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ISSUE BRIEF

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Health Insurance Coverage and Access to Care for LGBTQ+ Individuals: Current Trends and Key Challenges

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KEY POINTS

- Individuals in the LGBTQ+ community face unique challenges and barriers to care. Expanding access to health insurance coverage is one important tool in improving access to care in this population.
- Analyzing sexual orientation data from the National Health Interview Survey (NHIS), we find that uninsured rates in the LGB+* community have fallen substantially since the passage of the Affordable Care Act (ACA), from 17.4 percent in 2013 to a low of 8.3 percent in 2016. However, the uninsured rate increased after 2016.
- While the NHIS does not have information on gender identity, non-government data sources suggest similar benefits of the ACA on coverage rates among transgender individuals.
- Overall uninsured rates in 2019 were 12.7 percent for LGB+ individuals vs. 11.4 percent for non-LGB+ individuals, with higher rates of Medicaid coverage but similar Marketplace enrollment and lower Medicare enrollment.
- The American Rescue Plan (ARP) increased the generosity of premium subsidies available in the Marketplace. If the same share of LGB+ enrollees who have Marketplace coverage have a zero-premium option under the ARP as exists for all Marketplace enrollees, we estimate that roughly 210,000 LGB+ Marketplace enrollees now have access to a zero-premium plan.
- Barriers besides coverage also contribute to persistent disparities in access and health outcomes. In the NHIS, LGB+ individuals report being more likely to delay care, less likely to have a usual source of care, and more likely to be concerned about medical bills than their non-LGB+ counterparts. Other contributing factors include a lack of healthcare professionals adequately trained in providing culturally competent care, as well as high cost-sharing and/or lack of coverage for certain services including hormone treatments and other gender-affirming care.

* We use terminology applicable to the original information sources we cite. When discussing findings based on analysis of the National Health Interview Survey (NHIS), which reports on individuals who self-identify as Gay/Lesbian, Bisexual, or "something else", we use the terminology "LGB+". Though NHIS does not include questions that allow for identification of transgender individuals, many individuals who identify as transgender are included in the LGB+ cohort. LGB+ does not include individuals who identify as "straight, that is, not gay" or those that responded, "I don't know." We use "LGB+" when referring to data from the NHIS, and the broader term "LGBTQ+" in all contexts other than that specific dataset.

INTRODUCTION

LGBTQ+ individuals have long faced challenges accessing health insurance coverage and quality healthcare. It is important to recognize that the LGBTQ+ population is diverse across a number of dimensions. While members of the LGBTQ+ community share the burden of often being stigmatized for their sexual orientation or gender identity and expression, their individual experiences vary by race/ethnicity, income, and other characteristics.

Policies including the Affordable Care Act (ACA) and American Rescue Plan Act (ARP) have expanded health insurance coverage to millions of Americans, including the LGBTQ+ community, but disparities in access to care and health outcomes persist. This Issue Brief analyzes national survey data to discuss demographic characteristics of the LGB+ community (described in greater detail below), recent trends in insurance coverage for this population, and various challenges and barriers to care faced by the broader LGBTQ+ community.

DATA SOURCES AND POPULATION FEATURES

Data collection on LGBTQ+ individuals is less consistent in federal and state data sources than other demographic information. For instance, the major surveys conducted by the Census Bureau that collect information on health or insurance coverage status do not collect information on sexual orientation or gender identity. Program enrollment data collected by the Centers for Medicare & Medicaid Services (CMS) also do not include this information. As a result, our understanding of healthcare issues faced by this population is more limited than for other groups, a factor which itself can contribute to disparities.

This Issue Brief presents data from the National Health Interview Survey (NHIS), conducted by the National Center for Health Statistics. NHIS provides data on LGB+ populations. This survey does not include questions on gender identity that would allow for identification of transgender people, which is an important limitation of this dataset. It is likely that there are transgender or other gender minority individuals present in the data,[1] however, and the NHIS is one of few nationally-representative surveys with information on sexual orientation, making it an important tool to understand parts of the LGBTQ+ community. The NHIS survey question regarding sexual orientation is only asked of adults aged 18 and older, the population analyzed in this report. The NHIS survey question regarding health insurance asks about the respondent's coverage status at the time of the interview. We analyze the most recent data available (from 2019) for most analyses presented below, and data from 2013 to 2019 to examine trends in health insurance and access to care in this population over time. NHIS began collecting data on the LGB+ population in 2013; however, coverage gains for this population would have begun in 2010, when the ACA dependent coverage provision went into effect, allowing young adults to remain on their parents' plans until age 26.

