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SUBSTANCE USE DISORDER INSURANCE BENEFITS: A SURVEY OF STATE BENCHMARK PLANS

STACEY A. TOVINO†

"Thank you so much for the generous introduction and thank you for the opportunity to be here today. I am so impressed by the incredible Health Law Program that Dr. Kelly Dineen has built in such a short amount of time[1] and it is an honor for me to be able to participate in this symposium. Thank you again for the opportunity to be here.

I was so excited when I learned that the focus of this symposium was 'Inequities and Injustice in Health Care' because a good portion of my scholarly work has focused on inequities and injustices in the context of health insurance.[2] In my time today, I would like to present the results of my latest research project—a survey of state benchmark health plan coverage of substance use disorder treatments and services, including treatments and services for opioid use disorder.[3] As I will explain, mental health insurance inequities and injustices re-

† Judge Jack and Lulu Lehman Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas. I thank the organizers and participants of the "Inequities and Injustices in Health Care" Symposium at Creighton University School of Law for their comments on the ideas presented in this article. I also thank the Creighton Law Review for the opportunity to participate in this symposium.

1. Creighton University School of Law, Academics, JD Concentration, Health Law, Meet the Director: Kelly Dineen, RN, JD, PhD, *at* https://law.creighton.edu/academics/jd-concentrations/health-law/meet-director (noting that Creighton University School of Law hired Dr. Dineen to build out the School of Law's Health Law Program and that Dr. Dineen joined the faculty in 2017).

2. The Author has reviewed the history of mental health insurance disparities in a number of prior articles addressing the legal rights of individuals with gambling disorder and other mental health conditions. *See e.g.*, Stacey A. Tovino, *Problem Gambling and the Business Lawyer*, *in* WHAT EVERY BUSINESS LAWYER NEEDS TO KNOW ABOUT GAMING LAW (Keith Miller ed., forthcoming 2019); Stacey A. Tovino, *A Right to Care*, 70 ALABAMA L. REV. 183 (2018); Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TULANE L. REV. 191 (2014); Stacey A. Tovino, *Dying Fast: Suicide in Individuals with Gambling Disorder*, 10 ST. LOUIS U. J. HEALTH L. & POL'Y 159 (2016) (invited symposium); Stacey A. Tovino, *Gambling Disorder, Vulnerability, and the Law: Mapping the Field*, 16 HOUS. J. HEALTH L. & POL'Y 102 (2016) (invited symposium). The overview of mental health parity law and mandated mental health and substance use disorder benefit law in these remarks are taken with permission, and with several recent updates as well as technical and conforming changes, from these and the Author's other prior works in this area.

3. Stacey A. Tovino, *State Benchmark Plan Coverage of Opioid Use Disorder Treatments and Services: Trends and Limitations*, S.C. L. REV. (forthcoming 2019) (surveying state benchmark health plan coverage of substance use disorder benefits with a focus on opioid use disorder benefits).

main, even after the implementation of President Obama's Affordable Care Act ("ACA"), and these inequities and injustices could get worse in the near future if the December 14, 2018, opinion of the United States District Court for the Northern District of Texas striking down the entire ACA[4] is affirmed by the United States Court of Appeals for the Fifth Circuit and/or the U.S. Supreme Court, as appropriate.

Before I present my survey results, let me provide some background information regarding mental health insurance benefit disparities in the United States. Historically, both public health care programs, including Medicare and Medicaid, as well as private health insurers distinguished between physical and mental disorders and provided inferior insurance benefits to individuals with conditions that could be classified as mental, such as major depression, bipolar disorder, schizophrenia, alchool use disorder, and the substance use disorders, as compared to conditions traditionally classified as physical, such as cancer, a broken arm, or high blood pressure.[5] Examples of these mental health insurance benefit disparities included the refusal by some health plans to cover any treatments or services provided for anyone who could be considered to have a mental, emotional, psychiatric, psychological, nervous, or similar condition, such as major depression, bipolar disorder, schizophrenia, alcohol use disorder, or one of the substance use disorders.[6]

Even when health plans voluntarily covered mental health and substance use disorder services, there were still noticable injustices and inequities. Historically, they tended to impose lower lifetime and annual spending limits, lower numbers of covered inpatient days, lower numbers of covered outpatient visits, higher deductibles, higher copayments, higher coinsurance amounts, more stringent medical necessity requirements, most frequently applied prior authorization requirements, and more stringent experimental or investigative exclusions on those offered mental health benefits.[7]

Just so you can see an example of what these exclusions actually look like, this slide shows provisions set forth within an older health plan issued in a midwest market that excludes coverage of all substance use disorder treatments, some alcohol use disorder treatments,

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4. Texas v. United States, 340 F. Supp.3d 579, 615 (D.N.D. Tex. 2018) ("In sum, the Individual Mandate 'is so interwoven with [the ACA's] regulations that they cannot be separated. None of them can stand.'") (internal citations omitted*); id.* at 585 (declaring the ACA's individual mandate unconstitutional and further declaring the remaining provisions of the ACA "inseverable" and therefore "invalid").

5. Tovino, *Problem Gambling and the Business Lawyer*, *supra* note 2*,* at Part I (reviewing the history of mental health insurance benefit disparities in the United States).

6. *Id*.

