

July 2015 | 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.^{1,2,3}

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 have served to increase access to care and insurance for LGBT individuals and their families. Most notably these include: the implementation of the Affordable Care Act (ACA); the Supreme Court's overturning of a major portion of the Defense of Marriage Act (DOMA) in *United States v. Windsor* and subsequent ruling in *Obergefell v. Hodges* legalizing same-sex marriage nationwide; and steps taken by the Obama Administration to promote equal treatment of LGBT people and same-sex couples in the nation's health care system. 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 2013 Supreme Court ruling on DOMA resulted in federal recognition of same-sex marriages for the first time and paved the way for recognition in many more states. Finally, the Court, in its 2015 decision in *Obergefell*, ruled that the Fourteenth Amendment requires a state to license same-sex marriages and to recognize such marriages performed out-of-state, thereby further expanding access and coverage across the country.

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 Supreme Court rulings on marriage equality, 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.⁴ 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.”⁵ 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.”⁶ 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.

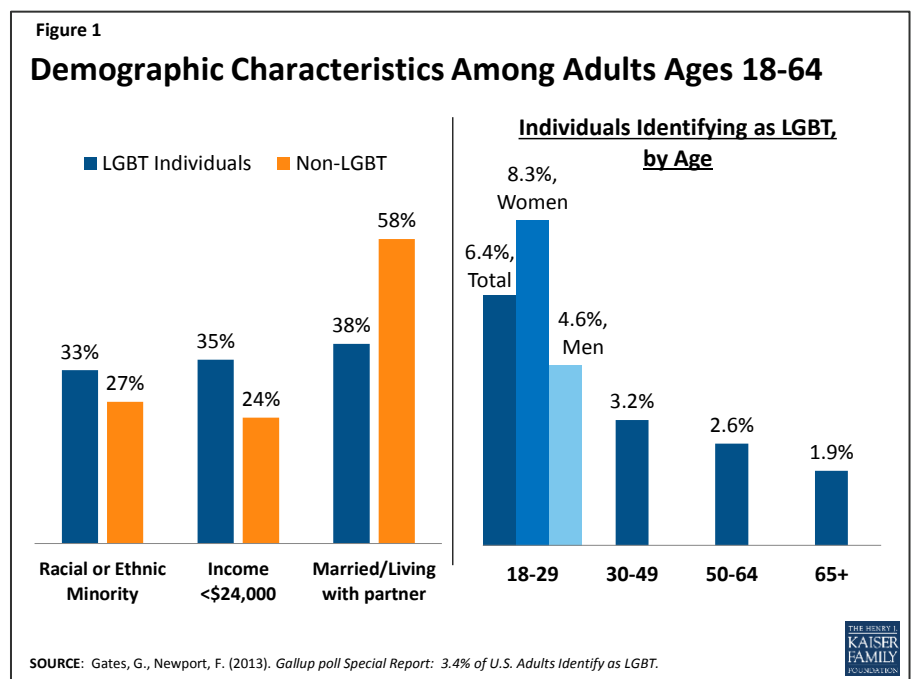
Lastly, while sexual orientation and gender identity are important aspects of an individual’s identity, they interact with many other factors, including sex, race/ethnicity, and class. The intersection of these characteristics helps to shape an individual’s health, access to care, and experience with 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.⁷ 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). The National Health Interview Survey (NHIS), the principal source of information on the health of the U.S. population, began including a question on sexual orientation in its 2013 survey and findings were released in July 2014.

Many data sources are used to make inferences about the LGBT population, and estimates on the size of the LGBT population vary:

- Data on the size of the LGBT population in the United States range. The latest data from the National Health Interview Survey (NHIS), a nationally representative survey of the U.S. population on health issues which now includes questions on sexual orientation, indicate that 2.3% of adults ages 18 and older in the U.S. identify as lesbian, gay, or bisexual, equating to more than 5.2 million people.⁸ Gallup poll data have found that between 3.4% and 3.6% of Americans ages 18 and older identify as LGBT, or about 9 million people.^{9,10,11,12} Estimates may vary due to differing methodologies for data collection. Most of these surveys include only those who self-identify as LGB¹³ 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. Other studies have looked beyond self-identification, to include behavior and attraction, and obtained higher estimates, including one that found that 10% of adults reported experience with same-sex partners.¹⁴ In addition, a recent analysis indicates that standard survey measures appear to significantly underestimate non-heterosexual identity and same-sex sexual experiences.¹⁵
- Data on those who identify as transgender are limited but a recent study found that an estimated 0.3% of the U.S. population is transgender, equating to approximately 700,000 people.¹⁶
- Estimates of self-identified LGBT individuals also vary by state. According to a 2012 Gallup poll, the share of adults who identify as LGBT ranges from a low of 1.7% in North Dakota to a high of 10% in the District of Columbia.¹⁷ 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 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**).¹⁸
- 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).¹⁹
- According to the 2013 American Community Survey, a smaller share of same-sex couples is raising children compared to both married and unmarried heterosexual couples.²⁰ Just over 40% of married and unmarried heterosexual couples are raising children, compared to 18% of same-sex couples, the majority of whom are female 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.²¹ Poverty rates on average are higher among lesbian and bisexual women, young people, and African Americans.²² 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. 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. 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 \$10,000.²³

