

January 2014 | Issue Brief

# Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.

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## EXECUTIVE SUMMARY

Lesbian, gay, bisexual, and transgender (LGBT) individuals often face challenges and barriers to accessing needed health services and, as a result, can experience worse health outcomes. These challenges can include stigma, discrimination, violence, and rejection by families and communities, as well as other barriers, such as inequality in the workplace and health insurance sectors, the provision of substandard care, and outright denial of care because of an individual's sexual orientation or gender identity.<sup>1,2,3</sup>

While sexual and gender minorities have many of the same health concerns as the general population, they experience certain health challenges at higher rates, and also face several unique health challenges. In particular, research suggests that some subgroups of the LGBT community have more chronic conditions as well as higher prevalence and earlier onset of disabilities than heterosexuals. Other major health concerns include HIV/AIDS, mental illness, substance use, and sexual and physical violence. In addition to the higher rates of illness and health challenges, some LGBT individuals are more likely to experience challenges obtaining care. Barriers include gaps in coverage, cost-related hurdles, and poor treatment from health care providers.

Several recent changes within the legal and policy landscape serve to increase access to care and insurance for LGBT individuals and their families. Most notably the implementation of the Affordable Care Act (ACA) and the Supreme Court's overturning of a major portion of the Defense of Marriage Act (DOMA), as well as recent steps taken by the Obama Administration to promote equal treatment of LGBT people and same-sex couples in the nation's health care system have reshaped policy affecting LGBT individuals and their families. The ACA expands access to health insurance coverage for millions, including LGBT individuals, and includes specific protections related to sexual orientation and gender identity. The Supreme Court ruling on DOMA resulted in federal recognition of same-sex marriages for the first time, which also serves to provide new health insurance coverage options. In addition, President Obama's administration has undertaken a variety of other initiatives to improve the health and well-being of LGBT individuals, families, and communities.<sup>4</sup>

This issue brief provides an overview of what is known about LGBT health status, coverage, and access in the United States, and reviews the implications of the ACA, the overturning of DOMA, and other recent policy developments for LGBT individuals and their families going forward.

## THE LGBT COMMUNITY

While there is no single definition of the “LGBT community” – indeed, it is a diverse and multidimensional group of individuals with unique identities and experiences, and variations by race/ethnicity, income, and other characteristics – LGBT individuals share the common experience of often being stigmatized due to their sexual orientation, gender identity, and/or gender expression.<sup>5</sup> In its landmark 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, the Institute of Medicine defines *sexual orientation* as “an enduring pattern of or disposition to experience sexual or romantic desires for, and relationships with, people of one’s same sex, the other sex, or both sexes.”<sup>6</sup> This definition incorporates elements of attraction, behavior, and identity. It is important to note that for some individuals, their sexual identity does not necessarily fall into any specific category but, rather, exists along a spectrum. In addition, not all persons who engage in same-sex behavior or experience same-sex attraction identify as lesbian, gay, or bisexual.

*Gender Identity* refers to “an individual’s internal sense of being male, female, or something else. Since gender identity is internal, one’s gender identity is not necessarily visible to others.”<sup>7</sup> Additionally, *gender expression* and *gender role conformity* further describe the extent to which a person does or does not adhere to expected gender norms and roles. *Transgender* refers to individuals whose sex at birth is different from their identity as male, female, or elsewhere along the gender spectrum. People who identify as transgender may live their lives as the opposite gender, and may seek prescription pharmacologic therapy and/or surgical transformation. Transgender people may identify as heterosexual, lesbian, gay, or bisexual, or somewhere else along the spectrum of sexual identity.

Lastly, while sexual orientation and gender identity are important aspects of an individual’s identity, they interact with many other factors, including sex, race/ethnicity, and class. The intersection of these characteristics helps to shape an individual’s health, access to care, and experience with the health care system.

## POPULATION CHARACTERISTICS

Assessing the health needs and barriers to care of the LGBT population has been challenging due to the historical lack of data collection on sexual orientation and gender identity. While some health surveys have asked about sexual orientation, it has not been routine to collect and analyze data on sexual orientation and gender identity in many major health surveys, particularly nationally representative ones, meaning that much of the data available to date have been from smaller, non-representative studies and convenience samples. Where data have been collected, they have mostly focused on same-sex couples using data systems that collect information on relationship status.<sup>8</sup> In addition, where data are available for individuals, there is more information about lesbian, gay, and bisexual persons than transgender individuals. There has been growing recognition of the need for research focused on the LGBT community, and the ACA has new data collection requirements on disparities, which include sexual orientation and gender identity (described below).

A review of studies to date indicates the following:

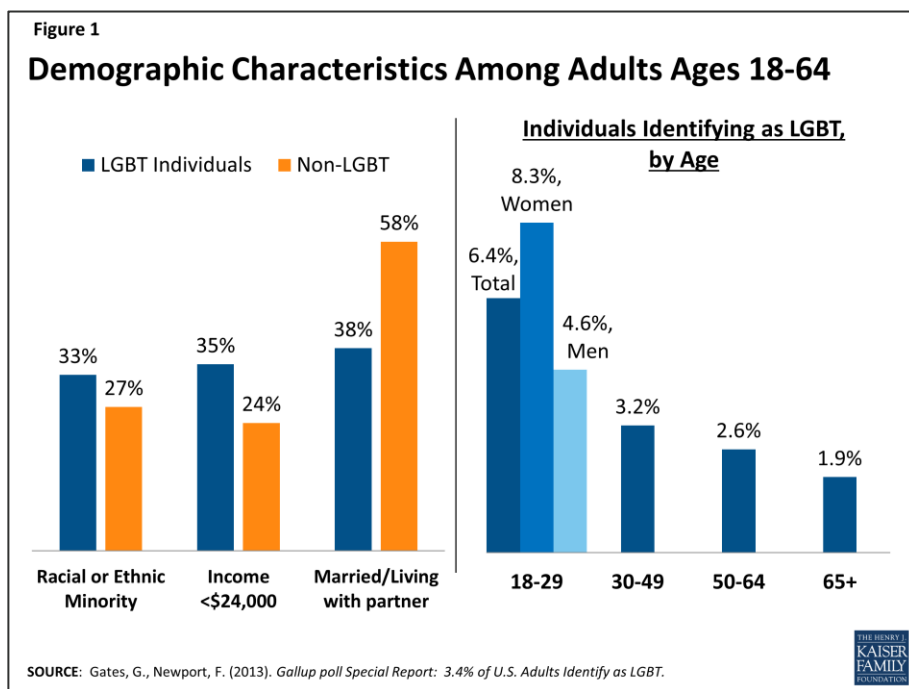
- The most recent national estimates of the size of the LGBT population are from a 2012 Gallup poll, which found that 3.4% of Americans, or more than 9 million people, identify as LGBT.<sup>9,10</sup> It is important to note

that such estimates include only those who self-identify as LGBT and do not include those who may have engaged in same-sex behavior or have same-sex attraction but do not identify as gay, lesbian, or bisexual. Prior studies have looked beyond self-identification, including one that found that 10% of adults reported experience with same-sex partners.<sup>11</sup> Pooled data from 2006-2010 from the National Survey of Family Growth found that 5.1% of women and 3.0% of men, ages 18-44, self-identified as gay, lesbian, or bisexual.<sup>12</sup> In addition, a recent analysis indicates that standard survey measures appear to significantly underestimate non-heterosexual identity and same-sex sexual experiences.<sup>13</sup>

