

# The Negative Effect of Stigma, Discrimination, and the Health Care System on the Health of Gender and Sexual Minorities

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Privilege is an element of oppression.<sup>1</sup> The most privileged individuals are often unable to acknowledge their superior status.<sup>2</sup> Heterosexuality and gender conformance carry socially and legally sanctioned privileges.<sup>3</sup> For example, nearly half (46%) of people in the United States believe that same-sex relationships should not be valid because they are morally, religiously, or traditionally wrong.<sup>4</sup> This heterosexist belief is validated by law, perpetuating discrimination against lesbian, gay, bisexual, transgender, and queer (LGBTQ) people.<sup>5</sup> Those who are less privileged must endure more stigma, discrimination, and violence because of their lesser status.<sup>6</sup> This Comment explains how different levels of privilege adversely affect the health of LGBTQ

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1. JULIE FISH, HETEROSEXISM IN HEALTH AND SOCIAL CARE 12 (2006).

2. *Id.*

3. *Id.*

4. Frank Newport, *Religion Big Factor for Americans Against Same-Sex Marriage*, GALLUP (Dec. 5, 2012), <http://www.gallup.com/poll/159089/religion-major-factor-americans-opposed-sex-marriage.aspx>, archived at <http://perma.cc/0cvsYX8E2Mn>.

5. *Stigma and Discrimination*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/msmhealth/stigma-and-discrimination.htm> (last updated Mar. 3, 2011), archived at <http://perma.cc/0QJT9tzd59L>.

6. *See generally id.* (explaining the effects of stigma on LGBTQ people).

individuals.<sup>7</sup> The first Part examines the ways in which stigma impacts LGBTQ health and contributes to health disparities. The second Part explores the reasons why legal remedies for discriminatory health practices are currently unavailable. The third Part identifies the aspects of the U.S. health system that contribute to disparities in access and care. The fourth Part evaluates the extent to which legislative attempts to reduce the disparities in health access have been ineffective. Finally, this Comment concludes by suggesting changes that could reduce and prevent some of these health disparities.

#### I. HETEROSEXISM, GENDERISM, AND RACISM ADVERSELY AFFECT HEALTH

Stigma and discrimination cause health disparities.<sup>8</sup> Stigma manifests when “labeling, stereotyping, separation, status loss, and discrimination” occur simultaneously as a result of power and privilege.<sup>9</sup> Nonheterosexuals experience labeling, stereotyping, separation, status loss, and discrimination because society has developed a negative image of their behavior, identity, relationships, and community.<sup>10</sup> Sexual stigma, like other forms of stigma, finds rationalization and justification in a social framework that endorses idealized gender roles, morality, and citizenship and defines sexual minorities as perverted and sinful.<sup>11</sup> We know from studies of racism that structural discrimination, interpersonal discrimination, and internalization of stigma are all ways that stigma can affect health.<sup>12</sup>

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7. “The social determinants of health are the conditions in which people are born, grow, live, work and age [including the health system]. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities . . . .” *Social Determinants of Health*, WORLD HEALTH ORG., [http://www.who.int/social\\_determinants/sdh\\_definition/en/.html](http://www.who.int/social_determinants/sdh_definition/en/.html) (last visited May 7, 2013), archived at <http://perma.cc/0JH4ksmMW1t>.

8. See Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. SOC. 363, 363-64 (2001).

9. *Id.* at 367.

10. Gregory M. Herek, Regina Chopp & Darryl Strohl, *Sexual Stigma: Putting Sexual Minority Health Issues in Context*, in THE HEALTH OF SEXUAL MINORITIES: PUBLIC HEALTH PERSPECTIVES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER POPULATIONS 171, 171-72 (Ilan H. Meyer & Mary E. Northridge eds., 2007).

11. *Id.* at 172.

12. Ameena T. Ahmed, Selina A. Mohammed & David R. Williams, *Racial Discrimination & Health: Pathways & Evidence*, 126 INDIAN J. MED. RES. 318, 321-25 (2007); Rodney Clark, Norman B. Anderson, Vernessa R. Clark & David R. Williams, *Racism as a Stressor for African Americans: A Biopsychosocial Model*, 54 AM. PSYCHOLOGIST 805, 805-16 (1999).

First, structural discrimination, or the environmental factors that an individual cannot control, determines their ability to access goods and services.<sup>13</sup> Affordability, transportation, and proximity are all environmental structures that determine access to care. Heterosexism, the discrimination against LGBTQ individuals by heterosexuals, plays a substantial role in creating structural discrimination against LGBTQ people.<sup>14</sup> For instance, sexual and gender minorities are disadvantaged in the labor market<sup>15</sup> because sexual and gender minorities are only protected from employment discrimination in a minority of states.<sup>16</sup> However, structural discrimination goes beyond differential employment outcomes.<sup>17</sup> Because health access is largely tied to employment, structural discrimination also hinders adequate health assessment, treatment, and prevention.<sup>18</sup> Nearly half the population in the United States (45.8%) relies exclusively on an employment-based health plan for health insurance coverage.<sup>19</sup> More comprehensive health benefit packages are generally associated with higher-paying jobs, while lower-paying jobs, disproportionately occupied by minorities,<sup>20</sup> generally offer limited or no health benefits. There are also significant differences in benefits and employee contributions toward family premiums between

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13. Ahmed et al., *supra* note 12, at 322.

14. Laura Dean et al., *Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns*, 4 J. GAY & LESBIAN MED. ASS'N 101, 102-03 (2000).

15. Juan Battle & Martha Crum, *Black LGB Health and Well-Being*, in THE HEALTH OF SEXUAL MINORITIES, *supra* note 10, at 320, 321.

16. Twenty-one states and Washington D.C. have laws protecting individuals from employment discrimination based on their sexual orientation for both public and private employers; eight states have laws protecting individuals in state and local government positions from sexual orientation discrimination. The other twenty-one states have no protection for individuals discriminated against by an employer for sexual orientation. Gender minorities have even less protection from employment discrimination. See JAIME M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL. & THE NAT'L GAY & LESBIAN TASK FORCE, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY (Feb. 2011), available at [http://www.thetaskforce.org/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf), archived at <http://perma.cc/PH3L-J95Q>. Fifteen states and Washington D.C. protect in both private and public sector employment, four protect only in the public sector, and the remaining thirty-one states do not offer any protection from employment discrimination. *Non-Discrimination Laws: State by State Information-Map*, ACLU (Sept. 21, 2011), <http://www.aclu.org/maps/non-discrimination-laws-state-state-information-map>, archived at <http://perma.cc/0tKjS5f4cWV>.

17. Laura Hoyt D'Anna, Hannah-Hanh D. Nguyen, Grace L. Reynolds, Dennis G. Fisher, Michael Janson, Cristy Chen & C. Kevin Malotte, *The Relationship Between Sexual Minority Verbal Harassment and Utilization of Health Services: Results from Countywide Risk Assessment Survey (CRAS) 2004*, 24 J. GAY & LESBIAN SOC. SERVICES 119, 120-22 (2012).

18. Dean et al., *supra* note 14, at 106.

19. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 29-31 (Sept. 1, 2010), available at <http://www.census.gov/prod/2011pubs/p60-239.pdf>, archived at <http://perma.cc/0ykSQwLipUM>.