7. *Id*.

and some residential treatments of the type frequently used by individuals with substance use disorders.[8] This next slide shows provisions set forth within a health plan issued in a northeast market that contains a wide variety of behavioral health exclusions.[9]

During the past twenty-five years, mental health parity advocates have been trying to chip away at these mental health benefit disparities one by one.[10] Even today, they are not gone and they soon may be getting worse all over again. That said, in 1996, President Clinton signed the original Mental Health Parity Act ("MHPA") into law.[11] As originally enacted, MHPA prohibited large employer group health plans that offered physical and mental health benefits from imposing more stringent lifetime and annual spending limits on their offered mental health benefits.[12] For example, MHPA would have prohibited a covered large group health plan from imposing a $5,000 annual cap or a $50,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for medical and surgical care or if the plan had higher caps for physical health care.[13]

Although President Clinton is usually appluaded for this first federal step towards mental health parity, the application and scope of MHPA were very limited. As originally enacted, MHPA regulated only group health plans of large employers, then defined as those employers that employed an average of fifty-one or more employees.[14] MHPA did not apply to the group health plans of small employers. MHPA also did not apply to individual health plans, Medicaid non-managed care plans, or any self-funded, nonfederal governmental plan whose sponsor opted out of MHPA.[15] In addition, individuals with substance use and addictive disorders, including opioid use disorder, which is

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8. Stacey A. Tovino, PowerPoint, Substance Use Disorder Benefits: A Survey of State Benchmark Plans, at Slide 3, presented at Creighton University School of Law, Creighton Law Review Symposium, Mar. 7, 2019 [hereinafter Tovino PowerPoint].

9. *Id*. at Slide 4.

10. Tovino, *Problem Gambling and the Business Lawyer*, *supra* note 2, at Part I (summarizing federal efforts to eliminate mental health insurance benefit disparities).

11. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)) [hereinafter MHPA].

12. *Id*.

13. *Id*.

14. *Id*. § 712(c)(1)(A)–(B) (applying in each case to "a group health plan (or health insurance coverage offered in connection with such a plan)"); *id*. (exempting from the MHPA application group health plans of small employers; defining small employers as those "who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year").

15. *See, e.g*., 42 U.S.C. § 300gg-21(a)(2)(A) (2012) (statutory provision permitting sponsors of self-insured nonfederal governmental health plans to opt out of particular federal requirements); 45 C.F.R. § 146.180(a)(1)(v) (2015) (regulatory provision doing the same).

what I am specifically interested in, were specifically excluded from MHPA's modest lifetime and annual spending cap protections.[16] So there were two tiers of patients with mental health conditions; those with protected conditions, such as major depression, and then the less deserving; that is, those with addiction.[17] Moreover, MHPA did not require parity in any other context other than annual and lifetime limits; that is, MHPA did not require parity between physical and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.[18]

Finally, MHPA was also neither a mandated offer nor a mandated benefit law. Nothing in MHPA required a covered group health plan to actually offer or provide any health insurance benefits for individuals with mental health conditions.[19] In my prior career, I would advise my client insurers not to offer any mental health benefits because, if they did, MHPA required them to make their offered mental health benefits equal to their offered physical health benefits in the context of lifetime and annual spending limits. You can probably see that my old job made me uncomfortable, which is now why I have a very different career.

Perhaps because of MHPA's limitations, President George W. Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").[20] MHPAEA built on MHPA by expressly protecting individuals with substance-related and addictive disorders, including opioid use disorder, and by imposing comprehensive parity requirements on large group health plans.[21]

In particular, MHPAEA provided that any financial requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses) as well as any treatment limitations (including inpatient day and outpatient visit limitations as well as non-quantitative

16. MHPA, *supra* note 11, § 712(e)(4) ("The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.").

17. *Id*.

18. *Id*. § 712.

19. *Id.* § 712(b)(2) ("Nothing in this Section shall be construed . . . as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage.").

20. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)) [hereinafter MHPAEA].

21. *Id.* § 512(a)(4) (adding a new definition of "substance use disorder benefits"); *see also id.* § 512(a)(1) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits).

treatment limitations such as prior authorization requirements) that large group health plans imposed on mental health and substance use disorder benefits could not be any more restrictive than the predominant financial requirements and treatment limitations imposed by the plan on substantially all physical health benefits.[22] MHPAEA thus would have prohibited a large group health plan from imposing higher deductibles, copayments, or coinsurance amounts, or lower inpatient day or outpatient visit maximums, or more frequently applied prior authorization requirements on mental health conditions compared to physical health conditions.[23] Like MHPA, however, MHPAEA only regulated large group health plans.[24] MHPAEA also was not a mandated benefit law, so a covered health plan could refuse to offer any mental health or substance use disorder benefits and remain in compliance with MHPAEA.[25]

Two years later, in 2010, President Obama responded to this limitation by signing into law the Affordable Care Act ("ACA").[26] Now, this is where it gets interesting really quickly, because everything I am about to say after this point about the ACA could go away if the U.S. Court of Appeals for the Fifth Circuit or the U.S. Supreme Court affirm the December 14, 2018, federal district court opinion of the Northern District of Texas striking down the entire Affordable Care Act.[27]

That said, one set of relevant ACA provisions that you see on these two slides here and here extended MHPA's and MHPAEA's mental health parity provisions to the individual and small group health plans offered on and off the ACA-created health insurance ex-

22. *Id*. § 512(a)(1).

23. *Id*.

24. *See, e.g*., 42 U.S.C. § 300gg-26 (2012) (stating that the MHPAEA applies only to "group health plan[s] or (health insurance coverage offered in connection with such plan[s])"); Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 407 (2010) (explaining that MHPAEA applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children's Health Insurance Program, and state and local government plans, but not Medicaid non-managed care plans); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., APPROACHES IN IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (noting that "[s]elf-insured non-federal government employee plans can opt out of the federal parity law" and that the MHPAEA's requirements do not apply to "[s]mall employer plans created before March 23, 2010," "[c]hurch-sponsored plans and self-insured plans sponsored by state and local governments," "[r]etiree-only plans," TriCare, Medicare, and "[t]raditional Medicaid (fee-for-service, non-managed care)").

25. MHPAEA, *supra* note 20, § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits).

26. Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.) [hereinafter ACA].

27. Texas v. United States, 340 F. Supp.3d 579 (N.D. Tex. 2018).

changes.[28] The reason this is relevant to the topic of this symposium is that many individuals who could not otherwise afford health insurance were encouraged by the ACA's individual health insurance mandate and premium tax credits to purchase a qualified health plan.[29] Once purchased, federal mental health parity law protected the purchasers. However, the ACA's extension of mental health parity to qualified health plan purchasers will be undone if the entire ACA is found to be unconstitutional.[30] In that case, these individuals would likely revert back to mental health insurance benefit disparities. I am uncomfortable with this potential result because it adversely impacts individuals with low resources who struggle with mental health and substance use disorders.