Table 1 presents demographic information for the LGB+ population in the NHIS, which represents and estimated 3.1 percent of the U.S. adult population, compared to the non-LGB+ population. On average, individuals identifying as LGB+ are younger, have higher rates of educational attainment, and lower average incomes than individuals identifying as non-LGB+. Approximately 34 percent of the LGB+ population is Black, Hispanic, American Indian/Alaska Native, or Asian American/Pacific Islander.

Table 1: Demographic and Personal Characteristics of Adults by Sexual Orientation, 2019

	LGB+	Non-LGB+
Age (Mean, 95% Confidence Interval)	36.6 (35.5, 37.8)	48.2*** (47.9, 48.5)
Male	38.1% (34.4%, 42.0%)	48.8%*** (48.1%, 49.5%)
Female	61.9% (58.0%, 65.6%)	51.2%*** (50.5%, 51.9%)
Gender Not Reported	1.5%	<0.01%
Race/Ethnicity		
Hispanic	15.3% (12.5%, 18.6%)	16.5% (15.3%, 17.8%)
White (non-Hispanic)	62.8% (58.5%, 66.9%)	63.6% (62.1%, 65.2%)
Black (non-Hispanic)	13.9% (11.1%, 17.3%)	11.5% (10.6%, 12.4%)
Asian American/Pacific Islander (non-Hispanic)	3.5% (2.4%, 5.2%)	5.9%** (5.3%, 6.4%)
American Indian/Alaska Native (non-Hispanic)	1.7% (1.0%, 2.8%)	1.4% (1.0%, 2.0%)
Other single or multiple races	2.8% (1.7%, 4.4%)	1.1%* (1.0%, 1.3%)
Rural (non-metropolitan)	9.1% (7.1%, 11.6%)	14.6%*** (13.5%, 15.7%)
Region		
Northeast	20.2% (17.2%, 23.6%)	17.5% (16.6%, 18.5%)
Midwest	18.0% (14.9%, 21.5%)	21.3%* (20.2%, 22.4%)
South	38.4% (34.4%, 42.5%)	37.8% (36.4%, 39.1%)
West	23.5% (20.1%, 27.2%)	23.4% (22.2%, 24.7%)
Education		
Less than high school/GED	6.1% (4.3%, 8.4%)	12.3%*** (11.6%, 13.1%)
High school/GED	21.7% (18.6%, 25.2%)	27.5%** (26.7%, 28.2%)
Post-high school	72.2% (68.4%, 75.7%)	60.2%*** (59.2%, 61.2%)
Missing	3.3%	0.7%
Married	24.4% (21.3%, 27.7%)	53.5%*** (52.6%, 54.3%)
Missing	0%	<0.01%
Mean annual family income previous 12 months (top coded at $220,000)	$69,613.76 ($64,903.51, $74,324.01)	$78,571.47*** ($77,227.30, $79,915.65)
Percent of population	3.1% (2.8%, 3.3%)	96.9% (96.7%, 97.1%)

Notes: Results are survey-weighted estimates using the 2019 NHIS adult file. Results in each row do not include item non-responders in the denominator when calculating rates and percentages. Numbers in parentheses are 95% confidence intervals. Tests for differences between LGB+ and non-LGB+ are indicated with * for p-value < 0.05, ** for p-value < 0.01, and *** for p-value < 0.001.