20. *Id.* at 31-38.

employers with a large proportion of lower-wage workers (where at least 35% of employees earn \$24,000 or less) and employers with a large proportion of higher-wage workers (where at least 35% of employees earn \$55,000 or more).<sup>21</sup> For instance, employees at lower-wage firms pay an average of \$1,000 more each year for family coverage than employees at higher-wage firms.<sup>22</sup> This occurs despite the fact that, on average, firms with many lower-wage employees pay less in total premiums for family coverage than firms with many higher-wage employees.<sup>23</sup> Additionally, workers at lower-wage firms are more likely to face high deductibles than those at higher-wage firms.<sup>24</sup> Specifically, nearly half of covered workers at low-wage firms have an annual deductible of \$1,000 or more, compared to less than a third of high-wage workers.<sup>25</sup>

Studies have shown that gay and bisexual men earn 10 to 32% less than heterosexual men when controlled for education, race, occupation, and years of work experience.<sup>26</sup> Lesbians and bisexual women earn the same as or up to 34% more than their heterosexual counterparts, but they still earn less than gay, bisexual, and straight men.<sup>27</sup> Notably, lesbian couples and their families are much more likely to qualify as poor than heterosexual couples and their families.<sup>28</sup> Transgender individuals report high rates of unemployment, with 64% reporting incomes of less than \$25,000 per year.<sup>29</sup> Some groups are much more likely to be poor than others. For example, black people in same-sex couples are more likely to be poor than their white counterparts and same-sex couples in rural areas are more likely to be poor than those in urban areas.<sup>30</sup>

Families with gay and lesbian parents are significantly more likely to be poor than families with married, heterosexual parents, after

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21. Press Release, The Henry J. Kaiser Family Found., Family Health Premiums Rise 4 Percent to Average \$15,745 in 2012, National Benchmark Employer Survey Finds (Sept. 11, 2012), *available at* <http://kkf.org/private-insurance/press-release/family-health-premiums-rise-4-percent-to/>, *archived at* <http://perma.cc/0UV9DzbePQL>.

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. RANDY ALBELDA, M.V. LEE BADGETT, ALYSSA SCHNEEBAUM & GARY J. GATES, POVERTY IN THE LESBIAN, GAY, AND BISEXUAL COMMUNITY, THE WILLIAMS INSTITUTE 13 (Mar. 2009), *available at* <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Albelda-Badgett-Schneebaum-Gates-LGB-Poverty-Report-March-2009.pdf>, *archived at* <http://perma.cc/0vgy5VrfmyZ>.

27. *Id.* at 14.

28. *Id.* at 5.

29. *Id.* at 16.

30. *Id.* at 9.

adjusting for a range of family characteristics.<sup>31</sup> Approximately two million children are being raised by LGBTQ parents.<sup>32</sup> Children with lesbian, gay, or bisexual (LGB) parents are twice as likely to live in poverty as children with heterosexual, married parents.<sup>33</sup> Racial minority same-sex couples are more likely to raise children than white same-sex couples.<sup>34</sup> Also, 38% of transgender Americans are parents.<sup>35</sup> Further, the states where LGBTQ couples are most likely to raise children<sup>36</sup> have the fewest LGBTQ legal protections.<sup>37</sup> Structural discrimination, lack of employment opportunities, and sparse employment and family law protections contribute to poorer health outcomes among LGBTQ people because they restrict opportunities and access to health care.

Second, perceived discrimination is linked to health through stress. The mental health of sexual and gender minorities is negatively affected by the “chronic stressors [caused by] the stigma they experience as a disadvantaged minority.”<sup>38</sup> Research that compared transgender individuals to nontransgender men and women (regardless of sexual orientation) found that transgender individuals were more likely to report suicidal ideation, to take psychotropic medications, and to have a problem with alcohol than nontransgender men and heterosexual women.<sup>39</sup> The higher likelihood of mental health and substance abuse issues among transgender and lesbian individuals was attributed to their discrimination being twofold: they endured sexism *and* heterosexism.<sup>40</sup> Although studies suggest a higher prevalence of mental health disorders among LGBTQ individuals, LGBTQ adults are typically mentally healthy.<sup>41</sup> The fact that some LGBTQ individuals do not suffer adverse effects from stress does not ameliorate the impact of discrimination on

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31. *Id.*

32. Jennifer Chrisler, Laura Deaton & Jeff Krehely, *Unequal Taxation and Undue Burdens for LGBT Families*, CTR. FOR AM. PROGRESS (Apr. 17, 2012), <http://www.americanprogress.org/issues/lgbt/news/2012/04/17/11451/unequal-taxation-and-undue-burdens-for-lgbt-families/>, archived at <http://perma.cc/T4BT-32ZJ>.

33. ALBELDA, BADGETT, SCHNEEBAUM & GATES, *supra* note 26, at i.

34. Chrisler, Deaton & Krehely, *supra* note 32.

35. *Id.*

36. Mississippi, Wyoming, Alaska, Arkansas, Texas, Louisiana, Oklahoma, Kansas, Alabama, Montana, South Dakota, and South Carolina. *Id.*

37. *Id.*

38. INST. OF MED. OF THE NAT'L ACAD., *THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING* 191 (2011), available at <http://www.ncbi.nlm.nih.gov/books/NBK64806/pdf/TOC.pdf>, archived at <http://perma.cc/0XjE1qavvov>.

39. *Id.*

40. *Id.*

41. *Id.* at 189-90.

their physical and mental health; individual resilience, further, is not the appropriate focus for medical or legal inquiry. In a system dictated by privilege, it is important to remember that “the study of why some people swim well and others drown when tossed into a river displaces study of who is tossing whom into the current—and what else might be in the water.”<sup>42</sup>

Third, interpersonal discrimination refers to interactions between individuals of a discriminatory nature that can often be directly perceived.<sup>43</sup> LGBTQ individuals experience an overwhelming amount of interpersonal discrimination as a result of heterosexism and genderism. This discrimination does not disappear in medical settings. The health system assumes heterosexuality and conformance with the gender binary, making LGBTQ health needs abnormal.<sup>44</sup> Bias from health care professionals reduces the likelihood that LGBTQ individuals will seek and receive quality health care.<sup>45</sup> In addition, a lack of cultural competence may cause health care professionals to ignore the particular preventive-care and treatment needs of LGBTQ patients (for example, pap smears, pain management after sex reassignment surgery, examination of the anal canal, etc.).<sup>46</sup> Medical forms and the method for reviewing medical history are often insensitive to the experiences of LGBTQ patients and discourage disclosure of sexual orientation and behavior.<sup>47</sup> For instance, over 10% of LGB people reported that health care professionals used harsh language, refused to touch them, or used excessive precautions, while 36% of LGB people with HIV reported that health care professionals refused to touch them or used excessive precautions.<sup>48</sup> Further, 21% of Black transgender people reported being refused medical care due to bias, and 34% reported postponing care when they were sick or injured because of fear of discrimination.<sup>49</sup> At

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42. Nancy Krieger, *Theories for Social Epidemiology in the 21st Century: an Ecosocial Perspective*, 30 INT'L J. L. & EPIDEMIOLOGY 668, 670 (2001).

43. Saffron Karlsen & James Y. Nazroo, *Relation Between Racial Discrimination, Social Class, and Health Among Ethnic Minority Groups*, 92 AM. J. PUB. HEALTH 624, 624 (2002).

44. GRANT ET AL., *supra* note 16, at 6, 72, 75-76; Sarah Morrison & Shirley Dinkel, *Heterosexism and Health Care: A Concept Analysis*, 47 NURSING F. 123, 123 (2012).