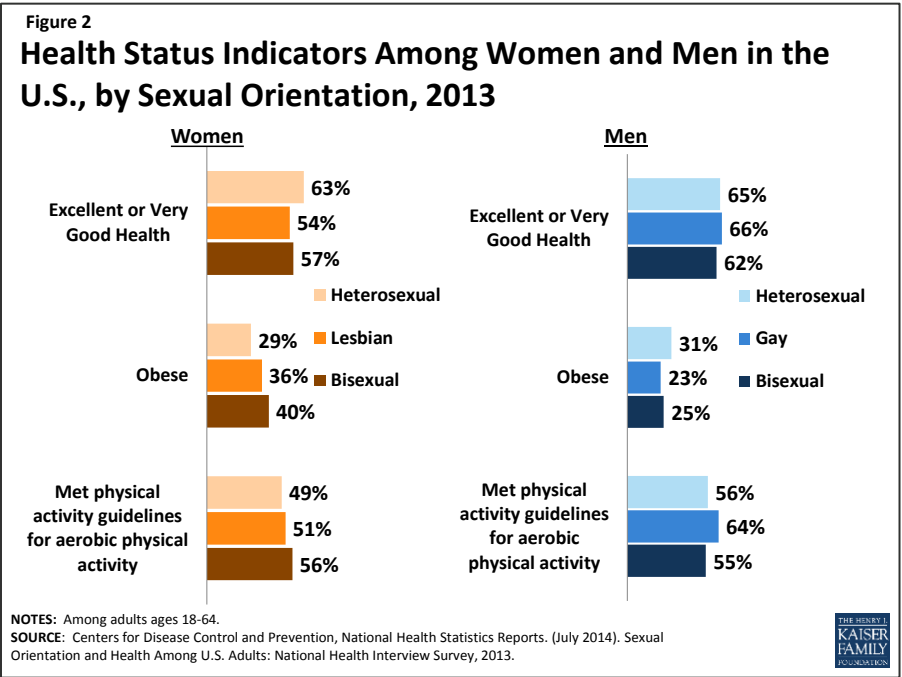
Health Challenges

Health is shaped by a host of social, economic, and structural factors.²⁴ 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.^{25, 26, 27} 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.^{28, 29}

- A recent literature review found that self-identified LGB 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.³⁰
- 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

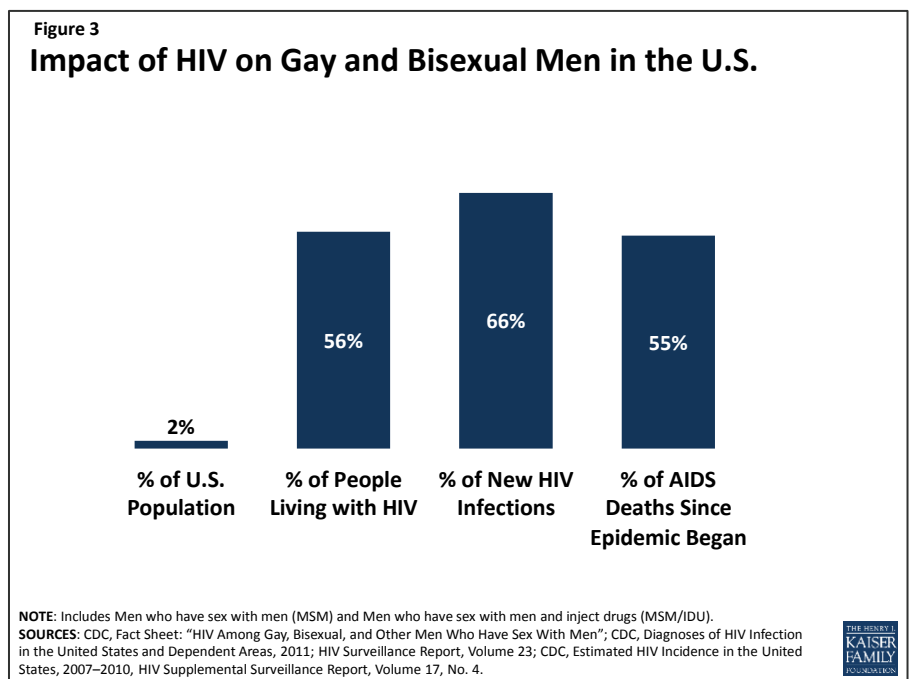


higher total numbers of acute and chronic health conditions such as headaches and urinary incontinence than heterosexual men.³¹

- According to data from the NHIS, fewer lesbian and bisexual women reported excellent or very good health compared to heterosexual women. There were no health status differences between men by sexual orientation (**Figure 2**).³²
- LGB individuals on average have higher rates of some risk factors for chronic illnesses. Obesity rates are higher among lesbian and bisexual women compared to heterosexual women, but are lowest among gay men. However, there were no significant differences by sexual orientation for women or men in rates of meeting physical activity guidelines.
- According to a 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%).³³

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.³⁴
- 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 2010.³⁵
- The CDC recommends that gay and bisexual men be tested for HIV at least once every year (and more frequently for those who are sexually active), but according to a new nationally representative survey conducted by the Kaiser Family Foundation, many do not meet this level. While seven in ten gay and bisexual men say they have gotten an HIV test at some point in their lives, just 30 percent say they were

tested within the past year. Three in ten (30%) say they have never been tested for HIV, rising to 44% of those under age 35. The leading reason that men give for not having had a recent test is that they do not consider themselves at risk for HIV.³⁶

- Access to medical care is critical for the health of people with HIV. Among MSM diagnosed with HIV in 2010, approximately three-fourths received medical care within three months of their diagnosis, but only half (51%) were retained in treatment over the course of the year. Rates were lowest among younger men and Black men.³⁷ In addition, according to the Kaiser survey, three in ten (31%) gay and bisexual men either say they don't have a regular place to go for medical care or they don't have a regular physician. These men (who tend to be younger, lower-income, and more racially diverse) are also less likely to report discussing HIV with doctors or getting tested for HIV.
- 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,³⁸ and a majority are unaware that they are infected.
- To date, there has only been one likely case of female-to-female sexual transmission of HIV in the United States.³⁹ 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.⁴⁰ MSM also account for 15% to 25% of all new Hepatitis B infections.⁴¹ 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.⁴² MSM are 17 times more likely to develop anal cancer than men who only have sex with women.⁴³ 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.