A second set of relevant ACA provisions required individual and small group health plans offered on and off the exchanges as well as certain other plans to actually offer mental health and substance use disorder services in addition to nine other categories of essential health benefits ("EHBs").[31] The catch is that the statutory EHB requirement was vague as to exactly which benefits had to be provided. For example, note that the EHB provision that you see on this slide does not say that if you have opioid use disorder, your insurance must cover detoxification services, medication-assisted treatment, or a dose of take-home naloxone.[32] For those of us who teach health law, we always say that federal health statutes are notoriously vague, and this statutory EHB provision is no exception.

What the federal government did to implement this EHB provision is require states to select a benchmark plan that provided coverage for the ten EHB categories, including mental health and substance use disorder services.[33] The ACA then required EHB-regulated plans in the state to provide health benefits that are "substantially equal" to those provided by the state's benchmark plan, including both covered and excluded benefits.[34] Since the initial benchmark plan selection process, states have had two additional op-

28. Tovino PowerPoint, *supra* note 8, at Slides 13-14.

29. ACA § 1401 (establishing a refundable tax credit providing premium assistance to individuals who purchase qualified health plan coverage).

30. *See Texas*, 340 F. Supp.3d at 613-15 (discussing the inseverability of the individual mandate with the rest of the ACA's provisions).

31. ACA § 1302(b)(1) (establishing the ten EHBs).

32. *See id*. § 1302(b)(1)(E) (requiring the provision of mental health and substance use disorder services, including behavioral health treatments).

33. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,866 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156) (adopting 45 C.F.R. § 156.100) [hereinafter First Benchmark Plan Regulations].

34. 45 C.F.R. § 156.115(a)(1) (2018).

portunities to select benchmark plans.[35] The most recent opportunity was in 2018, when states had the opportunity to select a third benchmark plan that would go into effect in 2020.[36] I think states got tired of picking new benchmark plans after the second go around because all states except for Illinois kept their second benchmark plan.

In my latest research project, I surveyed the most recently selected benchmark plans of all fifty states and the District of Columbia.[37] What I found is that: (1) these benchmark plans demonstrate substantial variation in terms of their substance use disorder coverage and limitations provisions; (2) some state benchmark plans continue to impose coverage restrictions on substance use disorder care that are not imposed on physical health care; and (3) some state benchmark plans have gone out of their way to help out individuals with substance use disorders in general and opioid use disorder in particular.

The first state benchmark plan I want to show you is that of Illinois, because Illinois is the only state to have taken advantage of the opportunity to select a third benchmark plan and the only state whose benchmark plan appears to be specifically designed to respond to the opioid crisis.[38] Illinois's third benchmark plan differs from its second benchmark plan in five ways, three of which specifically relate to opioid use disorder and one of which relates to mental health in general.[39] If you look at the screenshot of Illinois's third benchmark plan on this slide, you can see that it: (1) covers at least one intranasal opioid reversal agent prescription for certain initial prescriptions of opioids, a change from the second benchmark plan, which covered zero opioid reversal agents; (2) removes barriers to the prescription of medication-assisted treatment for opioid use disorder by removing prior authorization requirements, dispensing limits, first-fail policies, and lifetime limit requirements that used to be applicable to medication-

35. First Benchmark Plan Regulations, *supra* note 33; *see* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (Feb. 27, 2015) (to be codified 45 C.F.R. pt. 144, 147, 153-56, and 158) [hereinafter Second Benchmark Plan Regulations]; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018) (to be codified at 45 C.F.R. pt. 147, 153–58) [hereinafter Third Benchmark Plan Regulations].

36. Third Benchmark Plan Regulations, *supra* note 35.

37. Tovino, *supra* note 3.

38. Centers for Medicare and Medicaid Services, *Information on Essential Health Benefit (EHB) Benchmark Plans*, Illinois Access to Care and Treatment Plan, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip (last visited Nov. 30, 2018) [hereinafter Illinois Third Benchmark Plan]; Tovino, *supra* note 3, at Part III(A).

39. Illinois Third Benchmark Plan, *supra* note 38; Tovino, *supra* note 3, at Part III(A); Tovino PowerPoint, *supra* note 8, at Slide 20.

assisted treatment of opioid use disorder; and (3) limits opioid prescriptions for acute pain to no more than seven days, a controversial change on which Dr. Kelly Dineen is an expert.[40] In addition to these three specific, opioid-related changes, a fourth change benefits all individuals with mental health and substance use disorder services by covering tele-psychiatry.[41]

My survey found that prior authorization and prior certification are the most common substance use disorder coverage limitations or hurdles that an individual with substance use disorder must clear among all other states' second benchmark plans, which continue in effect through 2020, as well as Illinois's third benchmark plan.[42] That is, at least twenty-eight out of fifty-one state benchmark plans require an insured to request and obtain prior authorization or to get the medical necessity of at least one substance use disorder service pre-certified.[43] Without such prior authorization or pre-certification, substance use disorder coverage may be denied, limited, or delayed.[44] These twenty-eight states include Nevada, which is my current state of residence; Nebraska, which is where we are today; as well as a number of states that are geographically close to Nebraska, including Colorado, Oklahoma, North Dakota, and Wisconsin.[45] Whether these prior authorization requirements are problematic from an inequity or injustice perspective depends on whether they are enforced and whether there are equivalent prior authorization requirements set forth on the physical health side or on the non-addiction mental health side. The federal Department of Health and Human Services requires state benchmark plans to comply with mental health parity laws,[46] but many of them do not, which leads to confusion when patients complain about a non-coverage decision that is in accordance with the terms of the health insurance policy but is inconsistent with mental health parity law.

