beliefs, provided that:

- (1) Such objection is documented in advance.
- (2) Patients are informed of the objection.
- (3) Reasonable referral to willing providers is offered; and
- (4) Emergency care necessary to prevent death or serious permanent injury is not refused.

SEC. 8. TELEMEDICINE FREEDOM.

(a) INTERSTATE TELEMEDICINE PRACTICE.

- (1) Healthcare providers licensed in any State may provide telemedicine services to patients located in any other State when the standard of care does not require in-person physical examination.
- (2) No State shall require providers to obtain additional licenses, registrations, or permits as a condition of providing telemedicine services, provided the provider:
 - (A) Holds an active, unrestricted license in at least one State.
 - (B) Has not been subject to disciplinary action resulting in license suspension or revocation in any State; C) Complies with the informed consent requirements of Section 5(d).
- (3) For purposes of this subsection, the provider-patient relationship may be established through telemedicine consultation and does not require prior in-person contact; and
- (4) Providers engaging in interstate telemedicine practice remain subject to:
 - (A) The jurisdiction of their home state licensing board.
 - (B) The laws of the state where the patient is located regarding scope of practice, prescriptive authority, and standards of care; and
 - (C) Federal laws governing telemedicine, including HIPAA privacy requirements and DEA regulations for controlled substances.

(b) SPECIALIST CONSULTATIONS.—Healthcare providers may use telemedicine to consult with specialists licensed in any State to:

- (1) Determine whether treatment with that specialist is appropriate.
- (2) Obtain second opinions.
- (3) Receive guidance on complex cases.
- (4) Arrange for follow-up care regarding treatment with that specialist; or
- (5) Coordinate care when actual treatment will occur in person in a state where the specialist is licensed.

(c) SPECIALIST DEFINED.—For purposes of subsection (b), “specialist” means:

- (1) A healthcare provider qualified to diagnose, treat, and manage rare injuries or illnesses, where "rare injuries or illnesses" means medical conditions that have a low prevalence in the population, requiring specialized medical attention or treatment that is not commonly available locally; or
- (2) A healthcare provider certified or eligible for certification by a recognized specialty board or professional association, including:
 - (A) An American Board of Medical Specialties member board.
 - (B) A board or association with equivalent requirements approved by that provider's licensing board.
 - (C) A board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program; or
 - (D) A specialty organization recognized by the provider's respective profession.

(d) REIMBURSEMENT PARITY.

- (1) Federal health programs, including Medicare, Medicaid, TRICARE, Veterans Health Administration, and Federal Employees Health Benefits, shall reimburse telemedicine services at rates comparable to in-person services for the same or similar services.
- (2) Private insurance plans operating in interstate commerce shall provide coverage for telemedicine services without discrimination based on the modality of service delivery.
- (3) No law or regulation shall mandate specific reimbursement rates, but insurers may negotiate rates with providers as they do for in-person services; and
- (4) States participating in Medicaid shall reimburse eligible providers for telemedicine services to program recipients.

(e) TECHNOLOGY NEUTRALITY.—States and federal agencies shall not:

- (1) Prohibit asynchronous (store-and-forward) telemedicine where clinically appropriate.
- (2) Mandate specific technology platforms or equipment unless necessary for interoperability with public health systems.
- (3) Require in-person physical examination when the standard of care does not require it; or
- (4) Impose information compliance burdens beyond those required by federal law, including HIPAA and 42 CFR Part 2.

(f) TRAVELING PROVIDERS.—Healthcare providers licensed in any State may provide in-person services in any other State when:

- (1) Traveling with a patient to provide continuity of care.
- (2) Attending births for patients with whom they have established provider-patient relationships.
- (3) Providing emergency care; or
- (4) Engaged in temporary practice not exceeding 30 days per calendar year in any single State.

SEC. 9. CONTINUITY OF CARE.

(a) FOLLOW-UP CARE AUTHORIZATION.—A healthcare provider licensed in any state may provide follow-up care to a patient located in any other State when:

- (1) The provider has previously provided treatment or services to that patient, whether such treatment occurred:
 - (A) In person in a State where the provider is licensed.
 - (B) In person while the patient was temporarily located in a State where the provider is licensed.
 - (C) Through telemedicine services in accordance with Section 8; or
 - (D) In person under the traveling provider provisions of Section 8(f).
- (2) The follow-up care is reasonably related to the condition, treatment, or services previously provided; and
- (3) The provider complies with the informed consent requirements of Section 5(d).

(b) SCOPE OF FOLLOW-UP CARE.