BEHAVIORAL AND MENTAL HEALTH

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.^{44,45} The history of discrimination and stigma contributes to higher rates of mental illness.⁴⁶ 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.⁴⁷ 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.⁴⁸

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.⁴⁹

- The recent NHIS provides the first national comparisons of gay, lesbian and bisexual adults to heterosexual adults on alcohol consumption, smoking status, and one measure of mental health status (**Table 1**).

Table 1: Alcohol Use, Cigarette Use, and Serious Psychological Distress Among Bisexual, Gay or Lesbian, and Heterosexual Adults ages 18-64, 2013			
Five or more alcoholic drinks in 1 day at least once in past year	Bisexual	Gay or Lesbian	Heterosexual
All adults	41.5%	35.1%	26.0%
Women	34.9%	27.7%	17.2%
Men	56.3%	41.8%	35.1%
Current cigarette smoker	Bisexual	Gay or Lesbian	Heterosexual
All adults	29.5%	27.2%	19.6%
Women	29.4%	27.2%	16.9%
Men	29.6%	27.2%	22.3%
Experienced serious psychological distress in past 30 days	Bisexual	Gay or Lesbian	Heterosexual
All adults	11.0%	5.0%	3.9%
Women	10.8%	N/A	4.5%
Men	N/A	N/A	3.3%
All adults	41.5%	35.1%	26.0%

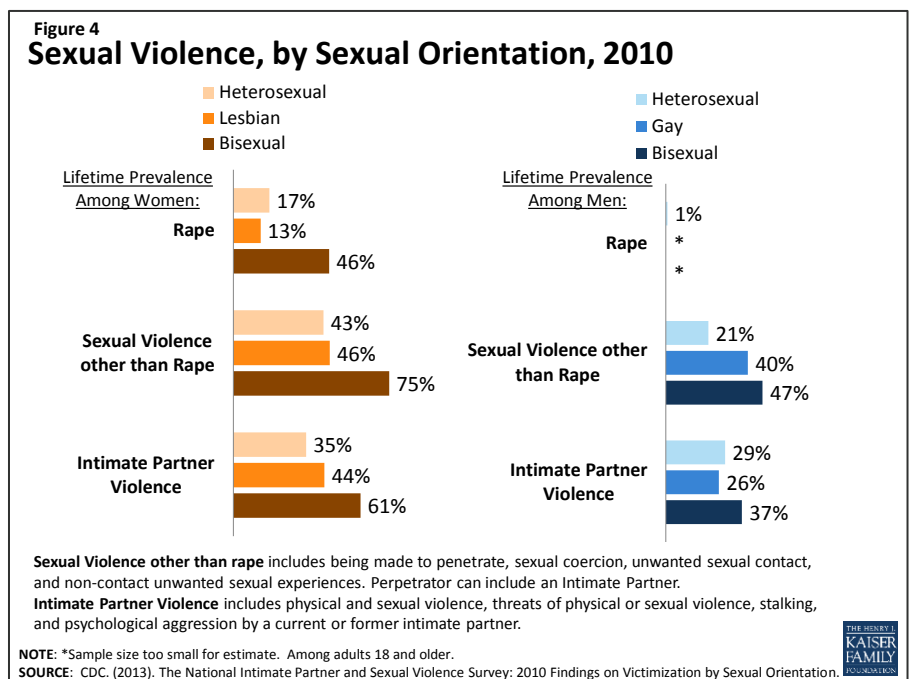
NOTE: N/A- data not available due to unreliability.
 SOURCE: Centers for Disease Control and Prevention, National Health Statistics Reports. (July 2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013.

- Consuming five or more alcoholic beverages in one day was reported by more bisexual (40%) and gay or lesbian (33%) adults than heterosexual adults (22%). Rates among men of all sexual orientations were substantially higher than for women.
 - Smoking rates were higher among bisexual and lesbian women compared to heterosexual women, but did not vary by sexual orientation for men. A separate 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.⁵⁰
 - One in ten bisexual women experienced serious psychological distress in the past 30 days, more than twice the rate of lesbian and heterosexual women. Approximately 3% of heterosexual men reported experiencing serious psychological distress, and data were unavailable for bisexual and gay men.
- Other 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.⁵¹ 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.⁵²
- Research suggests that MSM have higher use of certain substances. One study has estimated that MSM are more than 12 times as likely to use amphetamines and almost 10 times as likely to use heroin as heterosexual men. However, it's important to note that research in this field is older and data are not necessarily comparable to the heterosexual population.⁵³

SEXUAL ASSAULT AND PHYSICAL VIOLENCE

Sexual assault and physical violence can have lasting consequences for victims, families, and communities.⁵⁴