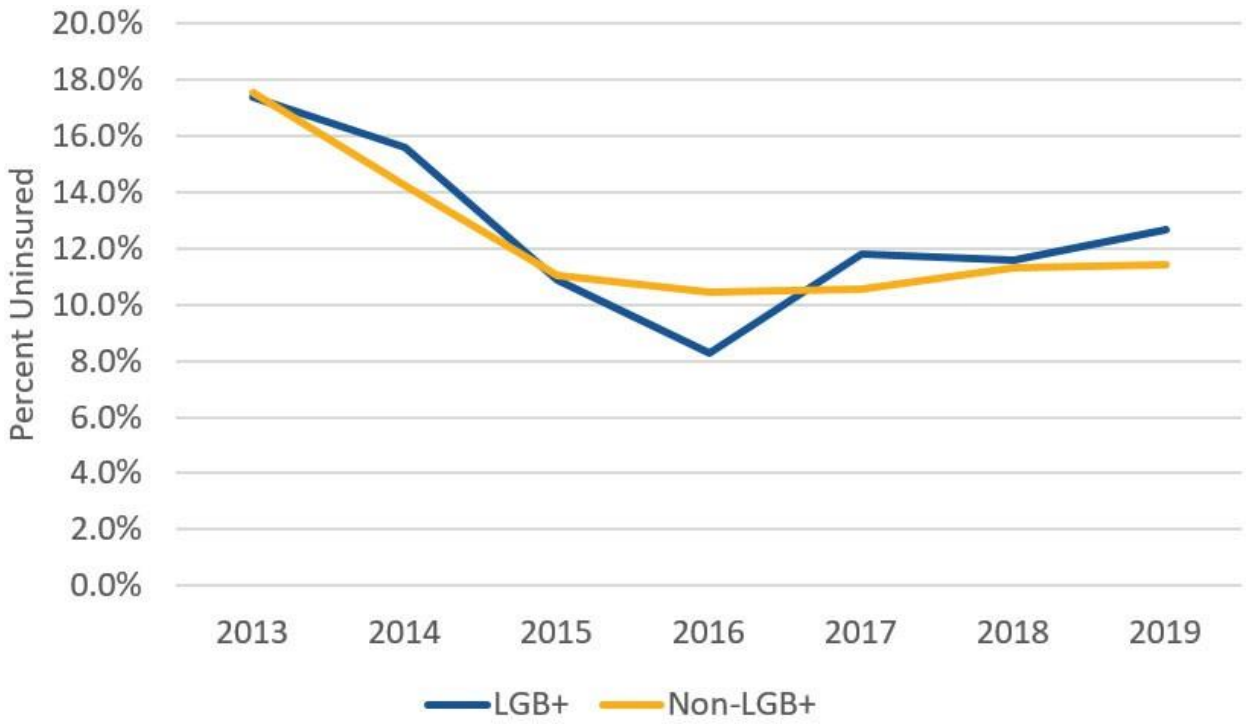
HEALTH COVERAGE

The ACA expanded access to health coverage for millions of Americans, including LGBTQ+ individuals. Figure 1 demonstrates the substantial decline in the uninsured rate among LGB+ individuals in the period after implementation of the ACA's coverage expansions, from 17.4 percent in 2013 to a low of 8.3 percent in 2016, before increasing to 12.7 percent in 2019. Overall, the uninsured rate dropped by more than half from 2013 to 2016, but factoring in the rebound during the 2017-2019 period, this represents a 27 percent relative decline in the uninsured rate from 2013 to 2019.

The largest single year increase in the LGB+ uninsured rate occurred when the rate increased from 8.3 percent in 2016 to 11.7 percent in 2017, a 40.1 percent increase. In comparison, the general population's uninsured rate increased from 10.4 percent to 10.7 percent in 2016-2017. Thus, the pattern of the increasing uninsured rate among LGB+ individuals from 2017-2019 is similar to national trends for other groups, but somewhat more pronounced, and occurred during a period of reduced funding for outreach, attempts to repeal the ACA, and other policies by the Trump administration that reduced enrollment (described at more length in a previous ASPE report).[2]

Research studies have also pointed to marriage equality as an important factor in expanding coverage over the past decade, via increased opportunities for spousal employer-sponsored insurance.[3]

Figure 1: Uninsured Rate over Time for LBG+ Adults, 2013 - 2019



Note: All estimates are derived from the National Health Interview Survey (NHIS).

Table 2 presents the different types of coverage for LGB+ and non-LGB+ individuals in 2019. LGB+ individuals had higher rates of Medicaid or public insurance enrollment, lower rates of Medicare enrollment, and lower rates of dual eligibility compared to the non-LGB+ population, which likely reflect differences in income and age across the two groups. The LGB+ population had approximately the same level of enrollment in health plans through the Marketplaces as did the non-LGB+ population, at 4.1 percent.