- (1) Follow-up care may continue for as long as clinically necessary based on the nature of the initial treatment and the patient’s ongoing medical needs.
- (2) The provider-patient relationship established through initial treatment remains valid for purposes of providing follow-up care unless:
 - (A) The patient terminates the relationship; or
 - (B) The provider formally withdraws from care in accordance with applicable standards of professional conduct.

(c) MODALITY OF FOLLOW-UP CARE.—Follow-up care authorized under this section may be provided through:

- (1) Telemedicine services in accordance with Section 8(a).
- (2) In-person services in a State where the provider is licensed.
- (3) In-person services in the State where the patient is located, in accordance with Section 8(f); or
- (4) Any combination of modalities as clinically appropriate.

(d) LICENSING REQUIREMENTS.

- (1) No State shall require a provider to obtain additional licenses, registrations, or permits solely to provide follow-up care authorized under this section.
- (2) Providers providing follow-up care remain subject to:
 - (A) The jurisdiction of their home licensing board.
 - (B) The laws of the state where the patient is located regarding scope of practice, prescriptive authority, and standards of care when services are delivered in that state; and
 - (C) Federal laws governing healthcare practice, including HIPAA privacy requirements and DEA regulations for controlled substances.

SEC. 9. BIRTH CENTER PROTECTIONS.

(a) DEFINITION.—As defined in Section 4(d), birth centers are freestanding facilities providing prenatal, birth, and postpartum services outside of hospitals.

(b) FREEDOM TO ESTABLISH AND OPERATE.

- (1) No State shall prohibit the establishment or operation of birth centers.
- (2) No certificate of need, certificate of public advantage, or similar approval shall be required.
- (3) No permission from hospitals, physicians, or other healthcare providers shall be required as a condition of opening or operating a birth center; and
- (4) Birth centers shall be permitted to operate in all areas where medical offices are permitted, subject only to generally applicable zoning and building codes.

(c) REASONABLE FACILITY STANDARDS.

- (1) States may establish reasonable health and safety standards for birth centers that are:
 - (A) Substantially related to actual public health and safety risks.
 - (B) Based on credible evidence of need.

- (C) Comparable to standards for medical offices and ambulatory surgical centers with similar risk profiles; and
 - (D) Not more burdensome than necessary to achieve legitimate safety objectives;
- (2) Birth centers accredited by the Commission for the Accreditation of Birth Centers (CABC) shall be deemed to meet all state facility licensure requirements without additional inspection or approval.
- (3) States may not require birth centers to:
- (A) Maintain hospital-grade operating rooms or equipment not necessary for the anticipated scope of services.
 - (B) Employ physicians or maintain physician supervision.
 - (C) Meet architectural or design standards exceeding those for comparable medical facilities.
 - (D) Obtain liability insurance at levels exceeding those required for medical offices; or
 - (E) Be located within specified distances from hospitals.

(d) TRANSFER PROTOCOLS.

- (1) States may require birth centers to maintain reasonable emergency transfer protocols, including:
- (A) Written procedures for identifying complications requiring transfer.
 - (B) Procedures for contacting emergency medical services.
 - (C) Staff training in emergency response; and
 - (D) Documentation of transfer outcomes for quality improvement.
- (2) States may not require:
- (A) Signed transfer agreements from receiving hospitals.
 - (B) Agreements from ambulance services.
 - (C) Letters of support from physicians; or
 - (D) Any form of permission or approval from other healthcare providers.
- (3) Hospitals receiving federal funds under Medicare, Medicaid, or the Hill-Burton Act shall accept emergency transfers from birth centers under the same terms as transfers from other facilities, in compliance with the Emergency Medical Treatment and Labor Act (EMTALA).

(e) INSURANCE AND LIABILITY.

- (1) Birth centers shall carry professional liability insurance where commercially available and reasonably obtainable.
- (2) Where such insurance is unavailable or prohibitively expensive, birth centers may operate upon providing written disclosure to patients of their insurance status.
- (3) States may not impose insurance requirements on birth centers that exceed those for medical offices providing comparable services; and
- (4) The standard of care applicable to birth centers shall be that recognized within the midwifery and birth center profession, not the standard of care for hospital obstetrics.

SEC. 10. SCOPE OF PRACTICE AND LICENSURE.

(a) PRACTICE TO FULL EXTENT OF TRAINING.

- (1) All healthcare providers shall be permitted to practice to the full extent allowed by their professional training, education, and credentialing, without restrictions designed to protect other professions from competition.
- (2) Scope of practice restrictions must be based on actual differences in training and competence, supported by credible evidence, and may not be imposed merely to reserve certain services for particular professions.
- (3) States shall recognize scope of practice standards established by nationally recognized credentialing bodies and professional associations; and
- (4) Nothing in this Act alters the scope of practice for licensed physicians, physician assistants, or nurses, but States may not expand those scopes of practice while simultaneously restricting those of complementary healthcare providers.