- 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.⁵⁶
- 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**).⁵⁷
- 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.⁵⁸ 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.⁵⁹ 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.⁶⁰ Transgender people, particularly transgender women and transgender people of color, are also at particular risk of physical violence.⁶¹ 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.⁶²

ADOLESCENT AND YOUNG ADULT HEALTH

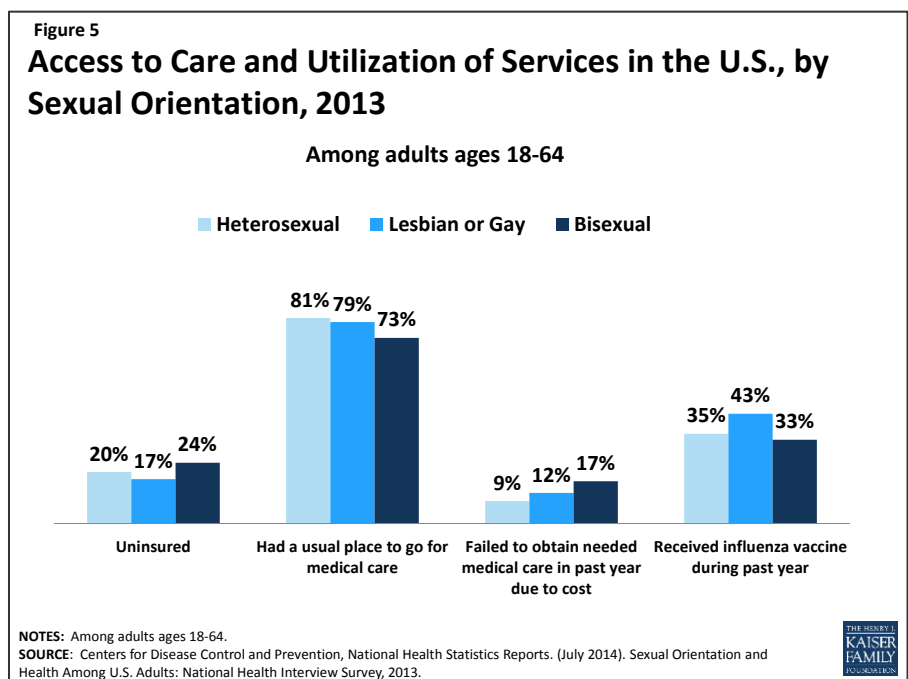
Adolescence and young adulthood are often times when individuals begin to identify as LGBT.⁶³ While these times can be challenging for many individuals, they are often especially so for LGBT youth. Despite growing societal acceptance and understanding, some young people still suffer discrimination at 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.⁶⁴
- Approximately 40% of homeless youth are LGBT, and the leading reasons for homelessness among this group are due to family rejection.⁶⁵
- 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.⁶⁶
- LGB youth are four times more likely to attempt suicide than heterosexual youth.⁶⁷
- Three times as many LGB youth report ever being raped compared to their heterosexual peers (16% vs. 5%).⁶⁸

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.

- Until recently, the available research on LGBT people has often been 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**). According to the NHIS, the uninsured rate did not vary significantly by sexual orientation in 2013. However, on other measures of access, including a usual place to go for medical care and going without medical care due to cost, bisexual adults fared poorer than other groups.

- A separate 2013 survey found that among LGBT individuals estimated to have incomes under 400% of the federal poverty level (FPL), almost 4 in 10 had medical debt and more than 4 in 10 reported postponing medical care due to costs.⁶⁹
- 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. 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.⁷⁰
- Marriage is tied to access to health insurance. Prior to the Supreme Court's *Windsor* ruling, however, same sex married couples were only able to obtain coverage for their spouse as a domestic partner, if their employer provided such coverage, and these benefits were considered taxable income. Nationally, four in ten (39%) firms that offered health insurance provided benefits to unmarried same-sex domestic partners in 2014, up from 21% in 2009, a percentage that varies by firm size, region, and industry, with larger companies, those in the Northeast, and manufacturing field most likely to offer coverage to unmarried same-sex partners (**Table 2**). With the *Windsor* and *Obergefell* rulings, this situation has changed (see below). Indeed, one study found that the legalization of same-sex marriage in New York was associated with an increase in employer-sponsored insurance among same-sex couples.⁷¹
- Some studies have found that lesbian women in couples have lower rates of breast and cervical cancer screenings than married heterosexual women.⁷² 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.^{73,74}
- 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.⁷⁵ 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.⁷⁶
- 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.⁷⁷ 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.⁷⁸ 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.^{79,80}
- 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.^{81,82} 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.⁸³ 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.⁸⁴ 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.⁸⁵

Impact of Changes in the Legal and Policy Landscape 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.⁸⁶ Additionally, the passage of the ACA in 2010, the Supreme Court’s ruling overturning DOMA in 2013, and subsequent ruling in *Obergefell* in 2015, significantly affect access to care and coverage for LGBT individuals and their families, expand nondiscrimination protections, increase data collection requirements, and support 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 millions, including LGBT individuals. For LGBT populations, three major areas are of particular saliency: 1) expanded access to coverage and insurance market reforms, 2) “nondiscrimination” protections, and 3) requirements for data collection and research.

