(A) $15,000,000 to carry out subsection (a); and

(B) $75,000,000, of which, subject to paragraph (4)—

(i) two-thirds of the amount appropriated shall be made available for allotments under subsection (b)(2); and

(ii) one-third of the amount appropriated shall be made available for allotments under subsection (c)(3).

(2) Authorization of appropriations for fiscal years 2007 through 2010

There are authorized to be appropriated $75,000,000 for each of fiscal years 2007 through 2010, of which, subject to paragraph (4)—

(A) two-thirds of the amount appropriated for a fiscal year shall be made available for allotments under subsection (b)(2); and

(B) one-third of the amount appropriated for a fiscal year shall be made available for allotments under subsection (c)(3).

(3) Availability

Funds appropriated for purposes of carrying out this section for a fiscal year shall remain available for obligation through the end of the following fiscal year.

(4) Reallotment

If, on June 30 of each fiscal year for which funds are appropriated under paragraph (1)(B) or (2), the Secretary determines that all the amounts so appropriated are not allotted or otherwise made available to States, such remaining amounts shall be allotted and made available under subsection (b) among States receiving grants under subsection (b) for the fiscal year based upon the allotment formula specified in such subsection.

(5) No entitlement

Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

(e) Applications

To be eligible for a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(f) Annual report

The Secretary shall submit to Congress an annual report on grants provided under this section. Each such report shall include information on the distribution of such grants among States and the use of grant funds by States.

(g) Definitions

In this section:

(1) Qualified high risk pool

(A)[1] In general

The term ''qualified high risk pool'' has the meaning given such term in section 300gg–44(c)(2) of this title, except that a State may elect to meet the requirement of subparagraph (A) of such section (insofar as it requires the provision of coverage to all eligible individuals) through providing for the enrollment of eligible individuals through an acceptable alternative mechanism (as defined for purposes of section 300gg–44 of this title) that includes a high risk pool as a component.

(2) Standard risk rate

The term ''standard risk rate'' means a rate—

(A) determined under the State high risk pool by considering the premium rates charged by other health insurers offering health insurance coverage to individuals in the insurance market served;

(B) that is established using reasonable actuarial techniques; and

(C) that reflects anticipated claims experience and expenses for the coverage involved.

(3) State

The term ''State'' means any of the 50 States and the District of Columbia and includes Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(July 1, 1944, ch. 373, title XXVII, § 2745, as added Pub. L. 107–210, div. A, title II, § 201(b), Aug. 6, 2002, 116 Stat. 959; amended Pub. L. 109–172, § 2, Feb. 10, 2006, 120 Stat. 185.)

AMENDMENTS

2006—Pub. L. 109–172 amended section generally, substituting provisions relating to relief for high risk pools for provisions relating to promotion of qualified high risk pools.

CONSTRUCTION

Nothing in the amendments made by title II of Pub. L. 107–210, other than provisions relating to COBRA continuation coverage and reporting requirements, to be construed as creating a new mandate on any party regarding health insurance coverage, see section 203(f) of Pub. L. 107–210, set out as a note under section 35 of Title 26, Internal Revenue Code.

§ 300gg–46. Disclosure to enrollees of individual market coverage

(a) In general

A health insurance issuer offering individual health insurance coverage or a health insurance issuer offering short-term limited duration insurance coverage shall make disclosures to enrollees in such coverage, as described in subsection (b), and reports to the Secretary, as described in subsection (c), regarding direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage.

(b) Disclosure

A health insurance issuer described in subsection (a) shall disclose to an enrollee the amount of direct or indirect compensation provided to an agent or broker for services provided by such agent or broker associated with plan selection and enrollment. Such disclosure shall be—

(1) made prior to the individual finalizing plan selection; and

(2) included on any documentation confirming the individual's enrollment.

[1] So in original. No subpar. (B) has been enacted.

(c) Reporting

A health insurance issuer described in subsection (a) shall annually report to the Secretary, prior to the beginning of open enrollment, any direct or indirect compensation provided to an agent or broker associated with enrolling individuals in such coverage.

(d) Rulemaking

Not later than 1 year after December 27, 2020, the Secretary shall finalize, through notice-and-comment rulemaking, the timing, form, and manner in which issuers described in subsection (a) are required to make the disclosures described in subsection (b) and the reports described in subsection (c). Such rulemaking may also include adjustments to notice requirements to reflect the different processes for plan renewals, in order to provide enrollees with full, timely information.

(July 1, 1944, ch. 373, title XXVII, § 2746, as added Pub. L. 116–260, div. BB, title II, § 202(c), Dec. 27, 2020, 134 Stat. 2899.)

EFFECTIVE DATE

Section applicable beginning 1 year after Dec. 27, 2020, see section 202(e) of div. BB of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note under section 1108 of Title 29, Labor.

SUBPART 2—OTHER REQUIREMENTS

CODIFICATION

Pub. L. 110–233, title I, § 102(b)(1)(A), May 21, 2008, 122 Stat. 892, redesignated this subpart, which was originally enacted as subpart 3 of part B of title XXVII of act July 1, 1944, as subpart 2.

§ 300gg–51. Standards relating to benefits for mothers and newborns

(a) In general

The provisions of section 2704[1] (other than subsections (d) and (f)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(b) Notice requirement

A health insurance issuer under this part shall comply with the notice requirement under section 1185(d) of title 29 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.

(c) Preemption; exception for health insurance coverage in certain States

(1) In general

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 300gg–23(d)(1)[1] of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) Construction

Section 300gg–62(a) of this title shall not be construed as superseding a State law described in paragraph (1).

(July 1, 1944, ch. 373, title XXVII, § 2751, as added Pub. L. 104–204, title VI, § 605(a)(4), Sept. 26, 1996, 110 Stat. 2941.)

REFERENCES IN TEXT

Section 2704, referred to in subsec. (a), is a reference to section 2704 of act July 1, 1944. Section 2704, which was classified to section 300gg–4 of this title, was renumbered section 2725, and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911, and was transferred to section 300gg–25 of this title. A new section 2704 of act July 1, 1944, related to prohibition of preexisting condition exclusions or other discrimination based on health status, was added, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and is classified to section 300gg–3 of this title.

Section 300gg–23(d)(1) of this title, referred to in subsec. (c)(1), was in the original ''section 2723(d)(1)'', and was translated as meaning section 2724(d)(1) of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(14)(B), formerly § 1562(c)(14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

EFFECTIVE DATE

Section applicable to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after Jan. 1, 1998, see section 605(c) of Pub. L. 104–204, set out as an Effective Date of 1996 Amendment note under section 300gg–44 of this title.

§ 300gg–52. Required coverage for reconstructive surgery following mastectomies

The provisions of section 2706[1] shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(July 1, 1944, ch. 373, title XXVII, § 2752, as added Pub. L. 105–277, div. A, § 101(f) [title IX, § 903(b)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438.)

REFERENCES IN TEXT

Section 2706, referred to in text, is a reference to section 2706 of act July 1, 1944. Section 2706, which was

[1] See References in Text note below.

[1] See References in Text note below.