45. Dean et al., *supra* note 14, at 103.

46. *Id.*

47. *Id.*

48. LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING: LAMBDA LEGAL'S SURVEY ON DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE LIVING WITH HIV (2010), available at <http://data.lambdalegal.org/publications/downloads/whcic-report-when-health-care-isnt-caring.pdf>, archived at <http://perma.cc/0MW4KnjBg9f>.

49. NAT'L CTR. FOR TRANSGENDER EQUAL., INJUSTICE AT EVERY TURN: A LOOK AT BLACK RESPONDENTS IN THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 3 (Sept. 8, 2011),

least one study suggests that this discrimination is associated with a number of negative health outcomes, including higher incidences of HIV and other sexually transmitted infections.<sup>50</sup> LGBTQ individuals accessing health care have to decide whether they will cover and allow the heterosexist and gender-conforming assumptions to persist, or risk facing discrimination.<sup>51</sup> Thus, significant differences in health outcomes between sexual and gender minorities can be attributed to stigma.

## II. HEALTH DISPARITIES

The extent to which discrimination impacts LGBTQ health is unclear, but the limited data that has been collected suggests that discrimination leads to significant health disparities. The level of discrimination faced, however, is variable, depending on the number of other types of discrimination the individual faces. For example, a white gay man faces more discrimination than a white straight man because of heterosexism. That white gay man faces less discrimination than a Black gay man because of racism. A lesbian faces sexism in addition to the other forms of discrimination faced by a similarly situated gay man. Bisexual men and women face additional discrimination because they are neither gay nor straight. Transgender individuals face gender discrimination in addition to any race and/or sexual orientation discrimination they otherwise experience.

The information available on racial health disparities is illustrative of the impact that discrimination can have on health outcomes. Since the beginning of the AIDS epidemic, Black people have borne the brunt of the assault.<sup>52</sup> Black people in the United States are more likely to be newly diagnosed with HIV infections, to be living with HIV, and to have died from HIV/AIDS than any other race or ethnicity in the United States.<sup>53</sup> Nearly half of new HIV infections in 2010, half of the people living with HIV in 2009, and almost half of new AIDS diagnoses in 2011 were among Black people, even though Blacks only make up 14% of the U.S. population.<sup>54</sup> The HIV prevalence rate among Black people is almost eight times higher than for white people; Black men are infected at six times the rate of white men and Black women at eighteen times the

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available at [http://www.transequality.org/PDFs/BlackTransFactsheetFINAL\\_090811.pdf](http://www.transequality.org/PDFs/BlackTransFactsheetFINAL_090811.pdf), archived at <http://perma.cc/0NRWo849Meh>.

50. D'Anna et al., *supra* note 17, at 133.

51. *See id.*

52. *See Black Americans and HIV/AIDS*, THE HENRY J. KAISER FAMILY FOUND. (Mar. 5, 2013), <http://www.kff.org/hivaids/6089.cfm>, archived at <http://perma.cc/027w6En6edp>.

53. *Id.*

54. *Id.*

rate of white women.<sup>55</sup> In 2010, new HIV infections were predominantly among Black men who have sex with men (51%).<sup>56</sup> Even though HIV rates are highest among transgender people (2.64% of transgender people, compared to .06% of nontransgender people, have HIV), Black transgender individuals are eight times more likely than their non-Black transgender counterparts to have HIV.<sup>57</sup> The higher incidence rate is exacerbated by the fact that Black people in the United States also receive fewer antiretroviral therapies for HIV/AIDS than white people.<sup>58</sup>

Health disparities between Black and white people in the United States are apparent in many other diseases and treatments. For example, Black men and women are nearly twice as likely to die before age seventy-five from heart disease or stroke than white men and women.<sup>59</sup> Similarly, in 2010, Black people accounted for 40% of tuberculosis cases among those born in the United States, despite the fact that Black people only comprise 14% of the total U.S. population.<sup>60</sup>

Many have attempted to attribute these differential health outcomes to factors such as education, insurance, socioeconomics, or cultural preferences, but none of these other factors have been as statistically significant as race.<sup>61</sup> Different levels of education do not explain the disparate health outcomes. For example, Black women with college or graduate degrees experience infant mortality rates that are higher than white women that did not finish high school.<sup>62</sup> Different insurance also does not explain the disparate health outcomes. For instance, a study of treatments provided within the same Health Maintenance Organization

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55. *Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB: African Americans/Blacks*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchhstp/healthdisparities/AfricanAmericans.html> (last updated Sept. 24, 2013), *archived at* <http://perma.cc/0WujDPTBFzs>.

56. *Id.*

57. NAT'L CTR. FOR TRANSGENDER EQUAL., *supra* note 49, at 3.

58. Martin F. Shapiro et al., *Variations in the Care of HIV-Infected Adults in the United States: Results from the HIV Cost and Services Utilization Study*, 281 JAMA 2305, 2313-14 (1999).

59. CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT: CDC HEALTH DISPARITIES AND INEQUALITIES REPORT—UNITED STATES 3 (2011), *available at* <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>, *archived at* <http://perma.cc/E48K-M6N5>.

60. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 55.

61. René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 91-92 (2001).

62. POVERTY & RACE RESEARCH ACTION COUNCIL, UNEQUAL HEALTH OUTCOMES IN THE UNITED STATES: RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE TREATMENT AND ACCESS, THE ROLE OF SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH, AND THE RESPONSIBILITY OF THE STATE 20 (2008), <http://www.prrac.org/pdf/CERDhealthEnvironmentReport.pdf>, *archived at* <http://perma.cc/0hj8Lki214x>.



(HMO)<sup>63</sup> revealed that Black patients were 20% less likely to receive coronary angiography, 35% less likely to undergo heart bypass surgery, and 40% less likely to have coronary angioplasty than white people with the same heart problems.<sup>64</sup> Further, Black people with similar income and insurance are more likely to have a limb amputated,<sup>65</sup> generally receive fewer pain medications when they have a bone fracture<sup>66</sup> or cancer,<sup>67</sup> and are less likely to receive aspirin on admission or beta-blockers upon discharge for a heart attack.<sup>68</sup>

Research also indicates that no significant cultural differences exist. For example, one study found that there was only a 3 to 5% racial difference regarding wanting a kidney transplant (76.3% of Black women versus 79.3% of white women and 80.7% of Black men versus 85.5% of white men), but the racial difference changed to over 20% for patients referred to a transplant center for evaluation (50.4% of Black women versus 70.5% of white women and 53.9% of Black men versus 76.2% of white men).<sup>69</sup> Discrepancies like this cause many scholars to point out the logical fallacy in using patient preferences as a variable to explain disparate medical treatment.<sup>70</sup> The refusal to undergo treatment is often associated with a fear of structural or interpersonal discrimination.<sup>71</sup> Any different preferences between Black and white patients, if they exist, are likely a product of racism; patient preferences do not explain racial disparities in treatment.<sup>72</sup> The research demonstrates that Black patients systematically receive less medical treatment than similarly situated white patients. The disparities in medical treatment between Black and

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63. "A group of participating healthcare providers that furnish medical services to enrolled members of a group health-insurance plan." BLACK'S LAW DICTIONARY 788 (9th ed. 2009).

64. David M. Carlisle et al., *Racial and Ethnic Disparities in the Use of Cardiovascular Procedures: Associations with Type of Health Insurance*, 87 AM. J. PUB. HEALTH 263, 263-65 (1997).

65. Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 355 NEW ENG. J. MED. 791, 793-94 (1996).

66. Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS EMERGENCY MED. 11, 13 (2000).

67. Charles S. Cleeland et al., *Pain and Treatment of Pain in Minority Patients with Cancer: The Eastern Cooperative Oncology Group Minority Outpatient Pain Study*, 127 ANNALS INTERNAL MED. 813, 813-15 (1997).

68. Saif S. Rathore et al., *Race, Sex, Poverty, and the Medical Treatment of Acute Myocardial Infarction in the Elderly*, 102 CIRCULATION 642, 645 (2000).

69. John Z. Ayanian et al., *The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation*, 341 NEW ENG. J. MED. 1661, 1661 (1999).

70. René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 93-95 (2001).

71. *Id.*

72. *Id.* at 95.

white people have been estimated to result in at least 60,000 deaths in the Black population annually.<sup>73</sup> This has important implications for sexual and gender minority health disparities because it indicates that their lack of health utilization may also be related more to heterosexism and genderism than education, insurance, or cultural preference.

### III. ANTIDISCRIMINATION AND HEALTH INSURANCE LAW

Despite the fact that race is a suspect class, subject to strict scrutiny,<sup>74</sup> and the substantial evidence of disparate health treatment between Black and white patients, a discrimination claim brought by a Black person would be unsuccessful under Title VI of the Civil Rights Act.<sup>75</sup> The Civil Rights Act prohibits the expenditure of federal funds on programs and activities that discriminate on the basis of race, color, or national origin.<sup>76</sup> Title VI applies to nearly every hospital and nursing home in the United States through the acceptance of federal Medicare and Medicaid funds.<sup>77</sup> The United States Supreme Court has held that Title VI only reaches instances of intentional discrimination.<sup>78</sup> The Court has also held that Title VI does not create a private right of action concerning policies with a disparate impact absent a showing of discriminatory intent.<sup>79</sup> But intentional discrimination is especially difficult to prove in a health care setting<sup>80</sup> because “[l]ower intensity care provided to a minority patient can . . . typically be defended as consistent with one or another widely accepted standard of care.”<sup>81</sup> The statutes and regulations governing health coverage do not contain language that limits the broad discretion that physicians can exercise.<sup>82</sup> Typically, “medically necessary” coverage is all that is provided through statute or contract.<sup>83</sup> Even though vague terminology is an issue frequently addressed in the legal arena, the guidelines regularly used for interpreting vagueness do not apply in the health setting.<sup>84</sup> No precedent is established when

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73. Charles DeShazer, Letter to the Editor, 342 *NEW ENG. J. MED.* 513, 518 (2000).

74. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 290-91 (1978).

75. 42 U.S.C.A. § 2000d (2011).

76. *Id.*; Bowser, *supra* note 70, at 125.

77. Bowser, *supra* note 70, at 125.

78. *Alexander v. Choate*, 469 U.S. 287, 293 (1985).

79. *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001).

80. Vernellia R. Randall, *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law*, 10 *DEPAUL J. HEALTH CARE L.* 1, 9-10 (2006).

81. Bowser, *supra* note 70, at 129-30 (quoting M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 *YALE J. HEALTH POL'Y L. & ETHICS* 95, 109 (2001)).

82. Bloche, *supra* note 81, at 100.

83. *Id.*

84. *Id.* at 100-01.

physicians make treatment decisions.<sup>85</sup> Moreover, decisions made by physicians are concealed.<sup>86</sup> Treatment decisions are normally protected by patient confidentiality and are only revealed for insurance coverage or legal proceedings.<sup>87</sup> Even though technology makes complex comparisons possible, there are too many factors to consider when dealing with an individual's health for that to be a viable alternative to physician recommendations.<sup>88</sup> Any attempt to anticipate, write specific definitions, or utilize empirical analysis for application to clinical decisions would be incredibly difficult.<sup>89</sup> Further, Title VI only covers facilities and providers that accept federal funding; those that do not accept can intentionally discriminate without legal consequences.<sup>90</sup> Thus, proving discrimination in a health setting is nearly impossible, despite the staggering disparities in health outcomes. Yet, because LGBTQ individuals are not protected by a Civil Rights Act, even evidence of intentional discrimination because of their sexual orientation or gender would be permitted.

“Although antidiscrimination may provide a useful model for civil-rights law, it does not lend itself to health-insurance law.”<sup>91</sup> Insurance is a contract where the insurer agrees to indemnify the insured against a specified loss. “[H]ealth insurers have historically engaged in risk-assessment and other profit-maximizing strategies that systematically disadvantage people with histories of illness and chronic health conditions.”<sup>92</sup> Traditional insurance practices include health-status-based rating, preexisting-condition exclusions, limited coverage, gender rating, and considerations of claims history.<sup>93</sup> Risk is distributed differently in individual and group health insurance markets, but both systems disadvantage individuals based on their health and likelihood to need health services. An employer's group health insurance evaluates the relative risk of the group as a whole, which makes it more affordable because the risk is spread over a larger number of individuals.<sup>94</sup> Thus, the smaller the group, the less risk can be spread out and the more the cost

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85. *Id.*

86. *Id.*

87. *Id.* at 102.

88. *Id.*

89. *Id.* at 101.

90. Randall, *supra* note 80, at 8-9.

91. Jessica L. Roberts, “Healthism”: A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 U. ILL. L. REV. 1159, 1195 (2012).

92. *Id.* at 1166.

93. *Id.*

94. *Id.* at 1167-68.

increases.<sup>95</sup> Despite spreading risk across a large number of policyholders, group insurers disadvantage their insureds on the basis of health status.<sup>96</sup> Insurers in the group market may reject the entire group or limit the amount or type of coverage available.<sup>97</sup> If a particular individual develops a health condition that is expensive to treat, that single diagnosis can impact the entire group's premium or coverage.<sup>98</sup> This impact on premiums often provides employers with an incentive to either ask employees with specific conditions to leave or fire them.<sup>99</sup>

Low-income families (which are disproportionately minorities<sup>100</sup>) cannot afford to pay for health insurance without a subsidy, and, as a result, many adults go without any health care coverage (16.3%).<sup>101</sup> Very few individuals obtain direct-purchase insurance (3.7%).<sup>102</sup> The reason that more individuals go without health insurance rather than paying direct is due in part to the insurer's use of health information to make eligibility and underwriting decisions based on potential risk.<sup>103</sup> When health insurance is based on risk, an individual may be classified as a high-rate class or declined altogether because of a preexisting condition or potential health risk.<sup>104</sup> A preexisting condition can be anything from breast cancer, depression, or HIV, to allergies or acne. Because health insurers take health status into account when setting premiums, those with higher risks pay higher rates.<sup>105</sup> Thus, individuals who are discriminated against in the labor market or by their employer's insurance designations because they are LGBTQ may also be unable to obtain health insurance directly because of a health condition or potential risk. As a result, those in greatest need of medical services are least likely to have access to care. This is problematic because insurance coverage is strongly correlated to better health outcomes.<sup>106</sup>

Even when individuals have health insurance, there are additional cost barriers to treatment (deductibles, coinsurance, and copays).<sup>107</sup> The result of these additional cost devices is that individuals with health

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95. *Id.* at 1168.

96. *Id.* at 1169.

97. *Id.*

98. *Id.*

99. *Id.*

100. DENAVAS-WALT ET AL., *supra* note 19, at 6.

101. *Id.* at 23.

102. *Id.* at 29.