COVERAGE

- The ACA extends coverage to millions of uninsured persons through the expansion of Medicaid, in states that choose to expand, as well as the creation of new federally subsidized health insurance marketplaces in all states. In states that expand their Medicaid programs, Medicaid eligibility is based solely on income, and is available to most individuals with incomes below 138% FPL regardless of their family status or disability. For those uninsured individuals who are not eligible for Medicaid, they can purchase coverage in insurance marketplaces, with subsidies available to individuals with incomes between 100% and 400% of FPL to help offset the costs of premiums. One study found 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.⁸⁷
- As of January 2014, individuals can no longer be denied insurance due to a pre-existing condition, such as HIV, 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 marketplace will have coverage for a set of essential health benefits, including prescription drugs and mental health services.
- Data indicate that health coverage for LGB adults has been increasing since implementation of the ACA. A recent analysis by the Urban Institute found that the share of uninsured LGB adults decreased significantly between June/September 2013 and December 2014/March 2015, falling from 21.7 percent to 11.1 percent, larger than the decline for non-LGB adults.⁸⁸ Survey data from Gallup⁸⁹ and the Center for American Progress⁹⁰ of LGBT adults also found reductions in the share reporting they were uninsured.

NONDISCRIMINATION PROTECTIONS

- As described above, bias and discrimination in the health care system have been an unfortunate reality for many LGBT people.⁹¹ In addition to provider level discrimination, and prior to the ACA, 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.⁹² 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.⁹³
- The ACA and subsequent federal regulations implementing the ACA prohibit such discrimination in many aspects of health care. 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).
- Federal regulations issued by the Department of Health and Human Services (DHHS) governing health insurance marketplaces⁹⁴ as well as regulations governing any health plan offering essential health benefits⁹⁵ bar discrimination in insurance provision based on sexual orientation and gender identity.
- Federal regulations governing health plan marketing practices prohibit health insurance issuers offering non-grandfathered insurance coverage in the group or individual markets (including health care marketplaces) from employing marketing practices or benefit designs that discriminate on the basis of certain specified factors, including sexual orientation and gender identity.⁹⁶ In 2014, the Centers for Medicare and Medicaid Services issued an FAQ⁹⁷ clarifying that these regulations include coverage of same-

sex married spouses. Per the FAQ, the regulations require health issuers who offer coverage to opposite-sex spouses to also offer coverage to same-sex married spouses, based on state of celebration, as of January 2015. However, the regulation does not apply to employers.

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.⁹⁸ As mentioned above, as of 2013, the NHIS includes a question on sexual orientation. In addition, 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.⁹⁹ In particular, the IOM recommends collecting such data in electronic medical records (EMRs), which are growing in use.¹⁰⁰

IMPACT OF SUPREME COURT RULINGS

Spousal coverage is an important pathway to insurance and other health benefits and legal protections 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 and several states banned same-sex marriage. This limited the ability of LGBT individuals and families to access a wide range of benefits, including health coverage as a dependent spouse. Two rulings by the Supreme Court have fundamentally changed this landscape.

- *United States v. Windsor*¹⁰¹: In June 2013, the Supreme Court's ruling in *United States v. Windsor* overturned a portion of DOMA and required the federal government to recognize legal same-sex marriages for the first time. The ruling and subsequent Agency policy interpretations and guidance have resulted in expanded access for many LGB families to a range of benefits, including dependent health coverage and family and medical leave. However, the ruling did not require states to recognize same-sex marriage or end state-level bans. As such, while the federal government extended benefits to legally married same-sex

couples based on “state of celebration”¹⁰² where possible, some benefits remained dependent on the legal status of same sex marriage in “state of domicile”¹⁰³ This led to a patchwork of coverage availability across the country until the *Obergefell* decision.

- *Obergefell v. Hodges*¹⁰⁴: In June 2015, the Supreme Court ruled in *Obergefell v Hodges* that the Fourteenth Amendment requires states to license same-sex marriages and to recognize such marriages lawfully licensed and performed out-of-state, resulting in legal recognition of same-sex marriage nationwide. This effectively ends the distinction between state of celebration and state of domicile and is expected to further expand access health coverage and care for LGBT individuals and families.

Specific changes that affect spousal coverage and benefits due to these rulings are as follows: (Also see **Table 3.**)

- **Tax Implications:** As a result of the *Windsor* ruling, the Internal Revenue Service (IRS) ruled that it recognized all legally married same sex couples, based on state of celebration, who could now file federal taxes as “married” and, where same-sex marriage was legal, state taxes as well. As a result of the *Obergefell* decision, same-sex couples can now file state taxes jointly in every state. Tax filing affects a number of health-related financial issues such as taxes on health benefits.¹⁰⁵ For example, dependent coverage, including spousal coverage, is excluded from an employee’s taxable income. Prior to the Supreme Court’s *Windsor* ruling, coverage for a same-sex spouse was considered taxable income, which raised taxes for those who received this coverage. The same is true for state taxes in states that did not recognize same-sex marriage prior to the *Obergefell* ruling. These rulings mean that married same-sex couples no longer face this higher tax burden at the federal and state levels.^{106,107}
- **Federal Employees & Federal Contractors:** The Supreme Court’s *Windsor* decision also prompted federal agencies to reverse previous limitations on spousal benefits in federal programs. Where the federal government determined it had jurisdiction to do so, such benefits were extended to all legally married same-sex couples based on state of celebration. For example, all federal employees who are legally married to a same-sex partner (regardless of where they live), were given the same eligibility for dependent spousal health coverage in the Federal Employees Health Benefits Program (FEHBP) as well as other dependent benefits, including dental and vision insurance, long-term care insurance, and flexible spending accounts.¹⁰⁸ In addition, in 2014, President Obama issued an executive order¹⁰⁹ adding sexual orientation and gender identity to the prohibited bases of discrimination in employment by federal contractors and subcontractors. As such, it requires contractors that provide spousal benefits to opposite-sex married couples to also provide them to same-sex married couples.¹¹⁰
- **Members of the Military and Veterans:** Following the *Windsor* decision, the Department of Defense recognized same-sex marriages based on state of celebration and extended spousal benefits, such as TRICARE health coverage, to the same-sex spouses of military service members and employees.¹¹¹ However, several benefits for Veterans continued to be tied to state of domicile, which meant that eligibility for spousal benefits for Veterans was uneven between marriage equality and non-equality states until the ruling in *Obergefell*. As a result of that decision, the Department of Veterans Affairs now recognizes all same-sex marriages¹¹² and will extend benefits to all same-sex spouses of Veterans, including CHAMPVA health coverage, survivor compensation, and burial benefits.