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40. *See* Illinois Third Benchmark Plan, *supra* note 38; Tovino PowerPoint, *supra* note 8, at Slide 20. *See generally* Kelly K. Dineen, *Definitions Matter: Defining Inappropriate Prescribing to Shape Effective Opioid Policy and Reduce Patient Harm*, KAN. L. REV. (forthcoming 2019) (critiquing regulation of physician opioid prescribing).

41. Illinois Third Benchmark Plan, *supra* note 38; Tovino, *supra* note 3, at Part III(A); Tovino PowerPoint, *supra* note 8, at Slide 20.

42. Tovino, *supra* note 3, at Part III(D).

43. *Id*.

44. *Id*.

45. *Id*.

46. 45 C.F.R § 156.115(a)(3) (2018). "Provision of EHB means that a health plan provides benefits that . . . With respect to the mental health and substance use disorder services, including behavioral health treatment services . . . comply with the requirements of § 146.136 of this subchapter . . . ." *Id*. *See also id*. § 146.136 (establishing mental health parity requirements).

One benchmark plan that is noteworthy in terms of its prior authorization requirement is that of Connecticut. It is noteworthy because its prior authorization requirement applies only to "outpatient treatment of opioid dependence" as you can see on this slide, but not to outpatient treatment of any other substance use disorder, such as cocaine use disorder.[47] Why the Connecticut Plan singles out opioid use disorder, but not other substance use disorders, for prior authorization is unclear. Are individuals with opioid use disorder any less deserving of immediate coverage than individuals with other substance use disorders? I think not.

My survey also revealed that, as written, twenty out of fifty-one state benchmark plans cover no opioid reversal agents.[48] The states that are geographically closest to Nebraska that fall into this category include Iowa, Minnesota, Oklahoma, and Utah.[49] Although ACA regulations currently require these benchmark plans to be read as including at least one opioid reversal agent,[50] the district court opinion striking down the entire ACA would reverse this regulatory fix,[51] which means that if the district court opinion is affirmed and there is no applicable, state mandated benefit law that requires coverage of opioid reversal agents, we have twenty states with popular plans that, per their terms, do not cover an opioid reversal agent. This slide shows Iowa's current benchmark plan, and you can see the zero, signaling that no opioid reversal agents are covered, in the lower, right-hand corner.[52] My survey also shows that ten state benchmark plans, including the Nebraska benchmark plan, expressly exclude substance use disorder services that are provided in a residential treatment facility, which is where many individuals with substance use disorder are recommended to receive their care.[53]

My survey also explores state benchmark plan coverage and exclusion provisions relating to methadone. Three states, Washington, Maryland, and Minnesota, specifically and expressly cover methadone as a treatment for substance use disorders.[54] On the other hand, six

47. Tovino PowerPoint, *supra* note 8, at Slide 22; ConnectiCare Insurance Company, Inc.: ConnectiCare Flex POS Plan at 82, *available at* https://www.cms.gov/cciio/resources/data-resources/ehb.html#Connecticut (last visited March 9, 2019).

48. *See* Tovino, *supra* note 3, at Part III(E).

49. *Id*.

50. 45 C.F.R. § 156.122(a)(1)(i), (ii) (2018) ("A health plan does not provide essential health benefits unless it . . . covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan . . . .").

51. *See Texas*, 340 F. Supp.3d at 613-15 (discussing the inseverability of the individual mandate with the rest of the ACA's provisions).

52. Tovino PowerPoint, *supra* note 8, at Slide 23.

53. *Id*. at Slide 24; Tovino, *supra* note 3, at Part III(F).

54. Tovino, *supra* note 3, at Part III(G).

states, Alabama, Arkansas, Delaware, Kentucky, Rhode Island, and Wisconsin, expressly exclude methadone from coverage.[55]

Two states—Alabama and Mississippi—establish quantitative treatment limitations applicable only to substance use disorder benefits that I did not also see on the physical health benefit side or even on the non-addiction mental health side.[56] Mississippi, for example, covers only seven inpatient days and twenty outpatient days per year for individuals with substance abuse, but of course there are no parallel limitations for folks with physical health conditions.[57] Alaska is interesting in that it excludes from coverage all chemical dependency services, including opioid use disorder services, as you can see right here.[58] This exclusion provision runs counter to the ACA's EHB provision, which specifically requires coverage of mental health and "substance use disorder benefits."[59]

My last example comes from Texas, where I attended law school and graduate school and where I am licensed to practice law. I like to pick on my own state. In Texas, we impose relatively low lifetime and annual spending caps—$10,000 and $5,000 respectively—on individuals who seek mental health care but we do not impose the same caps on individuals who seek physical health care.[60] These Texas provisions violate one ACA provision that extends MHPA to individual and small health plans[61] as well as a second ACA provision that eliminates lifetime and annual spending caps applicable to EHBs, including mental health and substance use disorder services.[62] And I will end by saying that this is how I got into health law in the first place, which is that my state has a rich history of mental health access and mental health insurance inequities and injustices. There is so much work to be done here. Thank you very much."

55. *Id*.
56. *Id*. at Part III(I).
57. *Id.*; Blue Cross Blue Shield of Mississippi: Network Blue at 13, *available at* https://www.cms.gov/cciio/resources/data-resources/ehb.html#Mississippi (last visited Mar. 9, 2019).
58. Tovino, *supra* note 3, at Part III(J); Premera Blue Cross Blue Shield of Alaska: Alaska Heritage Select Envoy at 28, *available at* https://www.cms.gov/cciio/resources/data-resources/ehb.html#Alaska (last visited Mar. 9, 2019).
59. *See* ACA, *supra* note 26, 1302(b)(1)(E).
60. Blue Cross Blue Shield of Texas: Blue Choice PPO RSH3 at 48, *available at* https://www.cms.gov/cciio/resources/data-resources/ehb.html#Texas (last visited Mar. 9, 2019); Tovino PowerPoint, *supra* note 8, at Slide 29.
61. Tovino PowerPoint, *supra* note 8, at Slides 13-14; ACA, *supra* note 26, §§ 1311(j), 1563(c)(4).
62. ACA, *supra* note 26, at 1001.