103. Roberts, *supra* note 91, at 1166.

104. *Id.*

105. *Id.* at 1166-67.

106. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 59, at 2.

107. Roberts, *supra* note 91, at 1169.

conditions that require ongoing care pay significantly more, and more often, than individuals who are not as frequently in need of medical services.<sup>108</sup> Having a single, chronic health condition can increase an individual's out-of-pocket expenses by over 70%, and having a second condition can increase it by over 300%.<sup>109</sup> Thus, many cost-control provisions simply shift the costs to people in the greatest need of care.<sup>110</sup>

Additionally, there is a systemic bias in health insurance. Health systems routinely fail to cover gay and lesbian partners or provide reimbursement for procedures of particular relevance to LGBTQ populations (for example, fertility services to lesbians and surgical procedures required for gender transitions).<sup>111</sup> Moreover, transgender people are generally more likely to be without health insurance.<sup>112</sup> For instance, one-third of Black transgender individuals are uninsured.<sup>113</sup> Even if transgender people have health insurance, transgender-specific exclusions routinely deny them coverage that is otherwise provided to nontransgender people.<sup>114</sup> In *Radtke v. Miscellaneous Drivers & Helpers Union Local No. 638 Health, Welfare, Eye & Dental Fund*, an employee's spouse was denied insurance eligibility because of her gender identity.<sup>115</sup> There, the insurer accepted the employee's spouse as an eligible dependent upon receipt of a valid marriage certificate.<sup>116</sup> Years later, the spouse's breast implant ruptured, and the insurer refused to cover the medical costs because they were related to "sex transformation."<sup>117</sup> The fact that the spouse had transitioned even led the insurer to question the validity of the marriage certificate.<sup>118</sup> The insurer concluded that the marriage was invalid because the spouse was male assigned at birth, and same-sex marriages are not legal in Minnesota.<sup>119</sup> The spouse provided a copy of her female birth certificate, another copy of the couple's marriage certificate, and various other documents from

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108. *Id.* at 1170.

109. *Id.*

110. *Id.*

111. Dean et al., *supra* note 14, at 104.

112. Andrew Cray & Kellan Baker, *FAQ: Health Insurance Needs for Transgender Americans*, CTR. FOR AM. PROGRESS (Oct. 3, 2012), <http://www.americanprogress.org/issues/lgbt/report/2012/10/03/40334/faq-health-insurance-needs-for-transgender-americans/>, *archived at* <http://perma.cc/JSA6-5FW8>.

113. *Id.*

114. *Id.*

115. *Radtke v. Miscellaneous Drivers & Helpers Union Local No. 638 Health, Welfare, Eye & Dental Fund*, 867 F. Supp. 2d 1023, 1026 (D. Minn. 2012).

116. *Id.*

117. *Id.* at 1027.

118. *Id.*

119. *Id.*

the IRS, Social Security Administration, and the State of Minnesota recognizing the marriage.<sup>120</sup> Despite this evidence, the insurer maintained that the marriage was invalid.<sup>121</sup> The court claimed that because Minnesota recognized the spouse as female, the marriage was valid and the issue of same-sex marriage was irrelevant.<sup>122</sup> Further, the court found that the insurer could have excluded this spouse if the trans-related health exclusion had been a provision when the spouse was accepted by the insurer, but they could not change the coverage terms as conditions became known.<sup>123</sup> Therefore, the insurer was required to cover the spouse as a qualifying dependent under the plan.<sup>124</sup>

Some have attempted to prohibit insurers from denying care to transgender people. For example, the insurance commissioner in Oregon recently required all insurance companies to provide the same level of health insurance to transgender individuals as is provided to all other individuals in the state.<sup>125</sup> The commissioner explained that if a health insurer provides breast-reduction surgery for back pain then it cannot deny the same surgery to a transgender individual when it is also medically necessary.<sup>126</sup> “This places an insured who is seeking coverage of a condition related to [gender identity] on equal footing with any other person by basing the decision about coverage on medical necessity, not on [gender identity].”<sup>127</sup> This decision reveals important actions that other insurance commissioners can take to promote LGBTQ equality within the health insurance system. In Oregon, the insurance commissioner found that such discrimination was unlawful under the state’s public accommodation statutes.<sup>128</sup> Further, the Oregon insurance commissioner found that even if insurance is not considered a public accommodation, the Insurance Code is violated when two individuals are treated differently on the basis of gender.<sup>129</sup> The Oregon Insurance Code is based on the Unfair Trade Practices Act, a model legislation that has been

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120. *Id.* at 1027-28.

121. *Id.* at 1031.

122. *Id.* at 1036.

123. *Id.* at 1036-37.

124. *Id.*

125. *Oregon Insurance Division Bulletin INS 2012-01*, OR. INS. DIV. (Dec. 19, 2012), <http://www.oregon.gov/DCBS/insurance/Legal/bulletins/Documents/bulletin2012-01.pdf>, archived at <http://perma.cc/PDZ3-JLRL>.

126. *Id.*

127. *Id.* at 3.

128. *Id.*

129. *Id.*

adopted by the majority of states.<sup>130</sup> Thus, most states would be able to adopt similar LGBTQ antidiscrimination protections. Additionally, most state insurance commissioners have the discretion to implement similar provisions that prevent unfair insurance practices.<sup>131</sup> Therefore, many insurance commissioners could take steps to eliminate discrimination in health insurance without having to pass state legislation or waiting for advocates to pursue litigation.<sup>132</sup> Unfortunately, most states have not taken any action to prohibit discriminatory insurance practices.

*Radtko* reflects the legal preference for gender conformance and heterosexual relationships and the problems with insurers and employers seeking to exclude people in need of health care. Obstacles to LGBTQ care are likely to increase as greater numbers of employers restrict health insurance provisions to cut costs and as health insurers require more detailed reports for ongoing mental and medical health care.<sup>133</sup> These health insurance trends are likely to increase LGBTQ people's fear of stigmatization and their perceived need to cover or avoid medical care.<sup>134</sup>

#### IV. LEGISLATIVE ATTEMPTS TO MAKE HEALTH INSURANCE LESS DISCRIMINATORY HAVE FAILED

These problems with health insurance are pervasive, but several pieces of legislation have attempted to solve them. First, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), most well-known for being a privacy and security act, also governed the range of health insurance coverage for groups and individuals.<sup>135</sup> HIPAA supporters cited eliminating discrimination for health conditions as among the legislation's most significant goals.<sup>136</sup> House Representative William Archer said that people with preexisting health conditions "may not be able to change jobs or even get insurance in the first place[, b]ut . . . this bill changes all that."<sup>137</sup> Thus, HIPAA restricts an insurer's ability to consider preexisting conditions.<sup>138</sup> HIPAA prohibits group

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130. Andrew Cray, *Every State Can Implement Transgender-Inclusive Health Coverage*, CTR. FOR AM. PROGRESS (Feb. 15, 2013), <http://www.americanprogress.org/issues/lgbt/news/2013/02/15/53599/every-state-can-implement-transgender-inclusive-health-coverage/>, archived at <http://perma.cc/TED2-3UKU>.

131. *Id.*

132. *Id.*

133. Dean et al., *supra* note 14, at 104.

134. *Id.*

135. Health Insurance Portability and Accountability Act, Pub L. No. 104-191, 110 Stat. 1936 (1996).

136. Roberts, *supra* note 91, at 1179.

137. 142 CONG. REC. 21,221 (1996).

