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(Original Signature of Member)

119TH CONGRESS
1ST SESSION

# H. R. _____

To amend the Public Health Service Act to include Middle Eastern and North African (MENA) individuals in the statutory definition of a ''racial and ethnic minority group'', to direct the Secretary of Health and Human Services to conduct a comprehensive study of MENA population health, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

Ms. TLAIB introduced the following bill; which was referred to the Committee on _____

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# A BILL

To amend the Public Health Service Act to include Middle Eastern and North African (MENA) individuals in the statutory definition of a ''racial and ethnic minority group'', to direct the Secretary of Health and Human Services to conduct a comprehensive study of MENA population health, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Health Equity and Middle Eastern and North African Community Inclusion Act of 2025'' or the ''Health Equity and MENA Community Inclusion Act of 2025''.

**SEC. 2. DEFINITION.**

In this Act, the terms ''Middle Eastern and North African'' or ''MENA'', with respect to individuals or populations, includes individuals or populations who identify with or belong to one or more nationalities or ethnic groups originating in a country (or portion thereof) in the Middle Eastern and North African region (such as Lebanese, Iranians, Egyptians, Moroccans, Yemenis, Chaldeans, Imazighen, Kurds, Palestinians, and Yazidis).

**SEC. 3. FINDINGS.**

Congress finds the following:

(1) On March 28, 2024, the Office of Management and Budget formally recognized Middle Eastern and North African populations in Statistical Policy Directive Number 15 (in this section referred to as ''SPD 15''), which established, since its issuance in 1977, the minimum standards for the collection, management, and presentation of data on race and ethnicity.

(2) In 1985, the Secretary of Health and Human Services produced a ''Report on Black and

Minority Health'', which analyzed persistent health differences between the general population and the non-White populations recognized in SPD 15 and served as the basis for the foundation of the Office of Minority Health (in this section referred to as the ''OMH'').

(3) Through the establishment of the OMH in 1986, the Secretary of Health and Human Services has developed health policies and programs that eliminate health disparities and improve the health of racial and ethnic minority populations.

(4) Congress has funded the OMH to ensure improved health status of racial and ethnic minorities, and to develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. The activities of the OMH have addressed health disparities, including with respect to physical activity and nutrition, clinical conditions, individual social needs, and the social determinants of health for ''racial and ethnic minority groups''.

(5) Before the amendments made by this Act, section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)) defined the term ''racial and ethnic minority group'' (for whom the OMH

works to improve health outcomes and eliminate health disparities) to exclude Middle Easterners and North Africans, and thereby prevented MENA populations from accessing critical resources intended to assist historically marginalized communities.

(6) Independent researchers and private sector research initiatives have found significant health disparities between MENA individuals and the non-Hispanic White population, as well as significant overlap between the health outcomes and health conditions of MENA individuals and those of other racial and ethnic minority groups.

(7) Poor health outcomes are often connected to impoverishment in other aspects of life and are exacerbated by additional barriers to access high-quality health coverage, whether in terms of language, eligibility, health literacy, or discrimination at the point-of-service.

(8) A recent study published in the journal, Proceedings of the National Academy of Sciences, suggested that MENA individuals are not perceived as White and do not perceive themselves as White.

(9) Research on the health outcomes and health conditions of MENA individuals is troubling and suggests that efforts must be made on the Federal

level to disaggregate the demographic data of MENA individuals from the demographic data of individuals in the non-Hispanic White category and fully understand the social determinants of health for health disparities and outcomes experienced by MENA individuals.

(10) MENA individuals are not included among the groups for whom the OMH works to improve health outcomes and eliminate health disparities, which further limits the opportunity of MENA individuals to access programs designed to address their experiences and health conditions.

(11) The OMH could better assess and eliminate health disparities by conducting a comprehensive study of the health of MENA individuals and recognizing MENA individuals as a racial and ethnic minority group.

**SEC. 4. INCLUSION OF MIDDLE EASTERNERS AND NORTH AFRICANS IN DEFINITION OF RACIAL AND ETHNIC MINORITY GROUPS.**

(a) IN GENERAL.—Section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)) is amended by striking ''Blacks; and Hispanics'' and inserting ''Blacks or African Americans; Hispanics; and Middle Easterners and North Africans''.