(b) MIDWIFERY PRACTICE.

- (1) Midwives may attend births, prescribe medications where authorized by state law, and provide prenatal, intrapartum, and postpartum care to the full extent allowed by their respective training and credentialing.
- (2) Scope of practice for midwives includes:
 - (A) Prenatal care, including physical examinations, risk assessment, laboratory ordering and interpretation, nutritional counseling, and education.
 - (B) Intrapartum care, including labor support, monitoring, assessment of labor progress, and management of normal physiologic birth.
 - (C) Postpartum care for mothers, including physical examinations, breastfeeding support, and management of normal postpartum recovery.

- (D) Newborn care, including physical examinations, screening, and well-baby care.
 - (E) Gynecological care, including family planning, contraception, and well-woman care.
 - (F) Management of common pregnancy complications within their training.
 - (G) Appropriate referral and consultation for conditions exceeding their scope.
 - (H) Emergency management and stabilization pending transfer when necessary; and
 - (I) Prescription of medication.
- (3) Nothing in this Act authorizes midwives without prescriptive authority to prescribe medications requiring prescriptions, but States may grant such authority through their licensing laws.
 - (4) Certified Professional Midwives, Certified Nurse-Midwives, Certified Midwives, and other credentialed midwives shall practice according to their respective standards of practice as established by their credentialing bodies; and
 - (5) States may not prohibit qualified midwives from providing services within their training and may not require physician supervision, collaboration agreements, or prior authorization.

(c) TRADITIONAL AND CULTURAL PRACTITIONERS.

- (1) Birth attendants with cultural or religious traditions that include attendance at births may provide midwifery services without state licensure when:
 - (A) They serve only women within their distinct cultural or religious community.
 - (B) They do not hold themselves out as licensed medical professionals; and
 - (C) They provide informed disclosure of their training and status.
- (2) Traditional healers, herbalists, and indigenous practitioners may practice their traditional modalities without licensure when serving their own cultural communities; and
- (3) States may not prohibit or criminalize traditional practices that are part of longstanding cultural or religious traditions.

(d) USE OF PROFESSIONAL TITLES.

- (1) Individuals may use titles that accurately reflect their training, education, credentials, and expertise, including “midwife,” “naturopathic doctor,” “doctor of naturopathic medicine,” “herbalist,” “traditional Chinese medicine practitioner,” “acupuncturist,” and similar titles.

- (2) States may protect specific titles (such as “physician,” “registered nurse,” or “licensed midwife”) from false or misleading use, but may not prohibit accurate use of descriptive titles.
- (3) Providers must disclose their licensure status and may not falsely claim to hold licenses they do not possess; and
- (4) Providers may identify their credentials and certifications, including those from other states, national organizations, or professional associations.

(e) VOLUNTARY LICENSURE ENCOURAGED.

- (1) No state agency may create new mandatory occupational licenses for providers who offer prenatal, labor and delivery, postpartum, or other complementary healthcare services; only state legislatures may establish new occupational licenses.
- (2) States are encouraged to establish voluntary licensure or certification programs that:
 - (A) Provide benefits such as insurance reimbursement, facility privileges, title protection, or professional recognition.
 - (B) Do not prohibit unlicensed practice by those who meet the training standards of recognized credentialing bodies.
 - (C) Establish reasonable educational and competency requirements.
 - (D) Recognize out-of-state licenses and national certifications through reciprocity; and
 - (E) Minimize costs and administrative burdens.
- (3) States shall recognize and accept:
 - (A) Licenses and certifications from other states through interstate reciprocity.
 - (B) National certifications from recognized credentialing bodies.
 - (C) Educational credentials from accredited institutions; and
 - (D) Documented training and experience meeting national standards.

(f) PROHIBITION ON AGENCY OVERREACH.

- (1) No state administrative agency may expand occupational licensing requirements beyond what is authorized by statute.
- (2) Medical boards may not use their authority to regulate the practice of medicine to prohibit or restrict complementary healthcare practices that are not within the practice of medicine; and

- (3) Licensing boards must focus enforcement on actual negligence, fraud, or incompetence, not on competition with licensed professions.

SEC. 11. INSURANCE COVERAGE AND REIMBURSEMENT.

(a) NON-DISCRIMINATION IN COVERAGE.

(1) Health insurance plans operating in interstate commerce, including employer-sponsored plans governed by ERISA, individual market plans, and plans offered through federal or state exchanges, shall not:

- (A) Categorically exclude coverage for complementary healthcare services.
- (B) Deny coverage for services solely because they are provided outside traditional medical settings.
- (C) Require prior authorization for complementary healthcare services when prior authorization is not required for comparable traditional services.
- (D) Impose higher deductibles, copayments, or coinsurance for complementary healthcare services; or
- (E) Apply annual or lifetime limits to complementary healthcare services that do not apply to traditional services.