138. 29 U.S.C. § 1181 (2012).

health insurers from using a number of health-related factors, such as health status and claims history, when making eligibility determinations.<sup>139</sup> HIPAA also prevents providers of group health insurance from requiring an individual in the group to pay higher premiums or make larger contributions than similarly situated group members on the basis of health related factors.<sup>140</sup>

However, health insurers are only prevented from excluding or medically underwriting a preexisting condition if the individual had coverage for a minimum of twelve months. Thus, if an individual was unemployed and unable to maintain health insurance, when they obtain health insurance again, the new health insurer can refuse claims related to any and all preexisting conditions for twelve months even though the individual is paying premiums. If you are diagnosed with cancer or are HIV-positive and need medication daily, waiting twelve months for treatment could cause the cancer to metastasize or the HIV to develop into AIDS. Paying out of pocket for treatments is an incredible expense that is impossible for most individuals. Further, when you have creditable coverage,<sup>141</sup> you are generally not eligible for any medical assistance programs, regardless of the insurer's refusal to cover the medical care.

The second legislative attempt to address discrimination was the Genetic Information Nondiscrimination Act of 2008 (GINA), which outlaws genetic-information discrimination in health insurance and employment.<sup>142</sup> Under GINA, a health insurer cannot (1) use genetic information to determine eligibility, coverage, or premiums; (2) request or require genetic information or genetic testing; (3) acquire genetic information for underwriting purposes; or (4) treat genetic information as a preexisting condition.<sup>143</sup> GINA's supporters portrayed it as an important protection against discrimination. Representative Louise Slaughter stated, "No American should have to worry that their genes—which they did not choose, and over which they have no control—will be used against them."<sup>144</sup> Similarly, Senator Olympia Snowe stated, "[G]enetic discrimination is, by its nature, a purposeful act based on an immutable

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139. 26 U.S.C. § 9802 (2012).

140. *Id.*

141. Creditable coverage is any public or private health insurance or health benefit plan, regardless of that plan's exclusions or maximum limits.

142. 42 U.S.C. § 2000ff-1 (2012).

143. *Id.*

144. 143 CONG. REC. 206 (1997).



fact—one’s very heredity.”<sup>145</sup> “GINA defines ‘genetic information’ as the results of an individual’s genetic tests, the results of an individual’s family members’ genetic tests, and the manifestation of a disease or disorder in an individual’s family.”<sup>146</sup> Despite protecting genetic information, GINA does not cover discrimination once the genetic condition is diagnosed in the covered individual.<sup>147</sup> For example, if an individual is diagnosed with Huntington’s Disease, a genetic disorder with a 100% correlation between genetic variant and condition, the diagnosis is not a “genetic test,” and that individual can be subject to health-insurance discrimination based on their disease.<sup>148</sup> Ultimately, GINA restricts a health insurer from considering a certain type of health-related information, even though it would provide more accurate risk assessments.<sup>149</sup> This represents a shift from a purely economic approach to health insurance to an antidiscrimination model, but it does not provide an insurance system without discrimination.<sup>150</sup>

The most recent legislation that aims to improve health insurance is the Patient Protection and Affordable Care Act (ACA). The ACA aims to increase health insurance access by requiring health insurers to cover people, forcing employers to provide health insurance, and expanding Medicaid.<sup>151</sup> Senate Finance Committee Chairman Max Baucus hailed the ACA, stating, “The era of egregious insurance company abuses is over.”<sup>152</sup> The ACA bans insurers from setting “discriminatory premium rates” based on a health condition, medical history, or disability.<sup>153</sup> It also expands the non-discrimination clause to include sex.<sup>154</sup> This means that there is a ban on health insurance companies’ ability to deny coverage or

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145. Olympia Snowe, *Senate Passes Snowe Bill Banning Genetic Discrimination By Insurers, Employers*, PROJECT VOTE SMART (Feb. 18, 2005), <http://votesmart.org/public-state-ment/102095/senate-passes-snowe-bill-banning-genetic-discrimination-by-insurers-employers#.Ux9hzOddVY4>, archived at <http://perma.cc/87F9-ANZC>.

146. Roberts, *supra* note 91, at 1184 (citing GINA, Pub. L. No. 110-233, §§ 101, 103(a)(2), 104(b), 201(4)(A)(i)-(iii), 122 Stat. 881, 883-88, 896, 900-02, 906 (2008)).

147. *Id.*

148. *Id.* (citing GINA, Pub. L. No. 110-233, § 101(d)(7)(B), 122 Stat. 881, 885-86 (2008)).

149. *Id.*

150. *Id.*

151. *About the Law*, HHS.GOV/HEALTHCARE, <http://www.hhs.gov/healthcare/rights/>, archived at <http://perma.cc/SZFL-QNRN>.

152. Press Release, Senate Fin. Comm. Chairman Max Baucus, Baucus Applauds New Consumer Protections, End to Insurance Company Abuses (Sept. 23, 2010), <http://www.finance.senate.gov/newsroom/chairman/release/?id=64b1a1e1-c552-45b1-8176-b67b423cb877>, archived at <http://perma.cc/BGE5-BL4Z>.

153. 42 U.S.C. § 300gg (2011); *id.* § 300gg-4.

154. *Id.* § 295m (1992).

charge more simply because of sexual orientation or gender identity.<sup>155</sup> However, the ACA does not clarify that it prohibits health insurers from excluding LGBTQ medical care on the basis that it is “not medically necessary” or “experimental.” Because no formal guidance has been issued for the nondiscrimination requirements, many states allow insurers to interpret these requirements on their own and place the burden on the insurance provider to explain why a policy is not discriminatory.<sup>156</sup> Allowing health insurers to determine discrimination will narrow anti-discrimination provisions. For example, even though some states, like Oregon and California, prohibited health insurers from discriminating based on gender identity, they still had health insurance companies denying care for transgender individuals through different mechanisms.<sup>157</sup> Thus, without specific language, oversight, and enforcement, the federal nondiscrimination provisions are unlikely to protect LGBTQ individuals sufficiently from insurers attempting to deny claims in order to maximize their profits.

The ACA allows individuals to buy health insurance if their employer does not provide it. Even though health insurers cannot charge more for health status or gender, they can charge more for premiums based on the following four criteria: (1) individual or family status, (2) geographic location (rating area), (3) age, and (4) tobacco use.<sup>158</sup> These four factors “may, in fact, serve as crude proxies for health status”<sup>159</sup> and may perpetuate existing disparities.<sup>160</sup>

First, the individual or family component of the ACA may discriminate against LGBTQ families. This was evident in *Radtke*, where the insurer or employer determined who could be considered a family member. As a result, LGBTQ people may be arbitrarily denied needed health care. This would be even more pervasive in states that do not recognize same-sex marriage, second-parent adoptions, or gender marker changes.

Second, the geographic component of the ACA could mean that people in poor, urban areas and rural communities, who already have less

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155. Press Release, Dep’t of Health & Human Servs., HHS Report on Accomplishments, New Efforts To Improve LGBT Health (July 31, 2013), <http://www.hhs.gov/news/press/2013pres/07/20130731a.html>, archived at <http://perma.cc/X5CP-22TH>.

156. KATIE KEITH, KEVIN LUCIA & CHRISTINE MONAHAN, THE CTR. ON HEALTH INS. REFORMS, NONDISCRIMINATION UNDER THE AFFORDABLE CARE ACT (July 2013), available at [http://chir.georgetown.edu/pdfs/NondiscriminationUndertheACA\\_GeorgetownCHIR.pdf](http://chir.georgetown.edu/pdfs/NondiscriminationUndertheACA_GeorgetownCHIR.pdf), archived at <http://perma.cc/0xSxCLGos7J>.