- **State and Municipal Employees:** While the *Windsor* decision resulted in eligibility for spousal coverage for all federal employees and contractor employees, a patchwork of policies remained for state and local public employees based on where they lived. As a result of the *Obergefell* ruling's recognition of same-sex marriages in all states, spousal coverage benefits should be extended to state and municipal employees across the nation to the same degree as their heterosexual counterparts.
- **Private Employers:** Neither the *Windsor* nor *Obergefell* decisions are binding on employers. In addition, as mentioned above, ACA regulations regarding health issuers are also not binding on employers. Therefore, while employers in marriage equality states were largely expected to offer same-sex spousal coverage after *Windsor*, and in all states after *Obergefell*, there remains some question about whether employers can legally limit spousal coverage to opposite-sex spouses. Still, many experts believe that an employer that offers health benefits to opposite-sex spouses but refuses to offer such benefits to same-sex spouses would likely be in violation of Title VII of the Civil Rights Act, which prohibits discrimination based on sex. The Equal Employment Opportunity Commission (EEOC)¹¹³ and at least one federal court¹¹⁴ have found Title VII to have standing in such cases. Moreover, a recent EEOC decision found that “sexual orientation is inherently a ‘sex-based consideration’ under Title VII.”¹¹⁵ The EEOC ruling allows such cases from both private and public sector employees to be brought forward for its review and will also be considered by federal courts in their review of cases, although it is not binding on them. In addition to potential Title VII violations, employers who provide spousal coverage for opposite sex couples but not same-sex couples may be subject to state non-discrimination laws. Given the remaining uncertainties regarding employers, this will be an important area to watch going forward.
- **ERISA Protections:** The Department of Labor issued guidance¹¹⁶ on the implications of the *Windsor* ruling for health plans and plan sponsors governed by the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that sets minimum standards for most voluntarily established pension and health plans. The guidance states that under ERISA, the definition of “marriage”, wherever it appears, will include same-sex marriage based on state of celebration. This makes clear that group health plans can extend certain protections to married same sex couples, most notably COBRA, the law that offers employees and their families a temporary extension of group health coverage following a job loss or other qualifying event. In addition, because ERISA requires group health plans that offer spousal coverage generally to permit special enrollment opportunities for newly-married spouses, this guidance makes clear that group health plans can extend special enrollment rights to same-sex marriages where spouses are otherwise eligible to participate. However, neither the guidance nor ERISA specifically addresses whether the employer that sponsors the group health plan is required to recognize a same-sex marriage.
- **State-Level Insurance Protections:** In addition to federal law, several states have nondiscrimination policies in insurance coverage and employment, although the majority of states do not have such protections. Nine states (CA, CO, DE, IL, ME, NV, OR, VT, WA) plus DC prohibit discrimination based on sexual orientation and gender identity in health insurance.¹¹⁷ Ten states (CA, CT, CO, IL, MA, NV, NY, OR, VT, WA) and DC prohibit transgender exclusions in health insurance through legislation or regulation.¹¹⁸ Twenty-two states plus DC prohibit discrimination by private employers on the basis of sexual orientation.¹¹⁹
- **Health Insurance Marketplaces:** *Windsor* also affected eligibility for assistance for same-sex couples in all ACA health insurance marketplaces (whether federally-facilitated or state based). Eligibility is based in part on an applicant's family structure and income. Federal regulations were issued stating that insurance

marketplaces must recognize same-sex marriages and base eligibility for tax credits on a couple's income.¹²⁰ (It is important to note that when a couple's income is used to determine eligibility for tax credits in the marketplace, it could mean they are more or less likely to qualify, depending on their specific situation).

- **Medicaid and CHIP:** Because Medicaid and the Children's Health Insurance Program (CHIP) are federal-state partnerships, the federal government determined that *Windsor* did not allow it to require states to recognize same-sex marriages for the purpose of determining eligibility, although it encouraged them to do so.¹²¹ This meant that eligibility could vary based on state laws regarding same-sex marriage. With the *Obergefell* ruling, however, all states must now recognize legal same-sex marriages and state Medicaid agencies are expected to do so (as with marketplaces, eligibility may be impacted when income is counted jointly).
- **Medicare:** These decisions have also resulted in expanded access to Medicare for same-sex couples. After *Windsor*, DHHS issued guidance clarifying that same-sex married beneficiaries in Medicare Advantage plans who each need care in a skilled nursing facility can receive care at same facility, as applicable to married Medicare beneficiaries more generally.¹²² Also after *Windsor*, individuals in same-sex marriages became eligible for free Medicare Part A (hospital) premiums in marriage recognition states if their spouse had sufficient work history to qualify for Medicare benefits, even if they themselves did not.¹²³ If they lived in a non-recognition state, however, they had access to reduced premiums only. *Obergefell* expanded access to free Part A premiums nationwide. In addition, a special enrollment period (SEP) for Medicare Part B (and Premium Part A) is available for an individual who gains and then loses insurance coverage related to spousal employment without facing a penalty (this was already based on state of celebration after *Windsor*).¹²⁴ As with other means-tested programs, eligibility may be impacted when income is counted jointly.