(2) Plans may establish medical necessity criteria and coverage standards, provided such criteria:

- (A) Are based on credible scientific evidence.
- (B) Are applied consistently across provider types.
- (C) Do not categorically exclude entire modalities of care; and
- (D) Include meaningful appeals processes.

(b) MIDWIFERY COVERAGE PARITY.

- (1) Health insurance plans shall cover midwifery services, including home births and birth center births attended by licensed or certified midwives, at a level of coverage comparable to physician-attended hospital births when the patient is an appropriate candidate for midwifery care.
- (2) Plans may not require physician orders, supervision, or co-signature for midwifery services.
- (3) Plans shall credential and contract with qualified midwives on terms no less favorable than those offered to other independent practitioners.

- (4) Reimbursement rates for midwifery services shall be negotiated in good faith and shall not be substantially lower than rates for comparable physician services without actuarial justification; and
- (5) The determination of whether a patient is an appropriate candidate for midwifery care shall be made using the risk assessment criteria established by the midwifery profession, not arbitrary insurance company criteria.

(c) FEDERAL PROGRAM COVERAGE.

- (1) Medicare shall provide coverage for complementary healthcare services when:
 - (A) The services are within the lawful scope of practice of the provider.
 - (B) The provider meets Medicare credentialing requirements or holds credentials recognized by at least one State; and
 - (C) The services meet criteria for medical necessity.
- (2) State Medicaid programs shall:
 - (A) Cover midwifery services, including home births and birth center births.
 - (B) Reimburse midwives directly at rates comparable to physicians for similar services.
 - (C) Allow beneficiaries to choose midwives as primary maternity care providers.
 - (D) Cover services from other qualified complementary healthcare providers where cost-effective and clinically appropriate; and
 - (E) Not impose barriers to access such as mandatory physician referrals or prior authorization requirements not applied to traditional services.
- (3) TRICARE and Veterans Health Administration programs shall provide coverage for complementary healthcare services comparable to private sector coverage.
- (4) Federal employees' health benefits plans shall include coverage for complementary healthcare services; and
- (5) No state may reduce or eliminate Medicaid coverage for complementary healthcare services as a condition of receiving federal Medicaid matching funds.

(d) REASONABLE RATE NEGOTIATION.

- (1) Nothing in this Act mandates specific reimbursement rates or price controls.
- (2) Insurers and providers may negotiate rates through arms-length bargaining.
- (3) Rates shall reflect the value of services, provider qualifications, and market conditions.

- (4) Insurers may not engage in systematic undervaluation of complementary healthcare services or discriminatory rate-setting designed to discourage access; and
- (5) Providers may choose whether to participate in insurance networks based on offered rates.

(e) **TRANSPARENCY.**

- (1) Insurance plans shall provide clear information about coverage for complementary healthcare services in plan documents and summaries of benefits.
- (2) Denial of coverage shall include specific reasons and appeals procedures.
- (3) Plans shall maintain networks that include adequate numbers of complementary healthcare providers to meet beneficiary demand; and
- (4) Network adequacy standards shall consider complementary healthcare providers when assessing geographic and specialty access.

SEC. 12. LIABILITY PROTECTIONS AND STANDARDS OF CARE.

(a) **APPLICABLE STANDARD OF CARE.**

- (1) In any civil action relating to services provided under this Act, the applicable standard of care shall be that which is recognized and accepted within the specific healthcare discipline or profession of the defendant provider, not the standard of care for conventional medical practice or different healthcare disciplines.
- (2) The standard of care for midwifery services shall be that established by the relevant midwifery credentialing body and professional associations, including:
 - (A) For Certified Professional Midwives: standards established by the North American Registry of Midwives (NARM) and the Midwives Alliance of North America (MANA).
 - (B) For Certified Nurse-Midwives: standards established by the American College of Nurse-Midwives (ACNM) and the American Midwifery Certification Board (AMCB).
 - (C) For other credentialed midwives: standards established by their respective credentialing bodies.
- (3) Expert witnesses testifying about standards of care must:
 - (A) Hold credentials in the same or substantially similar discipline as the defendant.
 - (B) Have active current practice or teaching experience in the discipline.
 - (C) Be familiar with the professional standards applicable to the discipline; and
 - (D) Not be testifying about standards from a different discipline or profession.

- (4) Courts may not apply conventional medical standards to complementary healthcare practice, and the mere fact that a provider practices differently from conventional medicine does not establish negligence.