- According to the Gallup poll, the share of adults who identify as LGBT ranges from a low of 1.7% in North Dakota to 10% in the District of Columbia.<sup>14</sup> This range could reflect local policies and societal attitudes regarding LGBT equality, which may be correlated with an individual's willingness to self-identify as a LGBT or live in a certain locale.
- Racial and ethnic minorities, young people, and women are more likely than their counterparts to identify as LGBT (**Figure 1**).<sup>15</sup>

- One in five (20%) LGBT individuals indicate they are married, and an additional 18% are in a domestic partnership or living with a partner (some of whom could be in heterosexual marriages or domestic partnerships).

- According to the 2012 American Community Survey, same-sex couples are less likely than both married and unmarried heterosexual couples to be raising children.<sup>16</sup> Just over 40% of married and unmarried heterosexual couples are raising children,



compared to 18% of same-sex couples, 11% of male same-sex couples and 24% of female same-sex couples.

- Compared to the general population, sexual and gender minorities are disproportionately poor overall, but there is variation between subgroups. A recent Pew Research poll of LGBT individuals found that about 4 in 10 (39%) earned \$30,000 or less per year, compared to 28% of the U.S. population overall.<sup>17</sup> Poverty rates on average are higher among lesbian and bisexual women, young people, and African Americans.<sup>18</sup> According to an analysis of the 2006-2010 National Survey of Family Growth, more than one-quarter (28%) of lesbian and bisexual women are poor, compared with 21% of heterosexual women.<sup>18</sup> Just over 1 in 5 gay and bisexual men (23%) are poor, compared to 15% of heterosexual men. However, when comparing couples, lesbian couples have the highest poverty rates, followed by heterosexual couples and male same-sex couples.<sup>18</sup> Further, a recent survey of more than 6,400 transgender people from across the U.S. found that the transgender population is approximately 4 times as likely as the non-transgender population to have an annual income of less than \$10,000.<sup>19</sup>

## HEALTH CHALLENGES

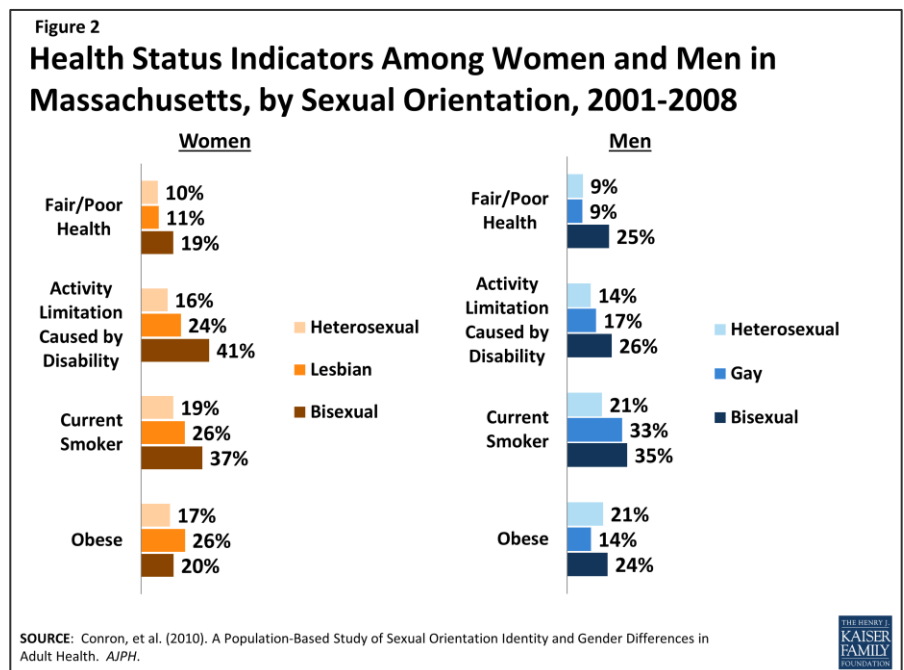
Health is shaped by a host of social, economic, and structural factors.<sup>20</sup> For LGBT individuals, these factors include the experience and impact of discrimination, stigma, and ostracism which affect health outcomes, access, and experience with health care.<sup>21, 22, 23</sup> Research available to date finds that while sexual and gender minorities have many of the same health concerns as the general population, they experience some health challenges at higher rates, and face several unique health challenges.

## CHRONIC CONDITIONS

Studies have found that sexual and gender minorities experience worse physical health compared to their heterosexual and non-transgender counterparts.<sup>24, 25</sup>

- A recent literature review found that self-identified LGB<sup>26</sup> individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities. Overall, LGB people report more asthma diagnoses, headaches, allergies, osteoarthritis, and gastro-intestinal problems than heterosexual individuals.<sup>27</sup>
- Additionally, there are differences between subgroups within the LGBT community. Lesbian and bisexual women report poorer overall physical health and higher rates of asthma, urinary tract infections, and Hepatitis B and C than heterosexual women. Lesbian and bisexual women also report heightened risk for and diagnosis of some cancers and higher rates of cardiovascular disease diagnosis. Similarly, gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions such as headaches and urinary incontinence than heterosexual men.<sup>28</sup>

- According to a study of Massachusetts residents, one of the few published studies that examines health status between different subgroups of LGB individuals, approximately one in ten heterosexual people, lesbian women, and gay men in the state rate their health as “fair” or “poor.” The rate is approximately twice as high among bisexual adults (**Figure 2**).<sup>29</sup>



- More than twice as many bisexual women experience activity limitations caused by disability than heterosexual women. Similarly, bisexual men are also much more likely to experience activity limitations caused by disability compared to heterosexual men.
- In addition to health outcomes, on average LGB individuals have higher rates of risk factors for chronic illnesses. Obesity rates are higher among lesbian and bisexual women compared to heterosexual women, but are lowest among gay men. Among both women and men, smoking rates are highest among bisexual groups,