Table 2: Health Insurance Coverage among Adults by Sexual Orientation, 2019

	LGB+	Non-LGB+
Insurance type		
Private, not Marketplace	58.8% (54.7%, 62.8%)	58.4% (57.3%, 59.4%)
Private, Marketplace	4.1% (2.8%, 5.9%)	4.0% (3.7%, 4.3%)
Medicaid/public	17.2% (14.3%, 20.4%)	10.3%*** (9.7%, 11.0%)
Other	3.9% (2.6%, 5.9%)	5.4% (5.0%, 5.8%)
Uninsured	12.7% (10.2%, 15.8%)	11.4% (10.8%, 12.1%)
Dual	0.5% (0.2%, 1.1%)	1.6%*** (1.4%, 1.8%)
Medicare	2.8% (2.0%, 4.0%)	8.9%*** (8.5%, 9.3%)
Missing	3.2%	2.9%

Notes: Weighted estimates using the 2019 NHIS adult file. Results in each row do not include item non-responders in the denominator when calculating rates and percentages. A small number of persons were covered by both public and private plans and were included in both categories. Numbers in parentheses are 95% confidence intervals. Tests for differences between LGB+ and non-LGB+ are indicated with * for p-value < 0.05, ** for p-value < 0.01, and *** for p-value < 0.001.

Table 3 presents uninsured rates among different LGB+ subgroups, compared to their non-LGB+ counterparts. The Black LGB+ population had higher rates of uninsurance compared to the Black non-LGB+ population. Hispanic LGB+ individuals had lower rates of uninsurance than did Hispanic non-LGB+ individuals. White Non-Hispanic, American Indian and Alaska Native, or other single or multiple race LGB+ individuals did not have statistically different uninsured rates than their non-LGB+ counterparts.

Table 3: Subgroup Analysis of Percent Uninsured of Adults by Sexual Orientation, 2019

	LGB+	Non-LGB+
By Age Group (<65)		
18-25	12.0% (7.6%, 18.4%)	16.2% (14.3%, 18.4%)
26-34	22.0% (15.7%, 30.0%)	18.1% (16.5%, 19.7%)
35-54	11.1% (7.7%, 16.1%)	14.0% (13.0%, 15.1%)
55-64	3.1% (1.2%, 8.2%)	10.0%*** (8.9%, 11.1%)
By Race/Ethnicity		
Hispanic	17.7% (11.3%, 26.7%)	27.6%* (25.5%, 29.8%)
White (non-Hispanic)	8.4% (6.2%, 11.4%)	7.5% (6.9%, 8.0%)
Black (non-Hispanic)	24.9% (15.3%, 37.7%)	11.7%* (9.9%, 13.7%)
Asian American/Pacific Islander (non-Hispanic)	[Could not be calculated due to small sample size]	
American Indian/Alaska Native (non-Hispanic)	41.6% (19.7%, 67.5%)	20.8% (15.9%, 26.8%)
Other single or multiple races	21.2% (6.9%, 49.4%)	13.2% (8.4%, 20.1%)

Notes: Results are survey-weighted estimates using the 2019 NHIS adult file. Numbers in parentheses are 95% confidence intervals. Tests for differences between LGB+ and non-LGB+ are indicated with * for p-value < 0.05, ** for p-value < 0.01, and *** for p-value < 0.001.

Table 4 describes the net change in uninsured rates by subgroup within the LGB+ population, for 2013 vs. 2019. Overall, we find that the largest reduction in the uninsured rate occurred among the youngest (18-25) and oldest (2019) groups, and among White Non-Hispanic LBG+ individuals. However, given small sample sizes and the wide confidence intervals for some of these subgroups, these results should be interpreted with caution.