(b) INFORMED CONSENT DEFENSE.

- (1) Documented informed consent that complies with the requirements of Section 5(d) shall constitute a complete defense to any claim of negligence based solely on:
 - (A) The patient's choice to pursue complementary healthcare services.
 - (B) The patient's choice of birth setting.
 - (C) The patient's choice of provider.
 - (D) The patient's refusal of conventional medical interventions; or
 - (E) Outcomes that were disclosed as potential risks during the informed consent process.
- (2) Informed consent does not provide a defense to:
 - (A) Claims based on negligent performance of services.
 - (B) Practice beyond the provider's scope of training and competence.
 - (C) Fraud or intentional misrepresentation.
 - (D) Failure to obtain valid informed consent; or
 - (E) Failure to refer or transfer when appropriate.

(c) ASSUMPTION OF RISK.

- (1) Patients who make informed choices to pursue complementary healthcare assume the inherent risks of those choices that are disclosed during informed consent.
- (2) Assumption of risk does not apply to:
 - (A) Risks not disclosed or not reasonably foreseeable.
 - (B) Risks created by provider negligence; or
 - (C) Harm resulting from breach of the applicable standard of care.

(d) Limitation on Damages in Certain Cases.

- (1) In actions against providers who obtained proper informed consent and practiced within their scope of practice and applicable standards of care, damages shall be limited to compensation for actual economic losses and reasonable noneconomic damages, and punitive damages shall not be available absent clear and convincing evidence of:

- (A) Intentional misconduct.
- (B) Gross negligence; or
- (C) Reckless disregard for patient safety.

(2) This limitation does not apply to:

- (A) Cases involving fraud or misrepresentation.
- (B) Cases involving sexual misconduct.
- (C) Cases where informed consent was not obtained; or
- (D) Cases involving practice outside the provider's scope of training.

(e) PROVIDER PROTECTIONS.

(1) Healthcare providers who comply with this Act and practice within their scope of competence shall not be subject to:

- (A) Criminal prosecution for practicing their profession.
- (B) License revocation or suspension absent evidence of actual patient harm caused by negligence or incompetence.
- (C) Civil liability solely for providing complementary healthcare services; or
- (D) Disciplinary action for respecting patient autonomy and informed refusal of interventions.

(2) Providers remain subject to accountability for:

- (A) Negligent performance within their scope of practice.
- (B) Practice beyond their competence or training.
- (C) Failure to obtain informed consent.
- (D) Fraud or misrepresentation.
- (E) Sexual misconduct; and
- (F) Violation of criminal laws unrelated to their professional practice.

(f) NO EXPANSION OF LIABILITY.—Nothing in this Act shall be construed to:

- (1) Create new theories of liability.
- (2) Expand provider liability beyond that which would otherwise exist.
- (3) Eliminate traditional defenses to malpractice claims; or
- (4) Alter the burden of proof in civil actions.

(g) PRESERVATION OF EXISTING RIGHTS.—Nothing in this Act limits or supersedes:

- (1) Patients' existing rights to bring malpractice actions.
- (2) States' authority to discipline providers for actual misconduct.
- (3) Criminal laws of general applicability; or
- (4) Federal laws protecting patients, including EMTALA and HIPAA.

SEC. 13. DATA COLLECTION AND RESEARCH.

(a) NATIONAL DATA REGISTRY.

- (1) The Secretary of Health and Human Services, acting through the Centers for Disease Control and Prevention, shall establish a voluntary national registry for complementary healthcare outcomes, including:
 - (A) Home births attended by midwives.
 - (B) Birth center births.
 - (C) Births attended by different types of credentialed midwives; and
 - (D) Other complementary healthcare services.
- (2) The registry shall collect standardized data on:
 - (A) Maternal and newborn outcomes.
 - (B) Transfer rates and reasons.
 - (C) Intervention rates.
 - (D) Patient satisfaction.
 - (E) Cost data; and
 - (F) Demographic information.
- (3) Participation shall be voluntary, and providers shall receive support for data collection and reporting.
- (4) Data shall be de-identified and used only for research and quality improvement.
- (5) The Secretary shall publish annual reports on registry findings; and
- (6) There is authorized to be appropriated \$10,000,000 annually for registry operations.

(b) RESEARCH FUNDING.