(b) SENSE OF CONGRESS.—It is the sense of Congress that subsection (a) should be implemented so as to ensure that—

(1) the definition of a ''racial and ethnic minority group'' in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)), as amended by subsection (a), is applied in the implementation and execution of Federal programs and activities that reference such definition; and

(2) no racial or ethnic minority group served by such programs and activities is negatively impacted by the amendment made by subsection (a).

(c) UNDEFINED REFERENCES.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) identify all regulations, guidance, orders, and documents of the Department of Health and Human Services for establishment or implementation of a health care or public health program, activity, or survey that—

(A) use the term ''racial and ethnic minority group'' or similar terminology; and

(B) do not define such term or terminology; and

(2) take such actions as may be necessary to clarify whether the definition of ''racial and ethnic minority group'' in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)), as amended by subsection (a), applies to such term or terminology.

(d) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the implementation of this section.

**SEC. 5. REPORT ON HEALTH OF MIDDLE EASTERN AND NORTH AFRICAN POPULATION.**

(a) STUDY REQUIRED.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct or support a comprehensive study regarding the unique health patterns and outcomes of MENA populations.

(b) REQUIREMENTS FOR STUDY.—The comprehensive study under subsection (a) shall include an enumeration of MENA populations across the United States, disaggregated by subpopulation, and with respect to each such population and subpopulation—

(1) the rates of—

(A) health risk factors, including—

(i) behaviors, such as tobacco use, excessive alcohol consumption, physical inactivity, and unhealthy diet;

(ii) physiological factors, such as obesity, diabetes, high blood pressure, high blood sugar, and high cholesterol;

(iii) environmental factors, such as exposure to toxic chemicals, air and water pollution, and unsafe working conditions, including prevalence of work-related injuries;

(iv) genetic factors, such as family history of chronic diseases, presence of specific gene mutations, and racial and ethnic predisposition to certain conditions;

(v) demographic characteristics, such as age, geographic location, and English language proficiency; and

(vi) social determinants of health, such as household income, health insurance coverage, socioeconomic status, education level, housing instability, educational and employment opportunities, and access to culturally and linguistically appropriate service providers;

(B) prevalence of chronic disease or illness, including—

(i) cancers, such as breast, lung, cervical, prostate, colorectal, liver, stomach, and oral cancer;

(ii) cardiovascular conditions, such as heart disease, atrial fibrillation, and stroke;

(ii) respiratory conditions, such as asthma, chronic obstructive pulmonary disease, and lung disease;

(iii) musculoskeletal conditions, such as osteoporosis and carpal tunnel syndrome;

(iv) neurological conditions, such as Parkinson's disease, Alzheimer's and other related dementias, epilepsy, and cerebral palsy;

(v) infectious diseases, such as HIV/AIDS, hepatitis B and C, and tuberculosis; and

(vi) autoimmune diseases, such as lupus, multiple sclerosis, ulcerative colitis, and rheumatoid arthritis;

(C) prevalence of disability and disorder, including—

(i) vision impairments, such as blindness and low vision;

(ii) hearing conditions, such as deafness and varying degrees of hearing loss;

(iii) physical impairments, such as musculoskeletal conditions, amputation, paralysis, repetitive strain injuries, and other conditions that affect movement or require assistive devices;

(iv) intellectual or developmental conditions, such as Down syndrome, Prater-Willi syndrome, Angelman syndrome, autism, and attention-deficit/hyperactive disorder (ADHD), as well as other conditions that affect cognitive abilities, learning, and adaptive behaviors;

(v) mental or behavioral conditions, such as depression, anxiety, insomnia, sleep apnea, bipolar disorder, schizophrenia, and traumatic brain injury;

(vi) substance use disorders, such as disorders in use of alcohol, opioids, stimulants, and cannabis, and risk factors stemming from such disorders, such as liver damage and gastrointestinal issues;

(vii) genetic or blood disorders, such as sickle cell anemia, G6PD deficiency, hypertension, and thalassemia; and

(viii) endocrine disorders, such as diabetes, polycystic ovary syndrome (PCOS), and hypothyroidism;

(D) maternal and reproductive health outcomes, including maternal morbidity and mortality, infertility, and postpartum depression;

(E) nutritional health outcomes, including malnutrition, vitamin D and iron deficiencies, among other vitamin deficiencies;