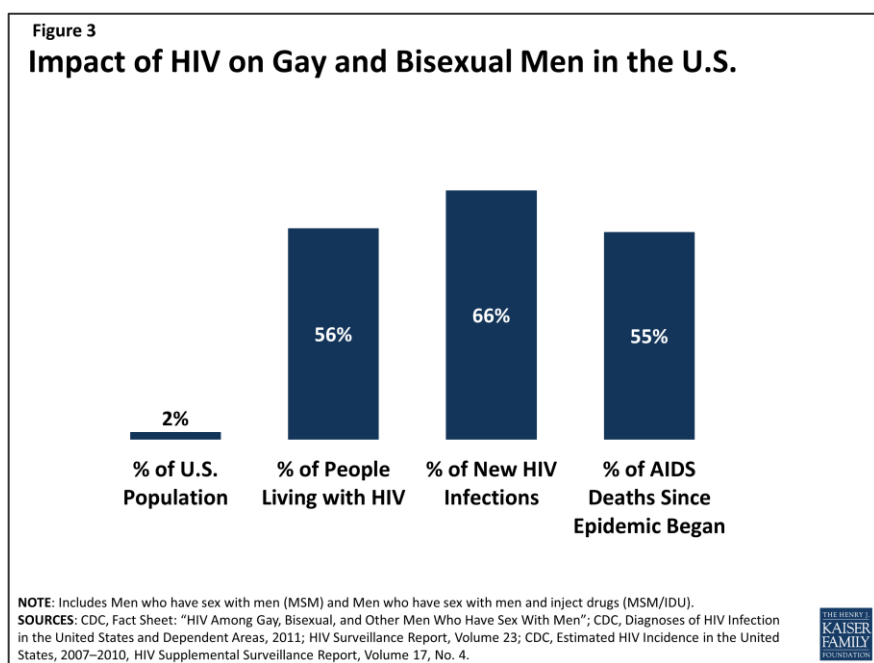
followed by lesbian and gay persons, and lowest among heterosexual people. A meta-analysis of several studies found that overall, LGBT people smoke cigarettes at 1.5 to 2.5 times the rate of heterosexual and non-transgender people.<sup>30</sup>

- According to another study of Massachusetts residents, transgender persons are the least likely among LGBT individuals to self-report their health as *Excellent* or *Very Good* (67% vs. 79%) and are twice as likely to report limitations in daily activities due to impairment of health problems (33% vs. 16%).<sup>31</sup>

## HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS (STIS)

One of the most significant health challenges facing the LGBT community has been the HIV/AIDS epidemic's impact on gay and bisexual men, and there are increasing data on the disproportionate impact of HIV on transgender women. After experiencing a dramatic rise in new infections in the 1980s, efforts by the gay community and public health officials helped to bring HIV incidence down; however, in recent years, new infections among gay and bisexual men in the U.S. have been on the rise, the only group for which infections are increasing (**Figure 3**).

- In 2010, gay and bisexual men and other men who have sex with men (MSM), while representing an estimated 2% of the U.S. population, accounted for more than half (56%) of all people living with HIV in the United States, and two-thirds (66%) of new HIV infections.<sup>32</sup>
- Between 2008 and 2010, the rate of new HIV infections among young black MSM increased by 20%, the highest increase among all sub-populations. Black MSM accounted for 36% of new HIV infections in 2010.<sup>33</sup>



- Transgender women, particularly transgender women of color, are also at high risk of HIV. Studies have found that more than one in four (28%) are HIV positive,<sup>34</sup> and a majority are unaware that they are infected.
- To date, there have been no confirmed cases for female-to-female sexual transmission of HIV in the United States.<sup>35</sup> However, HIV is an issue that affects lesbians as well as bisexual women, since individuals who identify as lesbian may still have sexual relationships with men, and lesbians and bisexual women are also at risk of HIV via transmission modes that do not involve sexual contact (such as injection drug use).
- STI rates are higher among some LGB groups than heterosexuals, and rates have been increasing for some infections. For example, MSM account for more than seven in ten (72%) new syphilis cases, an alarming increase that has re-emerged during the last several years.<sup>36</sup> MSM also account for 15%–25% of all new Hepatitis B infections.<sup>37</sup> Given the strong interaction between HIV and other STIs, this is a particular concern for MSM.



- Human Papillomavirus (HPV) is the most common STI, and is a major cause of cervical, anal, and mouth cancers.<sup>38</sup> MSM are seventeen times more likely to develop anal cancer than men who only have sex with women.<sup>39</sup> The HPV vaccine, which protects against certain strains of the virus that are associated with anal cancer, could reduce anal cancer rates among future generations of MSM.

## MENTAL HEALTH AND SUBSTANCE USE

Research has found that LGBT individuals are at elevated risk for some mental health and behavioral health conditions, with studies finding that they are two and a half times more likely to experience depression, anxiety, and substance misuse.<sup>40,41</sup> The history of discrimination and stigma contributes to higher rates of mental illness.<sup>42</sup> In fact, until the 1970s, homosexuality was considered a mental illness in the Diagnostic and Statistical Manual (DSM) of Mental Disorders and by various professional organizations. The diagnosis “gender dysphoria,” which has replaced the transgender diagnosis in the DSM, is intended to communicate the emotional distress that transgender people may experience as well as promote insurance coverage of services related to gender transition, such as counseling or hormone therapy, that typically have not been covered by insurance plans.<sup>43</sup> Still, stigma and prejudice against sexual and gender minorities remain pervasive and continue to have negative consequences for the mental health of the LGBT population.<sup>44</sup>

LGBT adults experience higher rates of mental illness, substance abuse, and discrimination compared to heterosexual and non-transgender adults. Additionally, lack of acceptance from family members is correlated with higher rates of mental illness and substance use among the LGBT population.<sup>45</sup>

- A few studies have attempted to estimate population-based rates of substance use among gay men; however data from these studies are older and not necessarily comparable to the heterosexual population. For the few studies that do allow for comparisons, rates are higher among MSM. An estimated 25% of LGBT adults abuse alcohol, compared to 5-10% of the general population.<sup>46</sup> MSM are more than 12 times as likely to use amphetamines and almost 10 times as likely to use heroin as heterosexual men.<sup>47</sup> Studies have found lesbians “more often smoke cigarettes and drink alcohol to excess” than heterosexual women.<sup>48</sup>
- More studies have used state-level data or sample populations to identify mental health trends among LGBT individuals. Nearly one fifth (19%) of bisexual adults in Massachusetts report they had recently seriously considered suicide, compared to 4% of lesbian and gay adults and 3% of heterosexuals.<sup>49</sup> There are notable differences between subgroups, with the rate highest among bisexual women (26%), followed by bisexual men (11%), gay men (6%), and approximately 3% among all other subgroups. Another nationwide study found a reported 41% prevalence of suicide attempts among the transgender population.<sup>50</sup>