- (1) The Director of the National Institutes of Health shall establish a research program to study:
 - (A) Comparative effectiveness of complementary healthcare versus conventional healthcare.
 - (B) Safety and outcomes of different birth settings and providers.
 - (C) Cost-effectiveness of complementary healthcare modalities.
 - (D) Patient satisfaction and experience of care.
 - (E) Integration of complementary and conventional healthcare; and
 - (F) Health disparities and access to complementary healthcare.
- (2) Research shall employ rigorous methodology appropriate to the questions studied, including comparative effectiveness research, prospective cohort studies, and patient-centered outcomes research.
- (3) Research priorities shall be developed with input from complementary healthcare professions, patient advocacy groups, and health services researchers.
- (4) There is authorized to be appropriated \$25,000,000 annually for research under this subsection.

(c) EVIDENCE-BASED POLICYMAKING.

- (1) State and federal healthcare regulations shall be based on credible scientific evidence, not speculation, theoretical concerns, or anti-competitive interests.
- (2) Agencies promulgating healthcare regulations shall:
 - (A) Review and consider research evidence regarding safety and effectiveness.
 - (B) Identify actual harms that regulations are designed to prevent.
 - (C) Consider less restrictive alternatives; and
 - (D) Conduct regulatory impact analyses.
- (3) Where credible evidence demonstrates that complementary healthcare practices are safe and effective, regulatory barriers shall be removed.

SEC. 14. ENFORCEMENT AND REMEDIES.

(a) PRIVATE RIGHT OF ACTION.

- (1) Any eligible patient whose access to healthcare has been burdened in violation of this Act may bring a civil action for declaratory and injunctive relief in federal district court.
- (2) Any eligible provider whose ability to practice has been burdened in violation of this Act may bring a civil action for declaratory and injunctive relief in federal district court.
- (3) Actions may be brought against:
 - (A) State officials enforcing laws or regulations that violate this Act.
 - (B) State licensing boards taking actions that violate this Act.
 - (C) Healthcare facilities that discriminate in violation of Section 7(e).
 - (D) Insurance companies that discriminate in violation of Section 11.
 - (E) Child protective services agencies acting in violation of Section 7(e)(2); and
 - (F) Any other governmental or private entity whose actions violate this Act.

(b) JURISDICTION AND VENUE.

- (1) Federal district courts shall have original jurisdiction over actions arising under this Act.
- (2) Actions may be brought in:
 - (A) The district where the plaintiff resides.
 - (B) The district where the defendant is located; or
 - (C) The district where the violation occurred.
- (3) State sovereign immunity is abrogated for actions under this Act pursuant to Congress's authority under Section 5 of the Fourteenth Amendment.

(c) AVAILABLE REMEDIES.—In actions brought under this Act, courts may award:

- (1) Declaratory relief declaring that a state law, regulation, or practice violates this Act.
- (2) Preliminary and permanent injunctive relief prohibiting enforcement of laws or practices that violate this Act.
- (3) Nominal damages of not less than \$1.
- (4) Compensatory damages for actual economic losses, including:
 - (A) Lost income from inability to practice.
 - (B) Costs of obtaining care in other jurisdictions.
 - (C) Expenses incurred due to state interference.

- (D) Fines or penalties imposed in violation of this Act.
- (5) Reasonable attorneys' fees and costs to prevailing plaintiffs under 42 U.S.C. § 1988.
- (6) Expert witness fees and litigation costs; and
- (7) In cases involving willful violations, punitive damages.

(d) STANDARD OF REVIEW.

- (1) Courts shall apply de novo review, without deference to state or federal agency interpretations.
- (2) Courts shall apply intermediate scrutiny to state restrictions on healthcare freedom.
- (3) States bear the burden of proof by clear and convincing evidence to justify restrictions.
- (4) Courts shall resolve ambiguities in favor of individual liberty and healthcare freedom.
- (5) Courts shall not defer to legislative findings unsupported by credible evidence; and
- (6) Courts shall consider less restrictive alternatives and ensure that restrictions are the least restrictive means of achieving legitimate governmental interests.

(e) EXPEDITED REVIEW.

- (1) Actions challenging criminal prosecutions or emergency restrictions shall receive expedited consideration.
- (2) Courts shall prioritize cases involving imminent harm, such as:
 - (A) Pending criminal charges against providers.
 - (B) Emergency licensing board actions.
 - (C) Immediate threats to close facilities; or
 - (D) Child custody proceedings based on healthcare choices.
- (3) Preliminary injunctions shall be granted upon a showing of likelihood of success on the merits and that the balance of equities favors the plaintiff, without requiring a showing of irreparable harm in cases involving fundamental rights.

(f) DEFENSE IN ADMINISTRATIVE AND CRIMINAL PROCEEDINGS.

- (1) Healthcare providers may assert violations of this Act as an affirmative defense in:
 - (A) State licensing board proceedings.
 - (B) Criminal prosecutions for unauthorized practice.
 - (C) Child protective services proceedings; and

(D) Any other administrative or judicial proceeding.