(F) child and adolescent health outcomes, such as pediatric developmental delays, childhood obesity, and early-onset chronic conditions;

(G) dental and oral health outcomes, including tooth loss, gum disease, and tooth decay;

(H) domestic violence, dating violence, sexual assault, sexual harassment, and stalking; and

(I) morbidity and mortality, including the rates of morbidity and mortality associated with

the rates referenced in subparagraphs (A) through (H);

(2) analysis of—

(A) the factors and conditions that contribute most to—

(i) the rates described in paragraph (1); and

(ii) the rates by which MENA subpopulations reported the outcomes referenced in subparagraphs (B) and (C) as a disease, illness, disorder, or disability;

(B) the leading causes of morbidity and mortality and pregnancy-associated morbidity and mortality;

(C) the extent to which access to health care facilities contributes to the associated outcomes of care, including the rates described in paragraph (1); and

(D) the disparities between MENA subpopulations and between the aggregate MENA population and other racial and ethnic populations in the rates described in paragraph (1);

(3) analysis, enumeration, or quantification of any other health or health-related parameters the Secretary determines necessary; and

(4) analysis of the extent to which any or all of the design, implementation, and evaluation of Federal health programs contribute to the health factors, outcomes, and conditions described in paragraphs (1) through (3).

(c) CONSULTATION.—The Secretary shall—

(1) carry out this section in consultation, as appropriate, with the Director of the Census Bureau, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, the Assistant Secretary for Mental Health and Substance Use, and other stakeholders (including community-based organizations); and

(2) determine through such consultation the subpopulations to be used for purposes of disaggregation of data pursuant to subsection (b).

(d) ONLINE PORTAL.—Upon conclusion of the comprehensive study under this section, the Secretary shall establish a public online portal to catalogue the results of the study, its underlying data, and information in the report submitted pursuant to subsection (e)(2).

(e) REPORTING.—

(1) INTERIM REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report outlining

the challenges associated with, and progress toward implementing, health data collection for MENA populations as a distinct category and the plan for completing a comprehensive study regarding the unique health patterns and outcomes of MENA populations.

(2) FINAL REPORT.—Not later than 30 days after the conclusion of the comprehensive study under this section, and not later than 2 years after the date of submission of the interim report under paragraph (1), the Secretary shall submit to Congress a report describing—

(A) the results of the study conducted under this section; and

(B) the rulemakings and other actions the agencies described in subsection (c)(1) can undertake to more equitably include MENA individuals in their programs, including whether and to what extent additional resources are needed to increase rates of response among MENA populations to Federal health surveys.

(f) PRIVACY.—

(1) IN GENERAL.—In carrying out the comprehensive study under this section, the Secretary shall implement robust privacy protections to safeguard the personal data of the individuals involved.

(2) MINIMUM PROTECTIONS.—The privacy protections referred to in paragraph (1) include the following:

(A) Personally identifiable information, such as names or addresses, shall not be collected when unnecessary for the purposes of the study.

(B) Any personally identifiable information that is collected shall be securely destroyed upon completion of the intended use of such information.

(C) All privacy protections and data handling procedures shall be clearly communicated to any individuals who may be subjects of the study, including through informed consent if applicable.

(3) PROHIBITION ON INCLUSION OF PII IN ONLINE PORTAL OR REPORTS.—The Secretary shall not include any personally identifiable information on the online portal under subsection (d) or in the reports under subsection (e).

(g) VIOLATIONS.—Any person who, by virtue of an official position or affiliation with the Secretary—

(1) has possession of, or access to, any record containing individually identifiable information the

disclosure of which is prohibited by or under this section; and

(2) knowingly discloses such a record to any person or agency not entitled to receive the record, shall be guilty of a misdemeanor and fined not more than $25,000.

(h) PERSONALLY IDENTIFIABLE INFORMATION DEFINED.—In this section, the term ''personally identifiable information'' means individually identifying information for or about an individual, including information likely to disclose the location or specific identity of a participating individual, regardless of whether the information is encoded, encrypted, hashed, or otherwise protected, including—

(1) a first and last name;

(2) a home or other physical address;

(3) contact information (including a postal, e-mail or Internet protocol address, or telephone or facsimile number);

(4) a social security number, driver license number, passport number, or student identification number; and

(5) any other information, including date of birth, racial or ethnic background, or religious affiliation, that would serve to identify any individual.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.