## SEXUAL ASSAULT AND PHYSICAL VIOLENCE

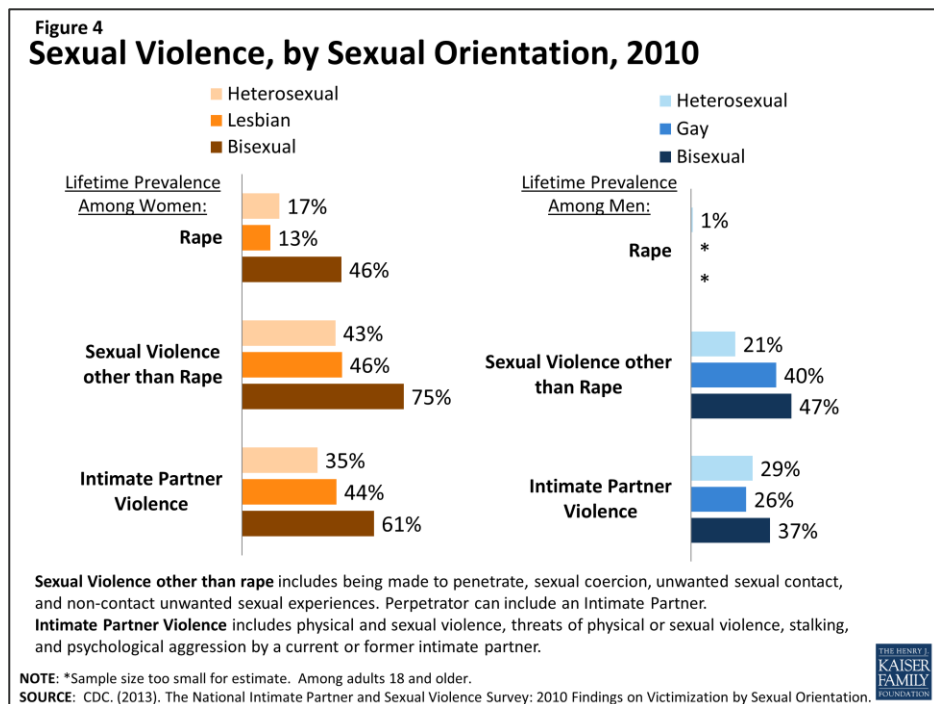
Sexual assault and physical violence can have lasting consequences for victims, families, and communities.<sup>51</sup> LGBT individuals experience higher rates of sexual and physical violence compared to heterosexual and non-transgender individuals. Violence toward LGBT people has inspired public policy responses. For example, federal legislation as well as some state laws allow for the classification of violence based on gender identity or sexual orientation bias as a “hate crime,” which has implications for penalties as well as funding to states and locales for deterrence and surveillance of these crimes.<sup>52</sup> Key statistics include the following:

- A recent poll of LGBT adults found that two thirds had experienced some form of discrimination because of their sexual orientation or gender identity, including subjection to slurs, rejection by a friend or family member, being physically threatened or attacked, receiving poor service at a place of business or treated unfairly by an employer, or made to feel unwelcome at a place of worship; a full 30% said they had been physically threatened or attacked.<sup>53</sup>

- Many women and men have experienced some form of sexual violence, but the rates are significantly higher among some LGBT groups. It is estimated that almost half (46%) of bisexual women have been raped, as have 17% of heterosexual and 13% of lesbian women. More than four in ten heterosexual and lesbian women and the majority (75%) of bisexual women have experienced other forms of sexual violence, such as coercion or harassment. Six in ten (61%) bisexual women have encountered intimate partner violence (IPV), as have 44% of lesbian and 35% of heterosexual women (Figure 4).<sup>54</sup>

- While sexual violence rates are higher among women overall, bisexual and gay men experience significantly higher rates than heterosexual men. Four in ten gay men and nearly half of bisexual men have encountered sexual violence other than rape. More than one-third (37%) of bisexual men have faced partner violence. For both men and women, the perpetrators were predominantly male.

- Anti-LGBT bias also puts LGBT people at risk for physical violence. According to the FBI’s crime reporting surveillance, one in five hate crimes was due to sexual orientation bias.<sup>55</sup> Studies using convenience samples have shown a significant number of LGBT individuals have been victims of physical and verbal assaults, as well as personal property damage, due to their sexual orientation or gender identity.<sup>56</sup> One recent nationally representative study examined self-reported experiences with physical violence due to sexual orientation among gay men, lesbian women, and bisexual individuals, and found almost 8% of individuals have experienced physical violence once and 5.5% have experience physical violence at least twice. Gay men were the most likely to experience physical violence due to their sexual orientation.<sup>57</sup> Transgender people, particularly transgender women and transgender people of color, are also at particular risk of physical violence.<sup>58</sup> Statistics from the National Coalition of Anti-Violence Programs indicate that half of the victims of anti-LGBT bias-motivated murders in 2012 were transgender women and the majority were also people of color.<sup>59</sup>



## ADOLESCENT AND YOUNG ADULT HEALTH

Adolescence and young adulthood are often times when individuals begin to identify as LGBT.<sup>60</sup> While these times can be challenging for many individuals, they are often especially so for LGBT youth. Despite growing societal acceptance and understanding, some young people still suffer discrimination at the hands of their

family and friends and in their schools and communities, experiences which can lead to serious challenges, such as housing problems, that affect health. There is growing awareness about bullying and violence affecting LGBT youth. These include efforts to promote greater attention to fostering inclusive school climates, teaching youth about online safety, establishment of reporting processes in schools and communities when violence or bullying occur, and referring young people for professional mental and behavioral health services when needed. Key statistics include the following:

- Like their adult counterparts, youth who identify as a sexual and/or gender minority experience higher rates of mental illness, substance abuse, violence, and discrimination compared to the general population. Additionally, LGBT youth are more likely to be homeless and live in poverty than non-LGBT youth. Research has found that parental rejection can increase the likelihood that an LGBT youth will suffer from depression, attempt suicide, use illegal drugs, and/or engage in risky sexual behaviors.<sup>61</sup>
- Approximately 40% of homeless youth are LGBT, and the leading reasons for homelessness among this group due to family rejection.<sup>62</sup>
- Almost two thirds (64%) of LGB students and 4 out of 10 (44%) transgender students report feeling unsafe at school because of their sexual orientation or gender identity.<sup>63</sup>
- LGB youth are four times more likely to attempt suicide than heterosexual youth.<sup>64</sup>
- Three times as many LGB youth report ever being raped, compared to their heterosexual peers (16% vs. 5%).<sup>64</sup>

## INSURANCE COVERAGE AND ACCESS TO CARE

Research has shown that LGBT populations have different patterns of health coverage and utilization of services and has begun to document gaps within the delivery system in meeting the needs of the LGBT population.