(E) Courts and hearing officers must consider this Act and apply its protections even if not raised by the parties.

(g) INTERVENTION BY PATIENTS AND PROVIDERS.

(1) In any action challenging a state law or practice as violating this Act, affected patients and providers shall have a right to intervene.

(2) Professional associations representing complementary healthcare providers may intervene to defend their members' rights.

(3) Patient advocacy organizations may intervene to defend patient rights.

(h) NO QUALIFIED IMMUNITY—Individual state officials sued in their official capacity under this Act may not assert qualified immunity or other immunity defenses, as this Act creates clearly established rights.

SEC. 15. FEDERAL OVERSIGHT.

(a) DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSIBILITIES.—The Secretary of Health and Human Services shall:

(1) Monitor state compliance with this Act.

(2) Issue guidance on implementation of this Act within 180 days of enactment and update as needed.

(3) Publish an annual report to Congress on:

(A) State compliance with this Act.

(B) Enforcement actions taken.

(C) Barriers to complementary healthcare access.

(D) Outcomes data from the national registry.

(E) Research findings; and

(F) Recommendations for legislative or administrative action.

(4) Investigate complaints of state violations.

(5) Provide technical assistance to states seeking to come into compliance.

(6) Maintain a public database of state laws and regulations affecting complementary healthcare; and

(7) Coordinate with other federal agencies on implementation.

(b) ENFORCEMENT BY THE DEPARTMENT OF JUSTICE.

- (1) The Attorney General may bring civil actions to enforce this Act against states that:
 - (A) Systematically violate the Act.
 - (B) Fail to come into compliance after notice; or
 - (C) Engage in practices causing substantial harm to patients or providers.
- (2) The Department of Justice shall establish a Civil Rights Division unit focused on healthcare freedom.
- (3) Individuals and organizations may file complaints with the Department of Justice requesting investigation and enforcement.
- (4) The Department of Justice shall publish reports on its enforcement activities.

(c) WITHHOLDING OF FEDERAL FUNDS.

- (1) The Secretary may withhold federal Medicaid matching funds from states that:
 - (A) Fail to provide Medicaid coverage for midwifery services as required by Section 11(c)(2).
 - (B) Systematically violate this Act despite notice and opportunity to cure.
 - (C) Criminalize lawful healthcare practice in violation of this Act; or
 - (D) Maintain certificate-of-need or other prohibited restrictions after the effective date.
- (2) Before withholding funds, the Secretary shall:
 - (A) Provide written notice of specific violations.
 - (B) Allow 180 days for the state to cure violations.
 - (C) Conduct hearings if requested; and
 - (D) Make findings supporting the withholding.
- (3) Withholding shall be limited to funds related to the programs affected by the violations.
- (4) Funds may be restored upon the state's compliance.

(d) PREEMPTION OF CONFLICTING STATE LAWS.

- (1) This Act preempts state laws, regulations, and practices to the extent they conflict with or frustrate the purposes of this Act.
- (2) State laws are preempted if they:
 - (A) Impose requirements prohibited by this Act.

- (B) Create barriers to healthcare freedom beyond those permitted by this Act.
 - (C) Discriminate against complementary healthcare.
 - (D) Prevent providers from practicing to the full extent of their training; or
 - (E) Otherwise frustrate the purposes of this Act.
- (3) State laws providing greater protection for healthcare freedom are not preempted.
 - (4) The existence of state regulation does not presumptively indicate a valid exercise of police power; states must affirmatively justify restrictions.

SEC. 16. RULES OF CONSTRUCTION.

(a) **CONSTITUTIONAL AUTHORITY.**—This Act is enacted pursuant to:

- (1) Congress's power under the Commerce Clause (Article I, Section 8, Clause 3) to regulate interstate healthcare commerce and to prevent state barriers to interstate commerce.
- (2) Congress's power under Section 5 of the Fourteenth Amendment to enforce Due Process and Equal Protection guarantees.
- (3) Congress's power under the Spending Clause (Article I, Section 8, Clause 1) to condition federal healthcare funding on state compliance; and
- (4) Congress's power to protect fundamental liberties recognized by the Ninth Amendment.

(b) **FUNDAMENTAL RIGHTS PROTECTED.**—This Act recognizes and protects:

- (1) The fundamental liberty interest in making healthcare decisions, including decisions about pregnancy, childbirth, and medical treatment.
- (2) The fundamental right to bodily autonomy and integrity.
- (3) The fundamental right to privacy in healthcare decisions.
- (4) The right to pursue a lawful occupation free from arbitrary or protectionist restrictions.
- (5) The right to choose one's healthcare providers; and
- (6) The right to access lawful healthcare services.