157. *Id.*

158. 42 U.S.C. § 300gg(a)(1)(A)(i)-(iv).

159. Roberts, *supra* note 91, at 1188.

160. *Id.* at 1189-90.

access to care, must pay more for insurance.<sup>161</sup> The U.S. Government states that it will be reviewing the rating areas to ensure they are “adequate.”<sup>162</sup> If adequate means nondiscriminatory, higher premiums will be unacceptable, but if adequate means “accurate for risk assessment purposes,” then requiring poor communities to pay higher health insurance premiums is likely to occur.<sup>163</sup> Given the socioeconomic disparities among LGBTQ individuals and families, the ability to determine rates based on geographic area could have an adverse effect on their ability to access health care.

Third, as people age they become more likely to require health care services. Under the ACA, older individuals can be charged up to three times more for their health insurance, but this determination cannot be based on health status.<sup>164</sup> The age exception could be problematic for older LGBTQ individuals, who tend to have poorer health outcomes and face employment and health discrimination because their age may serve as a proxy. Gay and bisexual men between the ages of fifty and seventy were 50% more likely to rate their health as fair or poor than their heterosexual counterparts.<sup>165</sup> Data also indicates that they have higher rates of diabetes, physical disability, and high blood pressure.<sup>166</sup> Similarly, lesbian and bisexual women between the ages of fifty and seventy were 26% more likely to say their health was fair or poor than heterosexual women in the same cohort.<sup>167</sup> Rates of physical disabilities were also higher among lesbian and bisexual women, but rates of diabetes and hypertension were similar to heterosexual women’s rates.<sup>168</sup> The Congressional Budget Office estimates that the national average premium for an individual purchasing health insurance would be \$5,800.<sup>169</sup> If an older individual can pay up to three times more, then an

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161. ERIKA ZILLER & JENNIFER LENARDSON, ME. RURAL HEALTH RESEARCH CTR., RURAL-URBAN DIFFERENCES IN HEALTH CARE ACCESS VARY ACROSS MEASURES (June 2009), <http://muskie.usm.maine.edu/Publications/rural/pb/Rural-Urban-Health-Care-Access.pdf>, archived at <http://perma.cc/LXD7-PSDB>.

162. Roberts, *supra* note 91, at 1192.

163. *Id.*

164. 42 U.S.C. § 300gg-4 (2011).

165. Roni Caryn Rabin, *Disparities: Illness More Prevalent Among Older Gay Adults*, N.Y. TIMES (Apr. 1, 2011), [http://www.nytimes.com/2011/04/05/health/research/05gay.html?\\_r=1&](http://www.nytimes.com/2011/04/05/health/research/05gay.html?_r=1&), archived at <http://perma.cc/57W-59UY>.

166. *Id.*

167. *Id.*

168. *Id.*

169. CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2009), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>, archived at <http://perma.cc/62AU-KBKU>.

individual could pay \$17,400 in annual health insurance premiums, regardless of any other factors. If an individual is below 400% of the federal poverty line then they only have to pay up to 9% of their income on premiums. Alternatively, there is no limit on premiums for people whose income is above that line.<sup>170</sup> Thus, in addition to the higher premiums older individuals may have to pay, they may also have to pay extra out-of-pocket costs for deductibles and co-pays. The ACA limits the maximum out-of-pocket expenses for co-pays and deductibles to \$6,350, but that provision has been delayed until 2015.<sup>171</sup> Ultimately, many low-income older people may continue to struggle to pay their additional health care expenses or avoid needed medical treatment altogether.

Fourth, tobacco use allows insurance companies to charge tobacco users one-and-a-half times more in premium rates than a nonuser's rate. While tobacco use correlates with diminished overall health, it also disproportionately correlates with low-income and LGBTQ individuals. Research suggests that gay men smoke at rates 1.1 to 2.4 times higher than heterosexual men.<sup>172</sup> Similarly, lesbian women smoke between 1.2 and 2.0 times more than heterosexual women.<sup>173</sup> Bisexual men and women have the highest smoking rates; they are 1.2 to 2.2 times more likely to smoke than gays and lesbians combined.<sup>174</sup> Higher incidences of smoking among LGBTQ individuals may be related to the specific targeting of the community by tobacco companies and to the stigma associated with being LGBTQ.<sup>175</sup> Consequently, the ability of insurers to penalize smokers through higher premiums will adversely affect LGBTQ individuals more than the general population.<sup>176</sup> Moreover, it is unclear how paying higher premiums to a health insurer when one smokes will offset expenses later—in the event they have lung cancer, emphysema, or another smoke-induced, serious health condition—if they change insurers when they change jobs or elect different coverage.

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170. See 42 U.S.C. § 18071 (2010); see also 26 U.S.C. § 36B (2011).

171. Robert Pear, *A Limit on Consumer Costs Is Delayed in Health Care Law*, N.Y. TIMES (Aug. 12, 2013), <http://www.nytimes.com/2013/08/13/us/a-limit-on-consumer-costs-is-delayed-in-health-care-law.html?pagewanted=all>, archived at <http://perma.cc/YHP3-NQBP>.

172. AM. LUNG ASS'N, SMOKING OUT A DEADLY THREAT: TOBACCO USE IN THE LGBT COMMUNITY 7 (2010), available at <http://www.lung.org/assets/documents/publications/lung-disease-data/lgbt-report.pdf>, archived at <http://perma.cc/9JXQ-3EQJ>.

173. *Id.*

174. *Id.*

175. Elizabeth A. Smith & Ruth E. Malone, *The Outing of Philip Morris: Advertising Tobacco to Gay Men*, 93 AM. J. PUB. HEALTH 988, 989 (2003).

176. Roberts, *supra* note 91, at 1193.

The opportunity to purchase health insurance may appeal to employees who receive employer-sponsored healthcare, but an employee cannot decline their employer insurance and buy health insurance if their employer provides “affordable” coverage.<sup>177</sup> Simply wanting different insurance is not an adequate reason. For example, a transgender employee whose employer maintained a transgender-specific exclusion in their insurance would be unable to purchase health insurance without such an exclusion unless the employer’s coverage was “unaffordable.”

Additionally, employers who provide health insurance to their employees have the ability to charge employees more for health insurance if they do not participate in employer-sponsored wellness programs. Under the ACA, employers can charge 30% to 50% more if an employee does not sufficiently participate in a wellness program or fails to meet specific health goals.<sup>178</sup> While encouraging individuals to participate in wellness programs is a laudable goal, not everyone is equally capable of participating. Further, while incentives or disincentives to participate do improve participation, there is mixed evidence about whether the participation affects health outcomes.<sup>179</sup> These incentives offer more promise for business owners struggling to cover the costs of subsidizing employees’ insurance premiums. “[T]hese programs offer possible savings on health premiums and increased employee health and resulting efficiency. Careful design will minimize risks for claims of discrimination and encourage universal participation by the employer’s entire workforce.”<sup>180</sup> People with disabilities or prior health conditions that limit their physical abilities, older individuals, and low-income workers will likely experience limited opportunities to participate.<sup>181</sup> Thus, the wellness programs could cost up to 30% more in premium costs for those individuals who are unable, but not necessarily unwilling, to participate in programs.<sup>182</sup>

The ACA also expands Medicaid to provide access to health insurance to a portion of the population living below the poverty line.<sup>183</sup> However, many providers refuse to accept Medicaid altogether because

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177. 42 U.S.C. § 18081 (2010).