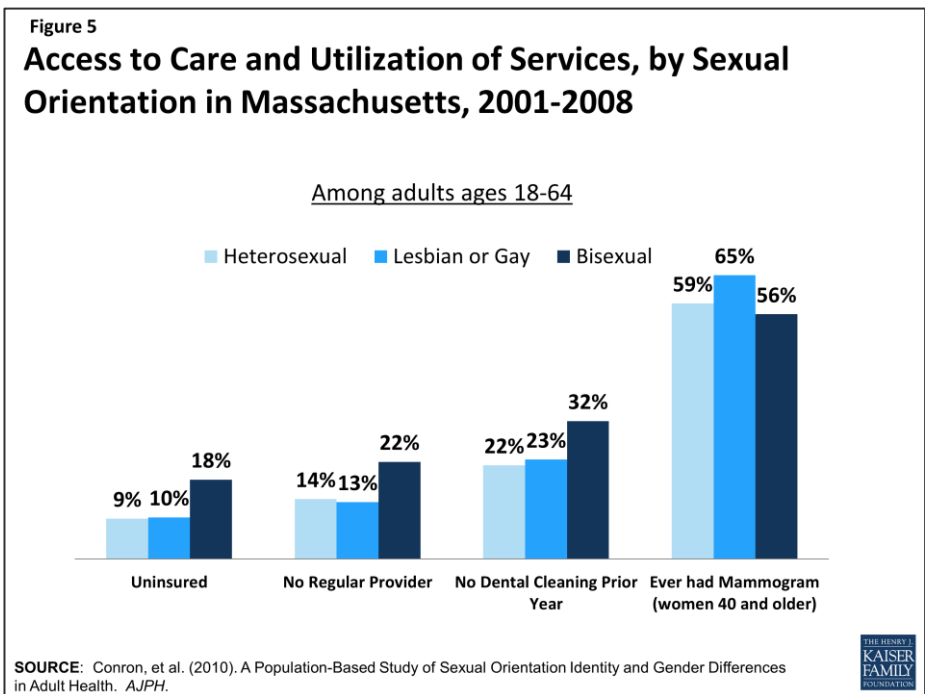
- A recent survey found that, of the close to 5.5 million LGBT individuals estimated to have incomes under 400% of the federal poverty level (FPL), one in three are uninsured currently and more than two-thirds have been uninsured for more than two years.<sup>65</sup> Among this group, LGBT individuals with insurance are less likely than individuals in the general population to get insurance through their employer and more likely to be enrolled in Medicaid. Additionally, almost 4 in 10 have medical debt and more than 4 in 10 report postponing medical care due to costs.<sup>66,67</sup>
- Since there are few studies on the LGBT population nationally as a whole, it is informative to look at some state-level estimates. Currently, an estimated 15% of the LGB population resides in California, and the California Health Interview Survey (CHIS) is one of the few state-level health surveys that regularly collect information on sexual orientation and health coverage. According to the 2008 CHIS, 77% of LGB adults in the state have health insurance, compared to 82% of heterosexual adults.<sup>68</sup> Among same-sex couples, estimates of the uninsured range from 11%<sup>69</sup> to 17%.<sup>70</sup> In a study of transgender adults, 19% were uninsured compared to 15% of heterosexual people. As with the general population, uninsured rates were higher among transgender persons of color compared to those who are white.<sup>71</sup>
- Research studies on same-sex couples find that LGB individuals have higher rates of unmet medical need because of cost and are less likely to have a regular provider.<sup>70</sup> Research has also found that women in same-



sex couples are less likely than heterosexual married women to have received timely medical care for both primary and specialty services. Among men in couples, gay men are three times as likely as their heterosexual counterparts to report delays in obtaining needed prescription medicines.<sup>72</sup>

- Some studies have found that lesbian women in couples have lower rates of breast and cervical cancer screenings than married heterosexual women.<sup>73</sup> In addition to lower mammography rates, lesbian women on average have higher rates of some risk factors for breast cancer, including greater alcohol use and lower likelihood of childbearing.<sup>74,75</sup>
- The available research on LGBT people is often limited to couples or combines lesbian, gay, and bisexual people while excluding transgender people. Studies that have stratified between these different groups suggest that there are important differences in access that are often masked in more aggregated studies. In particular, research finds that on some measures, bisexual individuals have more limited access to care while lesbian and gay individuals have rates comparable to heterosexual adults (**Figure 5**).

- The transgender population is much more likely to live in poverty and less likely to have health insurance than the general population. Research reflects the impact of these barriers. In one survey of transgender individuals, nearly half (48%) of respondents postponed or went without care when they were sick because they could not afford it.<sup>76</sup> In addition, many health plans include transgender-specific exclusions that deny transgender individuals coverage of services provided to non-transgender individuals, such as surgical treatment related to gender transition, mental health services, and hormone therapy.<sup>77</sup>



- An individual's relationship with providers is another important component of access to care. Significant shares of LGBT individuals report negative experiences when seeking care, ranging from disrespectful treatment from providers and staff, to providers' lack of awareness of specific health needs. In a survey of LGB people, more than half of all respondents reported that they have faced cases of providers denying care, using harsh language, or blaming the patient's sexual orientation or gender identity as the cause for an illness.<sup>78</sup> Fear of discrimination may lead some people to conceal their sexual orientation or gender identity from providers or avoid seeking care altogether.
- For transgender persons, discrimination may be as personal as refusing to use the patient's chosen name or as structural as providers' lack of knowledge about how to provide appropriate care to transgender people. For example, most transgender men still have a cervix and should be screened for cervical cancer, which requires a sensitive approach.<sup>79</sup> Studies of the transgender community show that up to 39% of transgender

people have faced some type of harassment or discrimination when seeking routine health care, and many report being denied care outright or encountering violence in health care settings.<sup>68, 80, 81</sup>

- Medical education does not routinely encompass LGBT health issues. More than half of medical schools and public health school curricula lack instruction about the health concerns of LGBT people beyond work related to HIV/AIDS.<sup>82, 83</sup> However, the medical community's awareness of LGBT health needs has grown. Several professional medical societies have formed policies and guidance that advocate on behalf of fair treatment and access for LGBT patients and health providers.<sup>84</sup> For example, the American Medical Association (AMA) has issued an explicit nondiscrimination policy as well as numerous other statements that recognize prior discriminatory practices in the medical setting, the importance of better understanding and addressing LGBT health needs, the impact of discrimination on health and well-being, and the need to include sexual orientation in research. The World Professional Association for Transgender Health also maintains a set of standards and principles to guide health care professionals in providing health care to transgender people.<sup>85</sup> Additionally, in 2011, the Joint Commission, an independent non-profit national organization that accredits and certifies more than 20,000 health care organizations and programs in the U.S., began to require that hospitals prohibit discrimination based on sexual orientation, gender identity and gender expression in order to be accredited.<sup>86</sup>

## IMPACT OF POLICIES ON COVERAGE AND ACCESS TO CARE

In addition to specific health needs, the health of and access to care for LGBT communities is shaped by federal and state policies on insurance, compensation and benefits, and marriage. In 2010, President Obama asked the Secretary of Health and Human Services (HHS) to identify steps to improve the health and well-being of LGBT individuals, families, and communities, which resulted in a series of recommended actions that are now being implemented.<sup>87</sup> Additionally, the passage of the ACA in 2010 and the overturning of DOMA in 2013 affects access to care and coverage for LGBT individuals and their families, expands nondiscrimination protections, increases data collection requirements, and supports family caregiving. Finally, states and private organizations have also moved to add nondiscrimination protections and enhance coverage for LGBT individuals.