(c) **NO DIMINUTION OF OTHER RIGHTS.**—Nothing in this Act shall be construed to:

- (1) Limit or diminish any rights protected by the Constitution.
- (2) Limit or diminish any rights protected by other federal statutes.
- (3) Prevent states from providing greater protections for healthcare freedom.

- (4) Limit, restrict, or otherwise affect the authority of the Federal Government, any State government, or any political subdivision thereof to regulate abortion or abortion services to the full extent permitted by the Constitution.
- (5) Require any healthcare provider to provide services contrary to their clinical judgment or ethical principles.
- (6) Eliminate medical malpractice liability for actual negligence.
- (7) Prevent appropriate discipline of providers who cause actual harm through incompetence or misconduct.
- (8) Prevent prosecution for criminal conduct unrelated to the lawful practice of healthcare.
- (9) Authorize practice beyond the scope of one's training and competence; or
- (10) Prevent parents from making healthcare decisions for their minor children, or courts from intervening in appropriate cases of medical neglect.

(d) NO FUNDAMENTAL RIGHT TO ABORTION.—Nothing in this Act shall be construed to create, recognize, establish, or imply the existence of any fundamental right, constitutional right, or other protected interest in:

- (1) Obtaining an abortion; or
- (2) Providing abortion services.

(e) RELATIONSHIP TO OTHER FEDERAL LAWS.

- (1) This Act supplements and does not replace other federal healthcare laws.
- (2) Providers remain subject to:
 - (A) EMTALA requirements for emergency treatment.
 - (B) HIPAA privacy and security requirements.
 - (C) DEA regulations for controlled substances.
 - (D) FDA regulations for drugs and devices.
 - (E) Federal anti-discrimination laws; and
 - (F) Federal fraud and abuse laws.
- (3) Where this Act conflicts with other federal statutes, this Act controls with respect to state restrictions on healthcare freedom.
- (4) Federal agencies shall interpret their regulations consistent with this Act's purposes.

(f) CONSTRUCTION IN FAVOR OF LIBERTY.

- (1) In applying this Act, courts and agencies shall exercise any doubt in favor of interpretations that:
 - (A) Maximize individual healthcare freedom.
 - (B) Limit governmental interference with healthcare choices.
 - (C) Protect the right to practice lawful occupations.
 - (D) Remove unnecessary barriers to healthcare access; and
 - (E) Respect patient autonomy and informed consent.
- (2) Restrictions on healthcare freedom shall be narrowly construed.
- (3) Exceptions and limitations shall be broadly construed in favor of access.

(g) NO MANDATORY PARTICIPATION.—Nothing in this Act:

- (1) Requires any individual to use complementary healthcare.
- (2) Requires any provider to offer complementary healthcare.
- (3) Requires any facility to provide or accommodate complementary healthcare.
- (4) Prevents providers from practicing conventional medicine exclusively.
- (5) Prevents facilities from establishing medical staff policies; or
- (6) Requires insurance coverage for services that are not medically necessary or are experimental.

SEC. 17. SEVERABILITY.

If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of this Act and the application of such provision to other persons or circumstances shall not be affected thereby. The provisions of this Act are severable.

SEC. 18. EFFECTIVE DATE AND TRANSITION.

(a) EFFECTIVE DATE.—This Act shall take effect 180 days after the date of enactment.

(b) REGULATORY TRANSITION.

- (1) Within 90 days of enactment, the Secretary of Health and Human Services shall issue interim guidance on implementation.
- (2) Within 180 days of enactment, federal agencies shall revise regulations to comply with this Act.
- (3) States shall have 180 days after enactment to bring their laws and regulations into compliance.

- (4) After the 180-day transition period, state laws and regulations that violate this Act shall be unenforceable.

(c) PENDING PROCEEDINGS.

- (1) This Act applies to all proceedings pending on or after the effective date.
- (2) Providers facing criminal charges or disciplinary actions based on conduct that is protected under this Act may move to dismiss such proceedings.
- (3) Courts shall apply this Act retroactively to vindicate constitutional rights.

(d) NOTICE TO STATES.

- (1) The Secretary shall notify all state governors, attorneys general, and health departments of this Act's requirements within 30 days of enactment
- (2) The Secretary shall offer technical assistance to states seeking to comply
- (3) The Secretary shall publish model state legislation and regulations consistent with this Act.

SEC. 19. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this Act, including:

- (a) \$10,000,000 annually for the national data registry established under Section 13(a).
- (b) \$25,000,000 annually for research under Section 13(b).
- (c) \$5,000,000 annually for federal oversight, enforcement, and technical assistance under Section 15; and
- (d) such sums as may be necessary for implementation, education, and compliance activities.