MEDICAID EXPANSION IN NEBRASKA: ADDRESSING SOCIOECONOMIC INEQUITIES

MOLLY MCCLEERY†

I. INTRODUCTION

In November 2018, Nebraska voters passed Initiative Measure No. 427 to expand Medicaid coverage in Nebraska.[1] Medicaid expansion will provide health insurance to nearly 90,000 low-income Nebraskans.[2] Often, these 90,000 Nebraskans are referred to as stuck in "the coverage gap," meaning they are ineligible for Medicaid but do not make enough money to qualify for premium tax credits on the Health Insurance Marketplace to make insurance affordable.[3] States that have not expanded Medicaid generally "have no eligibility for childless adults who are not disabled, and mandatory coverage levels for parents are very low."[4] The lack of coverage available for childless adults and very low eligibility levels for parents result in "significant inequities in adults' Medicaid income eligibility nationwide" that "lead to disparities in the rate of uninsured adults."[5] By expanding Medicaid to cover those traditionally unserved by Medicaid and the private insurance market, Nebraska is taking a significant step forward in addressing socioeconomic inequities in the state.

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1. *Nebraska Secretary of State – Election Night Results – November 6th, 2018*, NEB. SEC'Y OF STATE, https://electionresults.sos.ne.gov/resultsSW.aspx?text=Race&type=SW&map=CTY (last updated Dec.3, 2018, 1:31:38 PM). *See also* NEB. REV. STAT. ANN. § 68-992 (West 2018).

2. LEG. FISCAL OFFICE, FISCAL NOTE, 105th Leg. (Neb. 2017), https://nebraskalegislature.gov/FloorDocs/105/PDF/FN/LB441_20170308-103020.pdf.

3. RACHEL GARFIELD ET AL., KAISER FAMILY FOUND., THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID (2019), http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid.

4. JACK HOADLEY ET AL., GEORGETOWN UNIV. CTR. FOR CHILDREN & FAMILIES & UNIV. OF N.C. NC RURAL HEALTH RESEARCH PROGRAM, HEALTH INSURANCE COVERAGE IN SMALL TOWNS AND RURAL AMERICA: THE ROLE OF MEDICAID EXPANSION 2 (2018), https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf.

5. *Id*. at 2.

II. MEDICAID EXPANSION

The Patient Protection and Affordable Care Act ("ACA") included reforms designed to increase insurance rates among Americans with low and middle incomes, including the Health Insurance Marketplace, its premium tax credits, and an expansion of Medicaid coverage.[6] The ACA's Medicaid expansion extended coverage to adults between the ages of nineteen and sixty-four years old with incomes under 133 percent of the Federal Poverty Level ("FPL").[7] Adults covered by the ACA's Medicaid expansion are individuals not otherwise eligible for Medicaid as a result of pregnancy or disability.[8] Since individuals must have an income of at least 100 percent of the FPL to access premium tax credits on the Health Insurance Marketplace, Medicaid expansion serves those whose incomes are below the level needed to purchase affordable insurance on the Marketplace.[9]

In 2012, the United States Supreme Court heard two challenges to the ACA's constitutionality in *National Federation of Independent Business v. Sebelius*.[10] Specifically, the Court ruled on the constitutionality of the individual mandate provision and Medicaid expansion.[11] The Court upheld the constitutionality of the individual mandate.[12] However, it determined the Medicaid expansion exceeded Congress's power under the Spending Clause and effectively rendered it an option for states rather than a mandatory program.[13] Despite that decision, as of November 2018, thirty-six states, including Nebraska, and Washington D.C., had opted into Medicaid expansion.[14]

III. WHO WILL BE COVERED BY MEDICAID EXPANSION IN NEBRASKA?

On November 7, 2018, Nebraska voters passed Initiative Measure No. 427, a general election ballot measure to expand Medicaid.[15] Medicaid expansion will cover two main groups of Nebraskans: low-

6. *See* Garfield, *supra* note 3, at 1.
7. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (2017).
8. *Id*.
9. *See* Garfield, *supra* note 3, at 1.
10. 567 U.S. 519 (2012).
11. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S 519, 530 (2012).
12. *Sebelius*, 567 U.S. at 574-75.
13. *Id*. at 588.
14. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAMILY FOUND. (May 13, 2019), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.
15. NEB. SEC'Y OF STATE, *supra* note 1. *See also* Henry J. Cordes, *Nebraskans Approve Expanding Medicaid to Cover More of the State's Low-Income Residents*, OMAHA WORLD-HERALD (Nov. 7, 2018), https://www.omaha.com/livewellnebraska/health/nebraskans-approve-expanding-medicaid-to-cover-more-of-the-state/article_389878a4-74a3-5a82-a482-3bc43bb1bb79.html.

income parents whose incomes are too high for traditional Medicaid and low-income, childless adults.[16] Traditional Medicaid in Nebraska covers low-income parents up to 58% of the FPL.[17] In 2019, 58% of the FPL is $1,031 per month for a household of three.[18] Medicaid expansion will cover parents with incomes over that 58% FPL eligibility cap up to 138% of the FPL,[19] or $2,390 per month in 2019 for a household of three.[20] Additionally, childless adults with incomes between 0% of the FPL and 138% of the FPL will be eligible for Medicaid. For a household of one in 2019, 138% of the FPL is $1,396 per month.[21]

The data available regarding those who will be eligible for Nebraska's Medicaid expansion demonstrate the benefits the new program could have statewide for low-income, working Nebraskans. The program would be particularly impactful in providing a source of coverage for uninsured individuals in Nebraska's rural areas.[22] Nearly a quarter of Nebraskans in rural areas are uninsured and have incomes below 138% of the FPL, meaning they would be eligible for Medicaid expansion.[23] This is higher than Nebraska's metro areas, where 19% of individuals are uninsured and have incomes below 138% of the FPL.[24] Most states that have expanded Medicaid have reduced the discrepancy in insured rates between metro and rural areas through adopting the program.[25]

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16. *Medicaid Expansion to the New Adult Group*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/medicaid-expansion/ (last visited April 30, 2019).

