NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

FACT SHEET

The Patient CARE Act – Second Verse, Same as the First

February 2015

Senator Hatch, Senator Burr, and Representative Upton recently unveiled the 2015 iteration of the Patient CARE Act, a proposal that would significantly roll back the health coverage, guaranteed benefits, and consumer protections women and their families enjoy under current law. This proposal would completely repeal the Affordable Care Act (ACA) and substitute limited reforms that would result in higher costs and more limited coverage. The Patient CARE Act has not been introduced in Congress, so legislative language is not yet available, but summary documents reveal how dramatically this proposal – like its 2014 predecessor – would undermine women's access to affordable health insurance and comprehensive health care.

The CARE Act would lead to higher health care costs and less coverage for women

• The CARE Act would lead to higher costs for women and families:

- **This discriminatory proposal would allow insurance companies to charge women more for health insurance.** The ACA's insurance reforms ended individual and small group plans' practice of charging women more for health insurance simply because they are women. In the past, this practice cost women approximately $1 billion per year in higher premiums, with insurance plans charging women up to 85 percent more than men for the same policy – even when maternity services are not covered.[1] This proposal would eliminate existing protections, and women would again face higher premiums than men for the same coverage, although their health insurance may not cover maternity and other benefits women need.
- **Women could also be charged more if they have pre-existing conditions.** Today, plans cannot deny coverage or charge higher premiums based on a woman's medical history, but the CARE Act would wipe out these protections for women with pre-existing conditions. Insurance companies could refuse to sell women a policy or charge them more based on their medical history if they are not continuously insured. For example, under this proposal, health plans could refuse to cover a woman who has a single gap in health insurance because she had a cesarean delivery, which they can consider a pre-existing condition.
- **Changes in the tax code would hurt women and families.** The CARE Act would impose a new tax on women and families by taxing a portion of employer-sponsored health benefits. This would increase income taxes for some of the 57 million women who have health insurance through their employers or a family member's employer.[2]

• The CARE Act would result in millions of women losing coverage:

- **This proposal eliminates new Medicaid coverage and limits the financial help women and families use to pay for private insurance.** States currently may offer Medicaid coverage to all individuals with incomes below about $16,000 a year, and families earning less than about $33,000 a year. In addition, many women and families with somewhat higher incomes receive income-based tax credits and cost sharing reductions to help with the cost of private coverage. These affordable coverage options would be repealed or significantly reduced in the CARE Act. For example, this proposal would reduce eligibility for tax credits, and – depending on age, income, and where a woman lives – in many cases reduce the value of the tax credit as well. More than 3.5 million women received help with premiums in 2014[3]– but when faced with higher costs and more limited benefits under the CARE Act, many women would become uninsured or forgo needed care.

• The CARE Act would lead to worse health coverage for women and their families:

- **The CARE Act eliminates important guaranteed health benefits for women and families.** Insurance plans would no longer have to cover essential health benefits, so plans would not be required to cover important health services such as maternity care, preventive care and screenings, birth control, or disease management for chronic conditions. Today, women's preventive services are also available without cost sharing, but under this proposal, insurance companies and employer plans could charge women co-payments for, or decide not to cover, services like birth control and well-woman visits.

- **This proposal caps federal Medicaid funding, which would lead to less coverage and higher costs for low-income women and families.** Beyond eliminating the ACA's Medicaid expansion, this proposal would cut federal Medicaid funding for the traditional Medicaid program. The CARE Act would provide a fixed allotment of federal funding to states each year, rather than matching funds that can grow depending on enrollment, health care cost growth, and use of services. States could therefore face a financing shortfall, and may need to reduce eligibility rules, cut covered services, or pass costs on to women with Medicaid coverage. The proposal gives states wide-open flexibility to make dramatic changes such as reducing eligibility, imposing cost sharing, limiting benefits, and lowering payments to providers – and any of these choices would ultimately reduce low-income women's access to care.

- **States would also have limited federal Medicaid funding for long term care services and supports.** Women rely on long term care services more than men and are more likely to care for family members who do not have other sources of help with long term care. The proposal would cap federal funding for long term care and hurt women by restricting access to critical services for themselves and their loved ones.

1. Danielle Garrett, National Women's Law Center, *Turning to Fairness*, (March 2012) available at http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.
2. Kaiser Family Foundation, "Women's Health Insurance Coverage," (2013) available at http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/.
3. U.S. Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Open Enrollment Period*, (May 1, 2014) available at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.