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 (FMLA) 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.

- After the Supreme Court's *Windsor* ruling, the DOL expanded FMLA to include legally married same-sex spouses residing in states that recognized same-sex marriage.¹²⁵ In February 2015, the DOL expanded the FMLA to include same-sex couples based on state of celebration, regardless of their state of residence.¹²⁶
- 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 (whether or not they are legally

married) and state explicitly that discrimination based on sexual orientation and gender identity are prohibited.¹²⁷

- Providers must sometimes communicate information or discuss medical decisions on a patient's behalf with a patient "representative," who is often a spouse. If finalized, Federal regulations proposed in 2014 would require that providers and suppliers, such as hospitals, hospices, community mental health centers, and laboratories, that participate in Medicare and Medicaid must recognize same-sex spouses (marriage legalized based on state of celebration) as patient representatives.¹²⁸
- 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.¹²⁹
- Despite these protections, there are still areas where LGBT individuals and families are not protected. For example, paid sick leave is an important benefit that many workers do not have. Because it has been 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.¹³⁰

OTHER CHANGES

- Medicaid is the primary payer of long-term care, and qualifying for Medicaid long-term services can result in exhaustion of financial resources for those who seek services as well as their spouses. The program's "spousal impoverishment" protections aim to mitigate this by allowing a spouse who remains in the community to retain a certain level of income and assets without affecting eligibility. In 2011, states were given the option to extend these "spousal impoverishment" protections to married same-sex couples and domestic partners.¹³¹ After *Windsor*, such protections were required for married same-sex couples in marriage equality states. It is expected that with the *Obergefell* ruling, all states will be required to apply these protections to married same-sex couples.
- Coverage of transgender services has also been expanded in federal programs. In 2014, HHS invalidated a prior policy that had allowed Medicare plans to deny coverage for "transsexual surgery,"¹³² and OPM has stated that, as of 2016, the Federal Employees Health Benefits Program (FEHBP) may not issue blanket exclusions for gender transition services.¹³³ As a result, Medicare and FEHBP plans must cover gender transition services that are "medically necessary," although the definition of medical necessity is in part at the discretion of providers and plans. Several employers have also moved to make their plan offerings more comprehensive by removing exclusions for transgender health 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.¹³⁴

A number of health challenges disproportionately affect LGBT communities, particularly the HIV epidemic, stigma and violence, substance use, 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 marriage recognition throughout the country. This convergence of policy and legal breakthroughs holds promise for broader access to health services, coverage, and benefits for LGBT communities.

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, 2014

	Offer Health Coverage to Same-sex Partners	Do Not Offer Health Coverage to Same-sex Partners	Not Encountered
Firm Size			
All Small Firms(3-199 Workers)	39%	19%*	42%*
All Large Firms (≥200 Workers)	49%*	45%*	5%*
Region			
Northeast	60%*	21%	19%*
Midwest	28%	24%	47%
South	25%*	22%	53%
West	48%	11%	41%
Industry			
Manufacturing	69%*	20%	12%*
Wholesale	38%	36%	25%
Retail	25%	12%	63%
Finance	55%	22%	23%
State/ Local Government	16%*	27%	57%
All Firms	39%	20%	41%

* 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 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, 2014.

Table 3: Impact of Selected Federal Policy Changes on Coverage and Access to Care for LGBT Communities

Policy	Key Provisions and Impact
<p>The Patient Protection and Affordable Care Act (ACA)¹³⁵</p>	<ul style="list-style-type: none"> • Expands coverage to many uninsured persons through Medicaid and health insurance marketplaces in all states. 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. • Section 1557 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).¹³⁶ • Federal regulations governing health insurance marketplaces¹³⁷ and regulations governing plans that offer “essential health benefits” prohibit discrimination based on sexual orientation and gender identity. • Federal regulations governing health insurance issuers’ marketing practices requires all health issuers offering non-grandfathered plans in the individual and group markets that offer coverage to opposite-sex spouses to also offer coverage to same-sex spouses, based on state of celebration.^{138,139} • Promotes data collection and analysis on sexual orientation and gender identity through federally-sponsored surveys and programs. • Individuals will no longer be denied coverage due to a pre-existing condition, such as HIV, mental illness, or a transgender medical history. • New private plans are required to cover USPSTF recommended preventive services without cost sharing. Includes screenings for HIV, STIs, depression, and substance misuse.
<p>Supreme Court Rulings on Marriage Equality: <i>United States v. Windsor</i> (2013) and <i>Obergefell v. Hodges</i> (2015)</p>	<ul style="list-style-type: none"> • Legalization of same-sex marriage nationwide by overturning Section 3 of the Defense of Marriage Act, which had limited marriage to persons of the opposite sex (<i>Windsor</i>)¹⁴⁰, and ruling that the fourteenth amendment requires states to license same-sex marriages and to recognize such marriages performed out-of-state (<i>Obergefell</i>)¹⁴¹. • Department of Justice Federal Marriage Benefits for Same-Sex Couples¹⁴² <ul style="list-style-type: none"> ○ Announcement by Attorney General, following <i>Obergefell</i> ruling, that federal agencies will work to extend marriage benefits to married same-sex couples in all states (<i>Windsor</i> ruling had extended many but not all federal benefits to married same-sex couples based on state of celebration but some benefits not available in states that did not recognize same-sex marriage). • Internal Revenue Service (IRS) Ruling 2013-17¹⁴³ <ul style="list-style-type: none"> ○ After <i>Windsor</i>, 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 federal taxes as “married” and thus treats same-sex spousal health coverage as tax exempt for purposes of determining federal income tax. ○ 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. • U.S. Office of Personnel Management, Guidance on the Extension of Benefits to Married Gay and Lesbian Federal Employees, Annuitants, and their Families¹⁴⁴ <ul style="list-style-type: none"> ○ After <i>Windsor</i>, extended federal health (FEHB), vision, dental, long-term care, and flexible spending accounts benefits to legal same-sex spouses of federal employees, based on state of celebration.