17. NEB. DEP'T OF HEALTH & HUMAN SERVS., DIV. OF MEDICAID & LONG-TERM CARE, NEBRASKA MEDICAID ANNUAL REPORT FOR STATE FISCAL YEAR 2017-2018 9 (Dec. 3, 2018), https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Health_and_Human_Services__Department_of/107_20181130-141401.pdf.

18. NEB. DEP'T OF HEALTH & HUMAN SERVS., PROGRAM STANDARDS, FEDERAL POVERTY LEVELS (FPL), AND MAXIMUM INCOME (2019), http://dhhs.ne.gov/Documents/FPL%20Eligibility.pdf

19. *See* NEB. REV. STAT. ANN. § 68-992 (West 2018) (stating the eligibility requirements for adults under the Medicaid expansion). *See also* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 16 *(*explaining the ACA establishes an income disregard of five percentage points of the federal poverty level making the effective eligibility level 138% of the FPL even though 133% of the FPL is included in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII)).

20. *See generally Yearly Guidelines and Thresholds*, HEALTH REFORM BEYOND THE BASICS (June 2018), http://www.healthreformbeyondthebasics.org/wp-content/uploads/2017/11/REFERENCEGUIDE_Yearly-Guidelines-and-Thresholds_2019.pdf (last visited May 9, 2019) (listing annual income levels from which calculation of monthly income levels can be made).

21. *Id*.

22. Hoadley, *supra* note 4, at 1.

23. *Id*. at 4.

24. *Id*.

25. *Id*. at 6.

Medicaid expansion is a program that will support Nebraska's low wage workers.[26] Of the Nebraskans who would be eligible for Medicaid expansion, the majority, 70%, are employed.[27] Of the remaining 30%, over half are individuals with disabilities, students, non-working spouses, retirees, and young adult dependants.[28] The remainder are individuals classified as unemployed.[29] Individuals in the coverage gap hold occupations that form the backbone of Nebraska's economy, including food service, construction, and sales, amongst others.[30]

IV. MEDICAID EXPANSION'S ROLE IN ADDRESSING SOCIOECONOMIC INEQUITIES

Medicaid expansion in Nebraska has the potential to reduce socioeconomic inequities through increasing access to care and improving health outcomes for low-income Nebraskans. Individuals without insurance "are likely to under consume medical services," meaning they delay preventive care and screenings, do not purchase prescribed medication, and defer health care for financial reasons.[31] However, "[a] large body of research points to expansion-related improvements across a wide range of measures of access to care and utilization of medications and services" across states.[32] One example of a state that has seen notable improvements in access to care and preventive services utilization through Medicaid expansion is Kentucky.[33] Data from the Kentucky Department of Medicaid Services from the first two years of the program show a large increase in the number of Ken-

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26. *See generally* DEE MAHAN & ANDREA CALLOW, FAMILIES USA, MEDICAID EXPANSION HELPS MORE WORKING PEOPLE GET HEALTH COVERAGE, (Jan. 2016), https://familiesusa.org/sites/default/files/product_documents/MCD_ACS%20Data%20Report_web.pdf (establishing a "strong link" between health coverage gains for working residents and a state's decision to expand Medicaid).

27. FAMILIES USA ACTION, CAREERS OF WORKING NEBRASKANS WHO WOULD RECEIVE COVERAGE THROUGH MEDICAID EXPANSION (Sept. 2018), http://www.familiesusaaction.org/careers-of-working-nebraskans-who-would-receive-coverage-through-medicaid-expansion.

28. *Id*.

29. *Id*.

30. *Id*. at 2.

31. Allan Jenkins & Ron Konecny, Univ. of Neb. Kearney, NEBRASKA MEDICAID EXPANSION 2018 UPDATE 15 (2018); Martha Stoddard, *Medicaid Expansion Would Create Jobs and Economic Benefits, Study Finds*, OMAHA WORLD-HERALD (Oct. 15, 2018), https://www.omaha.com/livewellnebraska/health/medicaid-expansion-would-create-jobs-and-economic-benefits-study-finds/article_7184492e-e7f2-5708-bc67-7fc3fb6329d9.html.

32. ROBIN RUDOWITZ & LARISA ANTONISSE, KAISER FAMILY FOUND., IMPLICATIONS OF THE ACA MEDICAID EXPANSION 3 (2018), http://files.kff.org/attachment/Issue-Brief-Implications-of-the-ACA-Medicaid-Expansion-A-Look-at-the-Data-and-Evidence.

33. Laura Unger, *More Ky Patients Get Preventive Care*, COURIER JOURNAL (Aug. 7, 2015, 7:07 AM) https://www.courier-journal.com/story/life/wellness/2015/08/05/preventive-care-rises-among-kentucky-medicaid-patients/31190973/?auid=15871991&tr=y.

tuckians accessing preventive care.[34] Kentuckians enrolled in Medicaid were significantly more likely to access physical and dental exams and cancer screenings after Kentucky expanded Medicaid.[35] Specifically, between 2013 and 2014, the number of Kentuckians enrolled in Medicaid that had cancer screenings increased dramatically; breast cancer screenings went up 111%; cervical cancer screenings went up 88%; and colorectal cancer screenings went up 108%.[36] Additionally, preventive dental checkups rose by 116%, and physical exams increased by 187%.[37] Kentucky is just one example of the strides states have seen in access to care after expansion.[38]

It is also projected that Medicaid expansion will have benefits for the behavioral health of Nebraskans in the coverage gap.[39] Researchers from the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation analyzed data from 2010 to 2014 and found that 31.6% of uninsured Nebraskans between the ages of eighteen and sixty-four with incomes below 138% of the FPL had a mental illness or substance use disorder, compared to 26.2% of the state's full population.[40] However, only 14.1% of uninsured individuals between the ages of eighteen and sixty-four received treatment for mental illness or substance use disorder.[41] Looking specifically at 2014 data, the researchers found that 21,000 Nebraskans who would have been eligible for Medicaid expansion had experienced a mental illness or substance use disorder in the past year.[42] It is projected that if Medicaid were expanded, an estimated 4,000 fewer Nebraskans would experience symptoms of depression and 6,000 more Nebraskans would report "good, very good, or excellent health."[43]

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34. *Id*.