### IMPACT OF THE ACA

The ACA makes far-reaching changes in health coverage and delivery of care for all Americans. For LGBT populations, three major areas are of particular saliency: 1) expanded access to coverage and insurance market reforms, 2) new “nondiscrimination” protections, and 3) requirements for data collection and research.

#### *Coverage*

- The ACA will extend coverage to millions of uninsured persons through the expansion of Medicaid in some states, as well as the creation of new federally subsidized health insurance marketplaces. In states that expand their Medicaid programs, Medicaid eligibility will be based solely on income, and will be available to most individuals with incomes below 138% FPL regardless of their family status or disability. Uninsured individuals who are not eligible for Medicaid can purchase coverage in insurance marketplaces, with subsidies available to many individuals with incomes below 400% FPL to help offset the costs of premiums. It is estimated that nearly 390,000 uninsured LGBT individuals could qualify for Medicaid in states that plan

to expand Medicaid, and that approximately 1.12 million uninsured LGBT individuals could receive subsidies to help with the cost of coverage in insurance marketplaces.<sup>88</sup>

- As of January 2014, individuals can no longer be denied insurance due to a pre-existing condition, such as HIV infection, mental illness, or a transgender medical history. Additionally, new private plans are now required to cover recommended preventive services without cost sharing. This includes screenings for HIV, STIs, depression, and substance use. And, those who gain coverage through Medicaid or in the state marketplaces will have coverage for a set of essential health benefits, including prescription drugs and mental health services.

### ***Nondiscrimination Protections***

- As described above, bias and discrimination in the health care system have been an unfortunate reality for many LGBT people.<sup>89</sup> In addition to provider level discrimination, some policies in the insurance and financing system have disproportionately affected LGBT people, including pre-existing condition clauses permitting plans to deny insurance to people with conditions such as HIV, mental illness, or to transgender individuals, who may require specific health care services.<sup>90</sup> Furthermore, some plans have interpreted these exclusions broadly and used them to deny transgender people coverage for services that are not related to gender transition.<sup>91</sup>
- Section 1557 of the ACA prohibits discrimination based on sex, defined to include gender identity and sex stereotypes (but not sexual orientation), in any health program receiving federal funds (such as Medicaid, Medicare, and providers who receive federal funds). Separate federal regulations issued by the Department of Health and Human Services governing the health insurance marketplaces and plans offering the essential health benefits bar discrimination in insurance provisions based on sexual orientation and gender identity.<sup>92</sup> In addition to the new federal law, several states have nondiscrimination policies. Seven states plus DC have protections for sexual orientation and gender identity and one state has protections for sexual orientation only.<sup>93</sup>

### ***Data Collection***

- The ACA calls for the inclusion of routine data collection and surveillance on health disparities, which HHS and many other groups have recognized includes LGBT populations. National health care surveys will include questions on sexual orientation within the next couple of years so that analysis can be conducted specifically on LGB populations; efforts to develop questions on gender identity for national surveys are underway as well. Research on LGBT health has increased over time, and HHS has sponsored efforts to collect and report data on LGBT health, as evidenced with the inclusion of LGBT-specific data in publications such as the National Healthcare Disparities Report, the addition of Healthy People 2020 goals to increase routine data collection efforts on LGBT populations, and early efforts of collection and surveillance on sexual orientation and gender identity in national health care surveys.<sup>94</sup> As of 2013, HHS has added a sexual orientation question to the National Health Interview Survey (NHIS), the principal source of information on the health of the U.S. population, and several agencies within HHS have taken steps toward broader data collection. For example, the CDC has approved sexual orientation and gender identity questions that can be used on the state-administered Behavioral Risk Factor Surveillance System surveys and the Substance Abuse and Mental Health Services Administration is considering adding questions to its National Survey on Drug Use and Health. However, it is still not routine for researchers and health data systems to collect and report data by individuals' sexual orientation and gender identity.

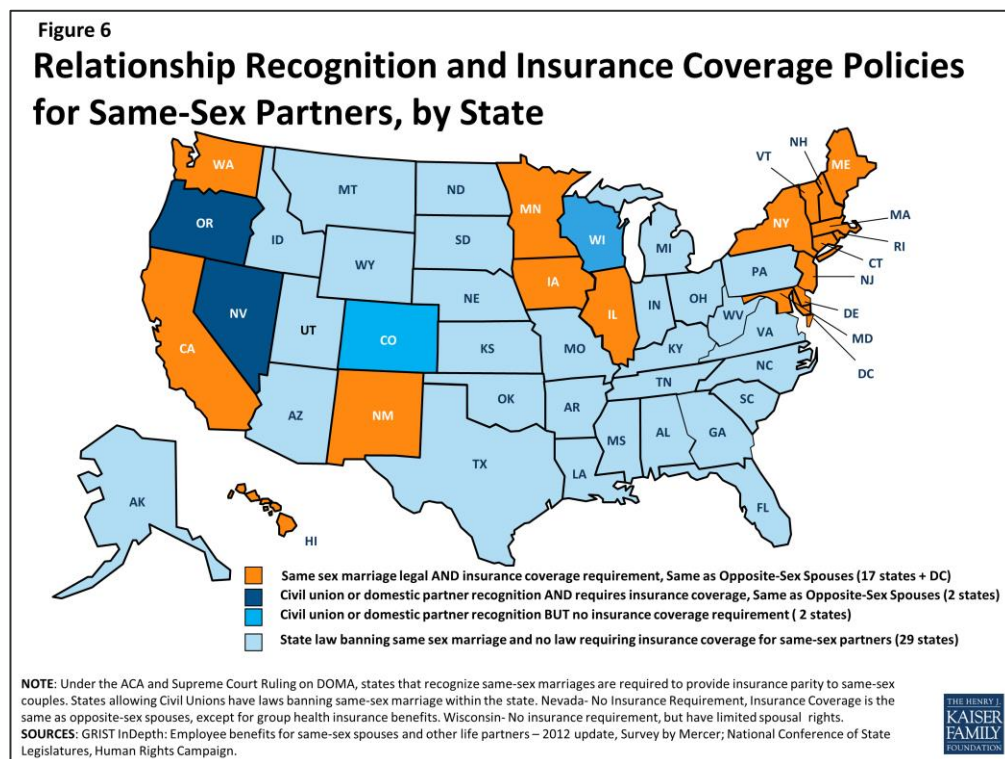
- At the provider and patient level, some groups advocate for clinicians to collect patient information on sexual orientation and gender identity to better understand an individual’s health profile and needs. Some providers have expressed discomfort with and inadequate knowledge on soliciting this information. Advocates’ recommendations include being direct with patients about why questions on sexual orientation and gender identity are being asked, ensuring that confidentiality will be maintained, informing patients of the right to opt-out, and asking multiple questions to assess both sexual orientation and gender identity.<sup>95</sup> In particular, the IOM recommends collecting such data in electronic medical records (EMRs), which are growing in use.<sup>96</sup>

## IMPACT OF DOMA RULING

Spousal coverage is an important pathway to insurance for millions of people, particularly in the context of employer-sponsored health insurance. Until recently, the federal government did not recognize same-sex marriage due to DOMA, which therefore limited LGB individuals’ access to a wide range of benefits, including health coverage as a dependent spouse. In June 2013, the Supreme Court issued a ruling in *United States v. Windsor* that overturned a portion of DOMA and requires the federal government to recognize legal same-sex marriages. The DOMA ruling and subsequent Agency policy interpretations and guidance have resulted in expanded access for some LGB families to a range of benefits, including dependent health coverage and family and medical leave. For more information on the impact of federal policy changes, please refer to **Table 1**.

