§ 150.461 Failure to pay assessment.

If any entity fails to pay an assessment after it becomes a final order, or after the court has entered final judgment in favor of CMS, CMS refers the matter to the Attorney General, who brings an action against the entity in the appropriate United States district court to recover the amount assessed.

§ 150.463 Final order not subject to review.

In an action brought under § 150.461, the validity and appropriateness of the final order described in § 150.459 is not subject to review.

§ 150.465 Collection and use of penalty funds.

(a) Any funds collected under § 150.461 are paid to CMS.
(b) The funds are available without appropriation until expended.
(c) The funds may be used only for the purpose of enforcing the HIPAA requirements for which the penalty was assessed.

Subpart E—Oversight
152.26 Appeals procedures.
152.27 Fraud, waste, and abuse.
152.28 Preventing insurer dumping.

Subpart F—Funding
152.32 Use of funds.
152.33 Initial allocation of funds.
152.34 Reallocation of funds.
152.35 Insufficient funds.

Subpart G—Relationship to Existing Laws and Programs
152.39 Maintenance of effort.
152.40 Relation to State laws.

Subpart H—Transition to Exchanges
152.44 End of PCIP program coverage.
152.45 Transition to the exchanges.

AUTHORITY: Sec. 1101 of the Patient Protection and Affordable Care Act (Pub. L. 111–148).
SOURCE: 75 FR 45029, July 30, 2010, unless otherwise noted.

Subpart A—General Provisions
§ 152.1 Statutory basis.
(a) Basis. This part establishes provisions needed to implement section 1101 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), which requires the Secretary of the Department of Health and Human Services to establish a temporary high risk health insurance pool program to provide health insurance coverage for individuals described in § 152.14 of this part.
(b) Scope. This part establishes standards and sets forth the requirements, limitations, and procedures for the temporary high risk health insurance pool program, hereafter referred to as the “Pre-Existing Condition Insurance Plan” (PCIP) program.

§ 152.2 Definitions.
For purposes of this part the following definitions apply:
Creditable coverage means coverage of an individual as defined in section 2701(c)(1) of the Public Health Service Act as of March 23, 2010 and 45 CFR 146.113(a)(1).
Enrollee means an individual receiving coverage from a PCIP established under this section.


§ 152.6 Program administration.

(a) General rule. Section 1101(b)(1) of the Affordable Care Act requires that HHS carry out the Pre-Existing Condition Insurance Plan program directly or through contracts with eligible entities, which are States or nonprofit private entities.

(b) Administration by State. A State (or its designated non-profit private entity) may submit a proposal to enter into a contract with HHS to establish and administer a PCIP in accordance with section 1101 of the Affordable Care Act and this part.

(1) At the Secretary’s discretion, a State may designate a nonprofit entity or entities to contract with HHS to administer a PCIP.