35. *Id*.

36. *Id*.

37. *Id*.

38. *See* LARISA ANTONISSE ET AL., KAISER FAMILY FOUND., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW 4-6 (2018), http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review (describing how most research shows Medicaid expansion has a positive impact on access to and utilization of care).

39. *See* JUDITH DEY ET AL., DEP'T. OF HEALTH & HUMAN SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, BENEFITS OF MEDICAID EXPANSION FOR BEHAVIORAL HEALTH 4-7 (2016), https://aspe.hhs.gov/system/files/pdf/190506/BHMedicaidExpansion.pdf (describing potential benefits on behavioral health to non-expansion states).

40. *Id*. at 4.

41. *Id*. at 6.

42. *Id*. at 5.

43. *Id.* at 6.

Medicaid expansion in Nebraska has the potential to further reduce socioeconomic disparities by improving the financial status of those who participate in the program.[44] In a study on the possible economic impacts of Medicaid expansion in Nebraska, Allan Jenkins, Ph.D., and Ron Konecny, Ph.D., two professors at the University of Nebraska-Kearney, wrote that states that expanded Medicaid "are seeing generally robust economic growth" and that expansion positively impacts a state's economy when considering increased employment and reduced bankruptcy filings.[45] Of the ten states with the most significant decrease in unemployment rates between 2013 and 2017, nine had opted into Medicaid expansion by January 1, 2014.[46] Additionally, "eight of the ten states with the greatest decrease in Chapter 7 bankruptcies over this period were states that had expanded Medicaid in 2014."[47] The researchers found "the overall economic effect of expansion is positive" when considering increased employment and reduced bankruptcy filings.[48] When projecting the impacts of Medicaid expansion in Nebraska, Jenkins and Konecny found that, had Nebraska expanded Medicaid in 2014, 283 fewer Nebraskans would have filed for Chapter 7 bankruptcy and that "the bankruptcy loss in the state would have been reduced by $25.1 million" for the same period.[49]

A recent study on Michigan's Medicaid expansion reinforces the assertions of Jenkins and Konecny that Medicaid expansion has an overall positive impact on the financial health of program participants.[50] The study found an association between Medicaid enrollment and "'large improvements in several measures of financial health, including reductions in unpaid bills, medical bills, over limit credit card spending, delinquencies, and public records (such as evictions, judgments, and bankruptcies)."[51] Specifically, the study estimates that Medicaid enrollment "reduces the amount of medical bills in collections by $515 (about 57% relative to the pre-ACA mean) and reduces the amount of debt past due that has not yet been sent to a third party collection agency of [sic] about $233 (about 28%)."[52] The study also

44. *See* JENKINS & KONECNY, *supra* note 31, at 12.
45. *Id*.
46. *Id*.
47. *Id*.
48. *Id*.
49. *Id*. at 31-32.
50. *See* Sarah Miller et al., *The ACA Medicaid Expansion in Michigan and Financial Health* (Nat'l Bureau of Economic Research, Working Paper No. 25053, 2018), https://www.nber.org/papers/w25053.pdf (describing the association between Medicaid and large improvements in measures of financial health in Michigan).
51. *Id*. at 4.
52. *Id*.

found a 16% reduction in the "the number of public records (such as evictions, bankruptcies, or wage garnishments)," and a 16% reduction in the likelihood of individuals overdrawing their credit cards.[53]

V. IMPLEMENTATION OF NEBRASKA MEDICAID EXPANSION

On April 1, 2019, pursuant to Initiative Measure No. 427, the Nebraska Department of Health and Human Services filed its State Plan Amendments to expand Medicaid with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.[54] In filing the State Plan Amendments, the Nebraska Department of Health and Human Services elected an October 1, 2020, start date for coverage.[55] As a result, Nebraskans, and specifically the 90,000 Nebraskans in the coverage gap, will wait several more months before seeing any of the potential reductions in socioeconomic inequities. Moreover, on April 1, 2019, the Nebraska Department of Health and Human Services released a concept paper outlining its plan for implementing Medicaid expansion through a Section 1115 waiver project called the Heritage Health Adult Program.[56] A Section 1115 waiver is a process by which a state receives permission from the federal government to break from traditional Medicaid law to experiment with delivering care in a new way.[57] The Heritage Health Adult Program would deviate from traditional Medicaid by including two levels of coverage known as Basic Coverage and Prime Coverage.[58] Basic Coverage would offer the regular Nebraska Medicaid benefits package with the exception of dental, vision, and over-the-counter drug coverage.[59] Prime Coverage would include the Medicaid benefits package plus dental, vision, and over-the-counter drug coverage.[60] Under the proposal, enrollees would be required to complete work and wellness activities to receive Prime Coverage; if the requirements are not met, they would receive Basic Coverage.[61] The concept paper also outlines a number of additional changes to Medicaid in Nebraska, including requiring enrollees to verify eligibility for the program every six

