Summary of the CARES Act
The Children’s Access to Reconstructive Evaluation & Surgery (CARES) Act of 2009 amends the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code to require a group health plan that covers surgical benefits to also cover outpatient and inpatient diagnosis and treatment of a congenital or developmental deformity, disease, or injury of a minor child (defined as child under the age of 22).

CARES Act also requires that such coverage: (1) be subject to pre-authorization or pre-certification requirements of the plan or issuer; and (2) include any surgical treatment deemed by the treating physician to be medically necessary to approximate a normal appearance. Defines "treatment" to include reconstructive surgical procedures that are performed on abnormal structures of the body caused by congenital defects, abnormalities, trauma, infection, tumors, or disease, including: (1) procedures that do not materially affect the function of the body part being treated; and (2) procedures for secondary conditions and follow-up treatment. Excludes cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

Summary of Pre-Existing Condition Regulations
Expansion of HIPAA. HIPAA generally defines a preexisting condition exclusion as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Based on this definition, PHS Act section 2704, as added by the Patient Protection and Affordable Care Act (PPACA), prohibits not just an exclusion of coverage of specific benefits associated with a preexisting condition in the case of an enrollee, but a complete exclusion from such plan or coverage, if that exclusion is based on a preexisting condition. Therefore, the new regulations not only protect against the denial of specific benefits but also the denial of enrollment.

Maintenance of HIPAA. The interim final regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage.

Application to children. The Affordable Care Act provides that these protections apply with respect to enrollees under age 19 for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

Grandfathered plans. The new pre-existing condition requirements apply to all plans or coverage, except for grandfathered individual policies.
**Potential effect.** The Administration estimates that 51,000 uninsured children with preexisting conditions could gain coverage as a result of these interim final regulations, with a possible range between 31,000 and 72,000.

**Remaining Gaps**

**Definition of a “child.”** CARES Act defines children up to age 22; regulations, 19.

**No explicit definition of “treatment.”** While the CARES Act includes a specific definition of “treatment”, the new regulations do not encompass that definition. However, future regulations may help define treatments, including the process to define the essential benefits required by qualified health plans.

**Grandfathered plans.** Grandfathered individual policies are not covered by this new regulation. An estimated 90,000 children covered by individual insurance with a condition waiver (or with a period during which coverage for a preexisting condition is excluded). The individual market issuers who insure these estimated 90,000 children with a condition waiver may decide to remain grandfathered health plans and thus these children will not be directly affected by these interim final regulations. However, the parents of those children could choose to switch from an individual policy that is a grandfathered health plan to a new policy that is not grandfathered, although the premium that they pay for such coverage could increase. Similarly, for those children currently covered but in a preexisting condition exclusion period, curtailing the exclusion period would require the termination of the current plan and purchase of a policy on or after September 23, 2010.

**Gaps in HIPAA.** As explicitly mentioned by the regulations, certain HIPAA gaps remain. Specifically, the interim final regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage. Therefore, health plans could opt not to cover any reconstructive surgery, regardless of when it occurred or its cause, and still be in compliance with the latest preexisting condition regulations.

**Medical Necessity.** Many later-stage reconstructive surgeries are denied based on the assertion that it does not restore function and therefore is labeled cosmetic. The regulations do not define medical necessity. However, it is possible that medical necessity may be defined as part of the process required to establish uniform definitions of standard insurance terms and medical terms (section 2715(b)(3)(A)).