- The Supreme Court decision has prompted federal agencies to reverse previous limitations on spousal benefits in some federal programs. For example, all federal employees who are legally married now have the same eligibility for dependent spousal health coverage in the Federal Employees Health Benefits Program (FEHBP) as well as other dependent benefits, such as dental and vision insurance, long-term care insurance, and flexible spending accounts.<sup>97</sup> The Department of Labor has also clarified that employers must now recognize married same-sex couples for federally required benefits such as COBRA, the program that offers employees and their families a temporary extension of group health coverage in the event that an employee loses his or her job.<sup>98</sup>
- More broadly, as a result of the Supreme Court ruling, the Internal Revenue Service (IRS) has ruled that it now recognizes all legally married couples (based on “state of celebration,” regardless of whether or not the couple lives in a state that recognizes same-sex marriage) and that they can file federal taxes as “married,” which affects a number of health-related financial issues such as the taxes they pay on health benefits.<sup>99</sup> Typically, dependent coverage is excluded from an employee’s taxable income. However, prior to the Supreme Court ruling, coverage for a domestic partner was considered taxable income, which raised taxes for those who received this coverage. The Supreme Court decision means that married same-sex couples will no longer face this higher tax burden at the federal level.<sup>100</sup>
- The decision also affects LGB individuals’ eligibility for assistance under the ACA’s coverage expansion, which is based in part on applicants’ family structure and incomes. Federal regulations have clarified that insurance marketplaces will recognize same-sex marriages and base eligibility for tax credits on couples’ income.<sup>101</sup> The federal government is encouraging states to recognize same-sex marriages for the purpose of determining Medicaid income eligibility, but the ultimate determination is under state jurisdiction since Medicaid is a federal-state partnership.<sup>102</sup>

- At the same time, the Supreme Court’s ruling does not require private companies to provide health insurance to same-sex spouses. Rather, access to spousal coverage is governed by a patchwork of state-level policies as marriage and partnership recognition are still based on state laws. As of December 2013, 17 states and the District of Columbia recognize same-sex marriages.<sup>103</sup> In these states, employees’ same-sex spouses should have the same eligibility as opposite sex spouses for dependent health insurance. Six states recognize domestic partnerships or civil unions, which provide many of the state protections of marriage such as the right to make health care decisions on behalf of a partner.<sup>104</sup> In addition to marriage recognition laws, some states have passed separate measures that require fully insured employers in the state to cover same-sex spouses. These measures may also encourage employers to extend benefits to those in civil unions and domestic partnerships **(Figure 6)**.



- Still, a majority of states impose bans on same-sex marriages or do not recognize same-sex marriages that were conducted legally in other states. To date, private employers in these states are not required to extend dependent coverage to same-sex spouses, but employers may choose to do so regardless of state marriage laws. Nationally, three in ten (31%) firms that offered health insurance provided benefits to unmarried same-sex domestic partners in 2012, up from 21% in 2009. This varies by firm size, region, and industry, with larger companies, those in the Northeast, and financial institutions most likely to offer coverage to same-sex partners **(Table 2)**.
- Several employers have also moved to make their plan offerings more comprehensive by removing exclusions for transgender health services. Furthermore, more employers are covering some transgender services. Among major U.S. employers, there has been a five-fold increase in the number of businesses offering at least one health plan that includes coverage of transgender services such as counseling, hormone therapy, and surgical procedures.<sup>105</sup>

## FAMILY CAREGIVING ISSUES

Caring for ill family members is another area of policy that has been evolving in recent years for LGBT people and their families. The Family Medical Leave Act provides workplace protections to employees if they take time off to care for a family member in the event of illness or birth of a child. Under DOMA, LGB individuals were not afforded the law’s protections to care for a spouse because the federal government did not recognize same-sex marriages; however, the Supreme Court’s decision extends the law to all legally married individuals at



qualifying employers. While this is an important step, it does not cover all workers. Additionally there are still other barriers that can limit the reach of these new policies.

- Paid sick leave is another important benefit that many workers do not have. Because it is legal in more than half the states to fire employees based on their sexual orientation or gender identity, LGBT employees without paid leave may be more reluctant to take time off when they or their family members are sick.<sup>106</sup>
- In addition to workplace protections, visiting loved ones in the hospital or another health care setting has not always been guaranteed for LGBT people. However, federal regulations in effect since 2011 require hospitals participating in Medicare and Medicaid (virtually all hospitals in the U.S.) to adopt written policies and procedures regarding a patient's rights to visit his or her same-sex partner and state explicitly that discrimination based on sexual orientation and gender identity are prohibited.<sup>107</sup>
- Concerns have also been raised about discrimination against older LGBT individuals and their families in long-term care facilities. Recent federal regulations now provide residents of long-term care facilities, such as nursing homes, the right to have visitors of their choice, including same-sex spouses and domestic partners.<sup>108</sup>

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A number of health challenges disproportionately affect LGBT communities, particularly the HIV/AIDS epidemic, stigma and violence, substance abuse, negative experiences in the health care system, and lack of insurance coverage. In addition to health outcomes, access to care has been a concern and intersects with many broader issues, including relationship recognition, legal identity recognition policies for transgender individuals, training and cultural competency of health professionals, as well as overarching societal and cultural issues, particularly a long history of stigma and discrimination. Recent policy and legal changes will serve to mitigate some of these challenges. In particular, the years ahead will see both the full implementation of the ACA as well as the full effects of overturning elements of DOMA. This convergence of policy and legal breakthroughs holds promise for broader access to health services, coverage, and benefits for LGBT communities.