178. Roberts, *supra* note 91, at 1188.

179. Julia James, *Health Policy Brief: Workplace Wellness Programs*, HEALTH AFF., [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=81](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=81) (last updated May 16, 2013), *archived at* <http://perma.cc/RSY2-PL8T>.

180. John DiNome, *Employers: Get Fiscally Fit with Wellness Programs*, FORBES (Feb. 28, 2013, 10:35 AM), <http://www.forbes.com/sites/theemploymentbeat/2013/02/28/employers-get-fiscally-fit-with-wellness-programs/>, *archived at* <http://perma.cc/XQ3B-M6GB>.

181. Roberts, *supra* note 91, at 1189, 1194.

182. *Id.* at 1188.

183. DENAVAS-WALT, *supra* note 19, at 29.

their reimbursement rates for medical care are much lower than private insurance.<sup>184</sup> Additionally, Medicare and Medicaid cover limited transgender health needs because the Centers for Medicare and Medicaid have not required transgender health needs specifically to be covered.<sup>185</sup>

## V. CONCLUSION

Changes to the health care system could reduce and prevent many LGBTQ health disparities. First, cultural competency and LGBTQ-inclusive policies and practices could lessen the pervasive stigma that causes many poor health outcomes. Health care providers and health systems should be required to receive cultural competency training regularly in order to address some of the interpersonal discrimination that causes LGBTQ individuals to avoid seeking necessary medical care. This would also require medical schools and treatment facilities to train physicians on disparity reduction and cultural competency for LGBTQ individuals. Moreover, the forms and information provided to patients should be LGBTQ-inclusive. Also, access to information about LGBTQ-friendly providers must be expanded.<sup>186</sup>

Second, to eliminate much of the discrimination that LGBTQ individuals face, antidiscrimination legislation should incorporate sexual orientation and gender identity in all public accommodations, employment, and federally funded health care institutions. This would

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184. A full discussion of Medicare and Medicaid are outside the scope of this essay. See generally Sofia B. Chaudhry et al., *Pediatric Access to Dermatologists: Medicaid Versus Private Insurance*, 68 J. AM. ACAD. DERMATOLOGY 738 (2012); Chapin White, *A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage Versus Increasing Physician Fees*, 47 HEALTH SERVICES RES. 963 (2012); Jeffrey T. Kullgren et al., *Nonfinancial Barriers and Access to Care for U.S. Adults*, 47 HEALTH SERVICES RES. 462 (2012); Paul B. Ginsburg, *Reforming Provider Payment—The Price Side of the Equation*, 365 NEW ENG. J. MED. 1268 (2011); Samuel S. Flint, *Ensuring Equal Access for Medicaid Children*, 31 HEALTH & SOC. WORK 65 (2006); Steve Berman et al., *Factors That Influence the Willingness of Private Primary Care Pediatricians To Accept More Medicaid Patients*, 110 PEDIATRICS 239 (2002); James Rickert, *Do Medicare and Medicaid Payment Rates Really Threaten Physicians with Bankruptcy?*, HEALTH AFF. BLOG (Oct. 2, 2012), <http://healthaffairs.org/blog/2012/10/02/do-medicare-and-medicaid-payment-rates-really-threaten-physicians-with-bankruptcy/>, archived at <http://perma.cc/UQ9K-RE4A>; Am. Hosp. Ass'n, *Underpayment by Medicare and Medicaid Fact Sheet* (Sept. 25, 2010), <http://www.aha.org/content/00-10/10medunderpayment.pdf>, archived at <http://perma.cc/6RUZ-3PT2>.

185. NAT'L CTR. FOR TRANSGENDER EQUAL., *MEDICARE BENEFITS AND TRANSGENDER PEOPLE* (2011), [http://transequality.org/Resources/MedicareBenefitsAndTransPeople\\_Aug2011\\_FINAL.pdf](http://transequality.org/Resources/MedicareBenefitsAndTransPeople_Aug2011_FINAL.pdf), archived at <http://perma.cc/9WTZ-75AF>; Dean Spade et al., *Medicaid Policy & Gender-Conforming Healthcare for Trans People: An Interview with Advocates*, 8 SEATTLE J. SOC. JUST. 497 (2009-2010).

186. Claire Pomeroy, *A Call to Action to Bring LGBT Health Disparities out of the Closet*, HUFFINGTON POST (Oct. 15, 2012, 5:59 PM), [http://www.huffingtonpost.com/claire-pomeroy/lgbt-health-care\\_b\\_1968437.html](http://www.huffingtonpost.com/claire-pomeroy/lgbt-health-care_b_1968437.html), archived at <http://perma.cc/8RQC-NRE5>.

protect LGBTQ individuals from employment, health, and other forms of discrimination, which would help to enforce the notion that heterosexism and genderism are prohibited by law, rather than sanctioned.

Third, it is essential that LGBTQ health data be collected and analyzed in order to reveal the disparities in health outcomes. Recently, LGBTQ health has become more of a priority at the national level.<sup>187</sup> Data has been able to highlight the poorer health outcomes of racial minorities, and the same needs to be done for sexual and gender minorities. Health systems should be required to collect information on race, sexual orientation, and gender identity for each patient. Based on the data collected, a facility receiving federal funds could face financial sanctions if significant disparities in care were revealed for minority patients.<sup>188</sup> This would shift the burden from individuals having to prove an intent to discriminate to the health care providers having to present evidence showing non-discriminatory reasons for the disparities in treatment and referrals.<sup>189</sup> Moreover, this would alert medical providers to the problem of health disparities and provide an incentive to address them.<sup>190</sup> This would also eliminate the requirement that the patient has to identify the intent or the substandard care provided. Further, businesses selecting insurance providers and facilities could make informed decisions not to select a racist, heterosexist, and gender-biased health system.<sup>191</sup>

Fourth, health insurance should not be tied to employment. When an individual has employer-sponsored health insurance, they have no control over the level of coverage, the care providers, or the treatments that are covered. If every individual, rather than a small portion of a population, had the ability to choose their health coverage and receive a subsidy based on income, there would be larger risk pools and more equitable access to health insurance. Additionally, rather than being subject to the health premiums selected by their employers, employees would be able to ensure that their health insurance does not incorporate exclusions that are going to adversely affect them.

Fifth, insurance commissioners should implement and enforce antidiscrimination rules and policies. Insurance commissioners could eliminate discrimination in health insurance without having to pass

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187. *Improving Health for LGBT Americans*, HHS.GOV/HEALTHCARE (June 26, 2013), <http://hhs.gov/healthcare/facts/blog/2013/06/improving-LGBT-health.html>, *archived at* <http://perma.cc/M7AY-K4BP>.

188. Bowser, *supra* note 70, at 127-28.

189. *Id.* at 129-30.

190. *Id.*

191. *Id.* at 130.

legislation or file individual litigation. These antidiscrimination rules must be specific, regulated, and enforced in order to ensure that insurance providers are not denying coverage to individuals simply because they do not want to pay for their necessary medical care.

Last, disparity reduction and prevention must be at the center of the LGBTQ fight for equality. Accessible health care must become a priority for every person, privileged or not. Fear of discrimination, lack of qualifying employment, and disadvantageous insurance practices should not have a detrimental and life-threatening impact on anyone's health.