

SEC. 202. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

(a) Grandfathered Health Insurance Coverage Defined- Subject to the succeeding provisions of this section, for purposes of establishing acceptable coverage under this division, the term ‘grandfathered health insurance coverage’ means individual health insurance coverage that is offered and in force and effect before the first day of Y1 if the following conditions are met:

(1) LIMITATION ON NEW ENROLLMENT-

(A) IN GENERAL- Except as provided in this paragraph, the individual health insurance issuer offering such coverage does not enroll any individual in such coverage if the first effective date of coverage is on or after the first day of Y1.

(B) DEPENDENT COVERAGE PERMITTED- Subparagraph (A) shall not affect the subsequent enrollment of a dependent of an individual who is covered as of such first day.

(2) LIMITATION ON CHANGES IN TERMS OR CONDITIONS- Subject to paragraph (3) and except as required by law, the issuer does not change any of its terms or conditions, including benefits and cost-sharing, from those in effect as of the day before the first day of Y1.

(3) RESTRICTIONS ON PREMIUM INCREASES- The issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner.

(b) Grace Period for Current Employment-Based Health Plans-

(1) GRACE PERIOD-

(A) IN GENERAL- The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in operation as of the day before the first day of Y1 must meet the same requirements as apply to a qualified health benefits plan under section 201, including the essential benefit package requirement under section 221.

(B) EXCEPTION FOR LIMITED BENEFITS PLANS- Subparagraph (A) shall not apply to an employment-based health plan in which the coverage consists only of one or more of the following:

(i) Any coverage described in section 3001(a)(1)(B)(ii)(IV) of division B of the American Recovery and Reinvestment Act of 2009 ([Public Law 111-5](#)).

(ii) Excepted benefits (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974), including coverage under a specified disease or illness policy described in paragraph (3)(A) of such section.

(iii) Such other limited benefits as the Commissioner may specify.

In no case shall an employment-based health plan in which the coverage consists only of one or more of the coverage or benefits described in clauses (i) through (iii) be treated as acceptable coverage under this division.

(2) TRANSITIONAL TREATMENT AS ACCEPTABLE COVERAGE- During the grace period specified in paragraph (1)(A), an employment-based health plan (which may be a high deductible health plan, as defined in section 223(c)(2) of the Internal Revenue Code of 1986) that is described in such paragraph shall be treated as acceptable coverage under this division.

(c) Limitation on Individual Health Insurance Coverage-

(1) IN GENERAL- Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may only be offered on or after the first day of Y1 as an Exchange-participating health benefits plan.

(2) SEPARATE, EXCEPTED COVERAGE PERMITTED- Nothing in--

(A) paragraph (1) shall prevent the offering of excepted benefits described in section 2791(c) of the Public Health Service Act so long as such benefits are offered outside the Health Insurance Exchange and are priced separately from health insurance coverage; and

(B) this division shall be construed--

(i) to prevent the offering of a stand-alone plan that offers coverage of excepted benefits described in section 2791(c)(2)(A) of the Public Health Service Act (relating to limited scope dental or vision benefits) for individuals and families from a State-licensed dental and vision carrier; or

(ii) as applying requirements for a qualified health benefits plan to such a stand-alone plan that is offered and priced separately from a qualified health benefits plan.