	<ul style="list-style-type: none"> • Executive Order 13672 Prohibiting Discrimination Based on Sexual Orientation and Gender Identity by Federal Contractors and Subcontractors¹⁴⁵ <ul style="list-style-type: none"> ○ Prohibit federal contractors and subcontractors from discriminating on the basis of sexual orientation or gender identity in employment, including in the provision of spousal health benefits. • Department of Defense Memorandum Subject: Extending Benefits to the Same-Sex Spouses of Military Members¹⁴⁶ <ul style="list-style-type: none"> ○ Legally married spouses eligible for dependent health coverage of service members and DOD civilian employees. • Department of Veterans Affairs – Recognition of Same-Sex Marriages¹⁴⁷ <ul style="list-style-type: none"> ○ <i>Windsor</i> extended VA benefits (including CHAMPVA health coverage, survivor compensation, and burial benefits) to same-sex spouses of Veterans based on state of domicile. Per <i>Obergefell</i>, benefits to be extended to all same sex spouses of Veterans nationwide. • 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 <ul style="list-style-type: none"> ○ All Health Insurance Marketplaces are to recognize legal same-sex marriages when determining eligibility for Premium Assistance and Tax Credits.¹⁴⁸ • Centers for Medicare and Medicaid Services (CMS) Guidance on Eligibility for Medicaid and CHIP¹⁴⁹ <ul style="list-style-type: none"> ○ After <i>Windsor</i>, states encouraged to recognize same-sex marriages by jointly counting spousal income when determining Medicaid eligibility but not required to do so. Since <i>Obergefell</i>, expected to apply nationwide to all Medicaid programs. • Social Security Administration Determination of Marital Status for spousal Medicare benefits <ul style="list-style-type: none"> ○ Same-sex spouses eligible for free Medicare Part A if spouse has sufficient work history to qualify for Medicare benefits.¹⁵⁰ (was based on state of domicile after <i>Windsor</i> and extended nationwide per <i>Obergefell</i>). ○ Special enrollment period for Medicare available to those who gain and then lose insurance coverage related to spousal employment.¹⁵¹ • Centers for Medicare and Medicaid Services (CMS) Impact of United States v. Windsor on Skilled Nursing Facility Benefits for Medicare Advantage Enrollees¹⁵² <ul style="list-style-type: none"> ○ After <i>Windsor</i>, clarifies that same-sex married beneficiaries in Medicare Advantage plans who each need care in a skilled nursing facility can receive care at same facility, as applicable to married beneficiaries more generally. • Department of Labor, Wage and Hour Division– The Family and Medical Leave Act¹⁵³ <ul style="list-style-type: none"> ○ As a result of the <i>Windsor</i> ruling, the DOL finalized a rule in 2015 that expanded the definition of “spouse” to include all legally married same-sex couples for purposes of providing 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.
Other	<ul style="list-style-type: none"> • Presidential Memorandum– Hospital Visitation¹⁵⁴ <ul style="list-style-type: none"> ○ Executive order and subsequent regulations¹⁵⁵ in 2010 stating that hospitals receiving funds from Medicaid and Medicare are to respect the rights of patients to designate visitors, including same-sex partners (whether married or not) and others designated by legally valid advance directives. ○ Regulations 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.

- **Centers for Medicare and Medicaid Services Memorandum 13-42-NH: Reminder- Access and Visitation Rights in Long Term Facilities**¹⁵⁶
 - LTC facilities must ensure that all individuals, including same-sex partners (whether married or not), seeking to visit a resident be given full and equal visitation privileges, consistent with resident preferences within reasonable restrictions that safeguard residents.
- **Centers for Medicare and Medicaid Services- Medicaid Spousal Impoverishment Protections**¹⁵⁷
 - In 2011, states were given the option to extend protections to include married same-sex spouses and domestic partners. 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. After *Windsor*, marriage equality states were required to extend such protections to married same-sex partners. Since *Obergefell*, protections are expected to apply nationwide to all Medicaid beneficiaries.
- **Department of Health and Human Services¹⁵⁸ and Office of Personnel Management¹⁵⁹ - Coverage for Gender Transition Services**
 - Prohibit bans on various gender transition services in Medicare, as of June 2014, and FEHBP plans, as of 2016
- **National Institutes of Health- LGBT Research Coordinating Committee**¹⁶⁰
 - This committee was formed to consider recommendations of the Institute of Medicine's study *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* and to suggest strategies for how the NIH can support research.

ENDNOTES

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