

§ 152.28 Preventing insurer dumping.

(a) *General rule.* If it is determined based on the procedures and criteria set forth in paragraph (b) of this section that a health insurance issuer or group health plan has discouraged an individual from remaining enrolled in coverage offered by such issuer or health plan based on the individual's health status, if the individual subsequently enrolls in a PCIP under this part, the issuer or health plan will be responsible for any medical expenses incurred by the PCIP with respect to the individual.

(b) *Procedures and criteria for a determination of dumping.* A PCIP shall establish procedures to identify and report to HHS instances in which health insurance issuers or employer-based group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in instances in which such individuals subsequently are eligible to enroll in the qualified high risk pool. Such procedures shall include methods to identify the following circumstances, either through the PCIP enrollment application form or other vehicles:

(1) Situations where an enrollee or potential enrollee had prior coverage obtained through a group health plan or issuer, and the individual was provided financial consideration or other rewards for disenrolling from their coverage, or disincentives for remaining enrolled.

(2) Situations where enrollees or potential enrollees had prior coverage obtained directly from an issuer or a group health plan and either of the following occurred:

(i) The premium for the prior coverage was increased to an amount that exceeded the premium required by the PCIP (adjusted based on the age factors applied to the prior coverage), and this increase was not otherwise explained;

(ii) The health plan, issuer or employer otherwise provided money or other financial consideration to disenroll from coverage, or disincentive to remain enrolled in such coverage. Such considerations include payment of the PCIP premium for an enrollee or potential enrollee.

(c) *Remedies.* If the Secretary determines, based on the criteria in paragraph (b) of this section, that the rule in paragraph (a) of this section applies, an issuer or a group health plan will be billed for the medical expenses incurred by the PCIP. The issuer or group health plan also will be referred to appropriate Federal and State authorities for other enforcement actions that may be warranted based on the behavior at issue.

(d) *Other.* Nothing in this section may be construed as constituting exclusive remedies for violations of this section or as preventing States from applying or enforcing this section or other provisions of law with respect to health insurance issuers.