Table 4: Changes in the Uninsured Rates, 2013 vs. 2019, for LGB+ Adults – By Subgroup

	2013	2019
Overall	17.4% (14.7%, 20.4%)	12.7% (10.2%, 15.8%)
By Age Group (<65)		
18-25	20.0% (13.4%, 28.7%)	12.0% (7.6%, 18.5%)
26-34	23.0% (17.0%, 30.3%)	22.0% (15.7%, 30.0%)
35-54	17.0% (12.8%, 22.2%)	11.1% (7.7%, 16.1%)
55-64	18.8% (12.1%, 28.2%)	3.1% (1.2%, 8.2%)
By Race/Ethnicity		
Hispanic	20.7% (13.6%, 30.3%)	17.7% (11.3%, 26.7%)
White (non-Hispanic)	15.4% (12.3%, 19.1%)	8.4% (6.2%, 11.4%)
Black (non-Hispanic)	25.4% (18.3%, 34.2%)	24.9% (15.3%, 37.7%)
Other single or multiple races	16.7% (8.8%, 29.4%)	16.0% (7.9%, 29.8%)

Notes: Weighted estimates using the 2019 and 2013 NHIS adult files. Results in each row do not include item non-responders in the denominator when calculating rates and percentages. Numbers in parentheses are 95% confidence intervals. For the purposes of this set of analyses, due to data constraints, "other single or multiple races" includes everyone who is not Hispanic, non-Hispanic White, and non-Hispanic Black. The first constraint is that American Indian/Alaska Native was not a separate category in the 2013 data and had to be included in the "other single or multiple races category" for both years for consistency. Another other data constraint is that the Asian American/Pacific Islander category is so small that estimates for that group could not be calculated separately.

While the NHIS does not have information on gender identity, non-government data sources suggest similar benefits of the ACA on coverage rates among transgender individuals as the NHIS trends for LGB+ populations. For instance, one survey reported that the uninsured rate for transgender was 14% in Medicaid expansion states, as opposed to 29% in non-expansion states, as of 2020.[4]

In addition to the ACA improving rates of healthcare coverage for the LGBTQ+ community, the ARP extends and expands Marketplace subsidies, which will enable many Americans including LGBTQ+ individuals to access more affordable coverage. A recent ASPE analysis estimated that 3 out of 5 uninsured adults now have access to a zero-premium plan on Healthcare.gov,[5] and 79 percent of current Marketplace enrollees have access to a zero-premium plan.[6] Based on the survey estimates above, if that same share (79 percent) of LGB+ enrollees in Marketplace coverage have a zero-premium option under the ARP, this would total roughly 210,000[†] LGB+ Marketplace enrollees having access to a zero-premium plan.

[†] There are approximately 209M adults age 18 or over in the U.S. Multiplying this figure by 3.1% (the percentage of the U.S. adult LGB+ population that is over age 18, shown in the last row of Table 1), then by 4.1% (the percentage of the LGB+ population with Marketplace coverage, shown in the second row of Table 2), and then by 79% (from the prior ASPE analysis mentioned in the text) this results in an estimate of approximately 210,000 LGBTQ+ Marketplace enrollees having access to a zero-premium plan.

CHALLENGES AND DISPARITIES IN ACCESS TO CARE AND HEALTH OUTCOMES

Individuals in the LGBTQ+ community face a wide range of challenges in accessing and utilizing care that can contribute to disparities in health outcomes.

Table 5 shows that LGB+ individuals in the NHIS are more likely report delaying care, less likely to have a usual source of care, and more likely to be concerned about medical bills than their non-LGB+ counterparts. The cost of services is a significant barrier to care for many LGB+ individuals. Even for those with health insurance, healthcare services utilized by LGBTQ+ individuals may be prohibitively expensive or not covered at all, particularly for transgender or other gender minorities. The relatively high percentage of the LGB+ population that has delayed counseling and therapy due to cost is particularly concerning given that individuals in this population face higher rates of multiple forms of violence, such as sexual assault, interpersonal violence, and harassment for which they can benefit from counseling.[7] Some LGBTQ+ subgroups, such as transgender women of color, experience disproportionate rates of violence, assault, and harassment.[8] These traumatic experiences may contribute to observed disparities in mental health, substance use disorder, and associated adverse health outcomes among LGBTQ+ individuals.[9] LGBTQ+ individuals are also at significantly higher risk for suicide and self-harm, compared to their non-LGBTQ+ counterparts.[10, 11]

