requirements of this part for the specified period for which CMS has determined the election to be invalid.

(k) *Enforcement.* To the extent that an election under this section has not been filed or a non-Federal governmental plan otherwise is subject to one or more requirements of this part, CMS enforces those requirements under part 150 of this subchapter. This may include imposing a civil money penalty against the plan or plan sponsor, as determined under subpart C of part 150.

(l) *Construction.* Nothing in this section should be construed to prevent a State from taking the following actions:

(1) Establishing, and enforcing compliance with, the requirements of State law (as defined in §146.143(d)(1)), including requirements that parallel provisions of title XXVII of the PHS Act, that apply to non-Federal governmental plans or sponsors.

(2) Prohibiting a sponsor of a non-Federal governmental plan within the State from making an election under this section.

[67 FR 48811, July 26, 2002, as amended at 74 FR 51693, Oct. 7, 2009]

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

Sec.

AUTHORITY: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

SOURCE: 75 FR 27138, May 13, 2010, unless otherwise noted.

§147.100 Basis and scope.

Part 147 of this subchapter implements the requirements of the Patient Protection and Affordable Care Act that apply to group health plans and health insurance issuers in the Group and Individual markets.

§147.108 Prohibition of preexisting condition exclusions.

(a) *No preexisting condition exclusions*—(1) *In general.* A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion (as defined in §144.103).

(2) *Examples.* The rules of this paragraph (a) are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, *see* §146.111(a)(1)(ii)):

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *P*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *N*. *N*'s policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1,* the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy.

Example 2. (i) *Facts.* Individual *C* applies for individual health insurance coverage with Issuer *M*. *M* denies *C*'s application for coverage because a pre-enrollment physical revealed that *C* has type 2 diabetes.

(ii) *Conclusion.* In this *Example 2, M*'s denial of *C*'s application for coverage is a preexisting condition exclusion because a denial of an application for coverage based on the fact that a condition was present before the date of denial is an exclusion of benefits based on a preexisting condition.

(b) *Applicability*—(1) *General applicability date.* Except as provided in paragraph (b)(2) of this section, the rules of this section apply for plan years beginning on or after January 1, 2014; in the case of individual health insurance coverage, for policy years beginning, or