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**Table 1: Impact of Selected Federal Policy Changes on Coverage and Access to Care for LGBT Communities**

Policy	Key Provisions and Impact
<p><b>The Patient Protection and Affordable Care Act (ACA)<sup>109</sup></b></p>	<ul style="list-style-type: none"> <li>• Broadens federal nondiscrimination in health care programs receiving federal funds and prohibits basing coverage eligibility, insurance premium pricing, benefit design, or any other aspect of coverage on sex, gender identity, or sex stereotyping.</li> <li>• Explicitly prohibits state insurance marketplaces and plans offering the essential health benefits from discriminating based on sexual orientation or gender identity.</li> <li>• Promotes data collection and analysis on sexual orientation and gender identity through federally-sponsored surveys and programs.</li> <li>• Individuals will no longer be denied coverage due to a pre-existing condition, such as HIV/AIDS, mental illness, or a transgender medical history.</li> <li>• New private plans are required to cover USPSTF recommended preventive services without cost sharing. Includes screenings for HIV, STIs, depression, and substance misuse.</li> <li>• Expands coverage to many uninsured persons through Medicaid and state-based health insurance marketplaces. Medicaid, in states that expand, will base eligibility solely on income (no categorical requirement) and tax credits are available to help subsidize the cost of coverage in marketplaces for low income individuals.</li> </ul>
<p><b><i>United States v. Windsor</i> – Overturn of Federal Defense of Marriage Act (DOMA)</b></p>	<ul style="list-style-type: none"> <li>• Overturned Section 3 of the Defense of Marriage Act, which limited marriage to persons of the opposite sex. Treats legal marriages between same-sex individuals the same as marriages between opposite sex individuals with regard to federal law.</li> <li>• <b>Department of Health and Human Services<sup>110</sup></b> <ul style="list-style-type: none"> <li>○ Guarantees that same-sex married beneficiaries in Medicare Advantage plans who both need care in a skilled nursing facility can receive care at same facility.</li> </ul> </li> <li>• <b>Center for Consumer Information and Insurance Oversight (CCIIO) Guidance on IRS Ruling 2013–17 and Eligibility for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions</b> <ul style="list-style-type: none"> <li>○ All Health Insurance Marketplaces are to recognize legal same-sex marriages when determining eligibility for Premium Assistance and Tax Credits.<sup>111</sup></li> </ul> </li> <li>• <b>Centers for Medicare and Medicaid Services (CMS) Guidance to advise of the implications of the Windsor decision for Medicaid and CHIP<sup>112</sup></b> <ul style="list-style-type: none"> <li>○ Allows states to decide whether to recognize same-sex marriages when determining Medicaid eligibility.</li> </ul> </li> <li>• <b>Internal Revenue Service (IRS) Ruling 2013–17<sup>113</sup></b> <ul style="list-style-type: none"> <li>○ Ruled that same-sex couples legally married will be treated as married for federal tax purposes, regardless of whether the couple lives in a jurisdiction that recognizes same-sex marriage or not (“state of celebration” takes precedent). Allows couples to file taxes as “married” and thus treats same-sex spousal health coverage as tax exempt for purposes of determining federal income tax.</li> <li>○ If same-sex spouse received employer-based dependent insurance, the employee may apply for refund of excess federal income taxes paid on the value of the coverage for past 2-3 years.</li> </ul> </li> <li>• <b>Department of Labor Technical Release Number 2013–04<sup>114</sup></b> <ul style="list-style-type: none"> <li>○ Requires all ERISA plans to include legally married same-sex couples in the definition of “spouse” and “marriage,” opening the door for broader dependent coverage of same-sex spouses.</li> </ul> </li> <li>• <b>Department of Defense Memorandum Subject: Extending Benefits to the Same-Sex Spouses of Military Members<sup>115</sup></b></li> </ul>

**Table 1: Impact of Selected Federal Policy Changes on Coverage and Access to Care for LGBT Communities**

Policy	Key Provisions and Impact
	<ul style="list-style-type: none"> <li>○ Legally married spouses eligible for dependent health coverage of service members and DOD civilian employees.</li> <li>● <b>Department of Justice Letter to The Honorable John Boehner<sup>116</sup></b> <ul style="list-style-type: none"> <li>○ Extends VA and DOD spousal benefits to same-sex spouses by no longer enforcing Title 38 of the U.S. Code, which had previously limited benefits to opposite-sex marriages only.</li> </ul> </li> </ul>
Other	<ul style="list-style-type: none"> <li>● <b>Presidential Memorandum– Hospital Visitation<sup>117</sup></b> <ul style="list-style-type: none"> <li>○ Executive order in 2010 stating hospitals that receive funds from Medicaid and Medicare are to respect the rights of patients to designate visitors, including those designated by legally valid advance directives.</li> <li>○ Hospitals may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability.</li> <li>○ Guidance issued in November 2010 supports enforcement of the right of patients to designate the person of their choice, including a same-sex partner, to make medical decisions on their behalf should they become incapacitated.</li> </ul> </li> <li>● <b>Centers for Medicare and Medicaid Services Memorandum 13–42–NH: Reminder– Access and Visitation Rights in Long Term Facilities<sup>118</sup></b> <ul style="list-style-type: none"> <li>○ LTC facilities must ensure that all individuals seeking to visit a resident be given full and equal visitation privileges, consistent with resident preferences within reasonable restrictions that safeguard residents.</li> </ul> </li> <li>● <b>Centers for Medicare and Medicaid Services– Medicaid Spousal Impoverishment Protections<sup>119</sup></b> <ul style="list-style-type: none"> <li>○ Protections have been extended to include same-sex spouses. This allows a spouse living in the community to maintain a certain level of assets when institutional expenses (usually a nursing home) threaten to deplete all resources and impoverish the community-based spouse.</li> </ul> </li> <li>● <b>National Institutes of Health– LGBT Research Coordinating Committee<sup>120</sup></b> <ul style="list-style-type: none"> <li>○ This committee was formed to consider recommendations of the Institute of Medicine’s study <i>The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding</i> and to suggest strategies for how the NIH can support research.</li> </ul> </li> </ul>

**Table 2: Among Firms Offering Health Benefits, Distribution of Whether Employers Offer Health Benefits to Unmarried Same-Sex Domestic Partners, by Firm Size, Region, Industry, 2012**

	Offer Health Coverage to Same-sex Partners	Do Not Offer Health Coverage to Same-sex Partners	Not Encountered / Not Applicable
<b>Firm Size</b>			
All Small Firms(3-199 Workers)	31%*	23%*	46%
All Large Firms (≥ 200 Workers)	42%*	52%*	5%*
<b>Region</b>			
Northeast	54%*	19%	27%*
Midwest	34%	24%	42%
South	15%*	24%	61%*
West	36%	27%	37%
<b>Industry</b>			
Manufacturing	25%	41%	34%
Wholesale	14%*	21%	65%
Retail	30%	4%*	66%
Finance	43%	40%	17%*
State/ Local Government	25%	15%	60%
<b>All Firms</b>	<b>31%</b>	<b>24%</b>	<b>45%</b>

\* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category (p<.05).

**NOTE:** The response option “not applicable/not encountered” captures the number of firms that report not having a policy on the issue. This response is distinguished from firms that report “no” since those firms have a set policy on the issue.

**SOURCE:** Kaiser/HRET, Employer Health Benefits Survey, 2012.

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