Table 5: Healthcare Access by Sexual Orientation, 2019

	LGB+	Non-LGB+
Delayed care due to cost in previous 12 months		
Dental care	26.9% (23.6%, 30.6%)	21.4%** (20.8%, 22.2%)
Counseling/therapy	18.4% (15.4%, 21.9%)	4.0%*** (3.7%, 4.4%)
Prescriptions	13.2% (10.5%, 16.6%)	7.6%*** (7.2%, 8.1%)
Medical care	15.3% (12.8%, 18.3%)	8.8%*** (8.3%, 9.2%)
Has usual source of care	87.1% (84.3%, 89.5%)	89.6% (89.0%, 90.1%)
Worried about being able to pay for a potential medical bill if got sick or was injured	53.8% (49.7%, 57.9%)	46.6%** (45.7%, 47.5%)

Notes: Weighted estimates using the 2019 NHIS adult file. The categories on delayed care were only asked of those who reported using that service in the past year, and item non-response was generally under 1% for these questions among those who were asked the question. Results in each row do not include item non-responders in the denominator when calculating rates and percent. Numbers in parentheses are 95% confidence intervals. Tests for differences between LGB+ and non-LGB+ are indicated with * for p-value < 0.05, ** for p-value < 0.01, and *** for p-value < 0.001.

However, LGBTQ+ individuals can face additional barriers to accessing care beyond healthcare costs. For instance, LGBTQ+ individuals may have difficulty finding LGBTQ-friendly providers. Based on original analysis of 2019 data from the Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health

Treatment Services Locator, we found that only half of the treatment facilities offer services for LGBTQ+ clients.[12] Lack of knowledge of the full range of lesbian, gay, bisexual, and transgender health needs can lead to suboptimal health services and programs for this population.[13]

Unfortunately, LGBTQ+ individuals routinely experience mistreatment and discrimination when trying to access healthcare. According to a recent survey, 18 percent of LGBTQ+ individuals reported avoiding going to a doctor or seeking healthcare out of concern that they would face discrimination or be treated poorly because of their sexual orientation or gender identity.[14] These negative experiences can translate into patients feeling fearful or have levels of mistrust in disclosing their sexual orientation or gender identity to providers and otherwise advocating for their own healthcare needs.[15] Research suggests that substantial majorities of LGBTQ+ people agree that it is important for their providers to know about their sexual orientation and gender identity. Conversely, when providers demonstrate knowledge of, and sensitivity about, their community and concerns, LGBTQ+ patients are more likely to establish effective therapeutic alliances.[16] Improving the cultural competency[‡] of health systems and providers not only improves the quality of care received by LGBTQ+ individuals, but when extended to racial/ethnic cultural competence, it may also reduce the resulting disparities experienced by Black, Indigenous, and people of color.[17]

POLICY OPPORTUNITIES & CONCLUSION

In addition to implementing the provisions of the ARP, which make insurance coverage more affordable for all enrollees, including LGBTQ+ individuals, the Department of Health and Human Services recently announced that it would apply the ACA's prohibition of discrimination on the basis of sex to include discrimination on the basis of gender identity and sexual orientation, consistent with the Supreme Court's ruling in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020).[18] This ensures that covered health plans (purchased through the Marketplace or otherwise) cannot deny coverage or charge higher premiums on the basis of sexual orientation or gender identity and that health plans purchased through the Marketplace that offer spousal coverage to heterosexual couples also extend such coverage to same-sex couples. This also ensures that covered healthcare providers are required to provide medically necessary care to people regardless of their sexual orientation or gender identity, such as ensuring that transgender men are not denied cervical pap smears.

Limited collection and availability of data related to the LGBTQ+ population make research related to this community more challenging. Improved and tailored sampling methodologies are required to thoroughly explore research questions on the health and well-being of the LGBTQ+ community. According to the National Institutes of Health (NIH)'s Sexual & Gender Minority Research Office (SGMRO), this begins with the development of novel measures and the evaluation of existing measures of LGBTQ+ status and experiences of stigma and discrimination. In addition, better understanding the role of generalizability in sexual and gender minority-focused research will be critical as this field of research expands.[19]

In order to improve the quality of healthcare for the LGBTQ+ community, organizations should strive to:

- gather data on sexual orientation and gender identity to expand research in this area and better understand the needs and experiences of these populations;
- promote meaningful relationships between healthcare providers and LGBTQ+ community partner organizations;

[‡] Cultural competency is defined as the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.

- institute organizational training on evidence-based and best practices in providing culturally competent and linguistically appropriate are for these populations; and
- develop and implement more inclusive systems of care that ensure LGBTQ+ and other minority populations receive equitable care.

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