53. *Id*.
54. *Medicaid Expansion in Nebraska*, NEB. DEP'T. OF HEALTH & HUMAN SERVS., http://dhhs.ne.gov/Pages/Medicaid-Expansion.aspx (last visited Apr. 30, 2019).
55. *Id*.
56. NEB. DEP'T. OF HEALTH & HUMAN SERVS., HERITAGE HEALTH ADULT PROGRAM – SECTION 1115 CONCEPT PAPER (2019), http://dhhs.ne.gov/Documents/HeritageHealthAdultProgramConceptPaper.pdf.
57. *Waivers 101*, FAMILIES USA, https://familiesusa.org/initiatives/waiver-resource-center/waivers-101 (last visited Apr. 30, 2019).
58. *See* NEB. DEP'T. OF HEALTH & HUMAN SERVS., *supra* note 54, at 4.
59. *Id*.
60. *Id*.
61. *Id*.

months versus the current annual reverification period.[62] The Section 1115 waiver application will likely be submitted to the federal government for approval in fall of 2019.[63]

As the Section 1115 waiver has not yet been submitted, approved, or operationalized, it is difficult to determine the impact that such a proposal would have on addressing socioeconomic disparities in Nebraska. However, experiences from other states demonstrate that complex waiver systems create challenges for enrollees in maintaining coverage.[64]

VI. CONCLUSION

Medicaid expansion in Nebraska has the potential to reduce socioeconomic disparities by increasing access to care,[65] especially in rural areas,[66] improving coverage rates for working Nebraskans,[67] and creating financial benefits for those enrolled.[68] However, it will be critical to monitor the implementation of the Heritage Health Adult Program to ensure the potential benefits of Medicaid expansion are fulfilled.

62. *Id*. at 3.
63. *Id*. at 6.
64. *See Proposals to Couple Medicaid Expansion with Work Requirements: Frequently Asked Questions*, CTR. ON BUDGET & POLICY PRIORITIES (Apr. 10, 2019), https://www.cbpp.org/research/health/proposals-to-couple-medicaid-expansion-with-work-requirements-frequently-asked. *See also* ANTONISSE, *supra* note 38, at 4 (explaining coverage losses in Indiana's Healthy Indiana Plan); Sara R. Collins, *Medicaid Work Requirements Increase Coverage Gaps*, THE COMMONWEALTH FUND (Feb. 28, 2019), https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-increase-coverage-gaps (describing coverage losses from Arkansas's Medicaid work requirement).
65. *See* RUDOWITZ & ANTONISSE, *supra* note 32, at 3.
66. *See* HOADLEY ET AL., *supra* note 4, at 1.
67. *See* MAHAN & STOLL, *supra* note 27, at 1.
68. *See* JENKINS & KONECNY, *supra* note 31, at 12

CONVERSION THERAPY: A BRIEF REFLECTION ON THE HISTORY OF THE PRACTICE AND CONTEMPORARY REGULATORY EFFORTS

TIFFANY C. GRAHAM†

I would like to open my remarks by thanking Dean Michael Kelly, Professor Kelly Dineen, and the *Creighton Law Review* for hosting this conversation about inequities in health care and, in particular, for their kind invitation allowing me to participate in this discussion.

Today I will be talking about conversion therapy, with a particular emphasis on the movement to ban – or at least minimize – the practice. I would like to begin with a simple definition. What *is* conversion therapy? Very simply, it is a series of practices meant to alter an individual's sexual orientation, gender identity, or gender expression.[1] It is rooted in the belief that the lived expression of LGBTQ+ identity is normatively problematic and subject to correction.[2] Even though the discussion regarding conversion therapy can extend be-

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† Associate Dean of Academic Affairs, the University of South Dakota School of Law. I would like to thank the members of the *Creighton Law Review* for giving me the opportunity to participate in this symposium, as well as Professors Kelly Dineen and Victoria Haneman for their support.

1. Christy Mallory et al., Conversion Therapy and LGBT Youth, The Williams Institute: UCLA School of Law (Jan. 2018), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Jan-2018.pdf. Even though it is common among many advocates to use the term "conversion therapy" to encompass the counseling and therapeutic practices covering attempts to alter sexual orientation, gender identity, and gender expression, others limit their use of the term to cover only sexual orientation change efforts. Id. See, e.g., Marie-Amélie George, Expressive Ends: Understanding Conversion Therapy Bans, 68 Ala. L. Rev. 793, 800-01 (2017).

2. Focus on the Family's Position: Counseling for Unwanted Homosexuality, Focus on the Family (2015), https://www.focusonthefamily.com/socialissues/sexuality/freedom-from-homosexuality/focus-on-the-familys-position-counseling-for-unwanted-homo sexuality. Focus on the Family, the advocacy organization, explains its support for counseling efforts to rid lesbian, gay, and bisexual individuals of their same-sex sexual desires or to eliminate same-sex sexual behaviors:

> Focus on the Family supports the right of those with unwanted homosexuality—feelings, attractions, thoughts, desires, actions or identity—to seek help from licensed mental health professionals. Both adults and minors (with parental consent) should have access to professionally based, ethically directed care that assesses, clarifies and aligns with their deeply-held values, faith and life goals. We uphold parents' foundational right and calling to sensitively determine the best course of care for their children and seek developmentally appropriate professional aid that respects and regards their family's needs and values.

Id.

yond sexual orientation and enter the world of gender identity, my remarks will focus on sexual orientation.

While there are licensed healthcare practitioners (counselors, therapists, etc.) who offer counseling that is designed to change an individual's sexual orientation, most of the people who are engaged in this work today are actually religious and spiritual leaders.[3] The Williams Institute ("Williams"), which is the preeminent think tank in the country focusing on LGBTQ issues, has studied conversion therapy, and as of January 2018, it found some remarkable statistics about the individuals who are *receiving* it:

Almost 700,000 LGBTQ individuals in the United States between the ages of 18 and 59 had received conversion therapy (approximately 350,000 of whom received it as adolescents);

Nine states had banned licensed practitioners from providing conversion therapy for minors; Williams estimated that in those states, 6,000 youths between the ages of thirteen and seventeen would have received conversion therapy if their states had not banned it;

Williams estimated that 57,000 youths around the entire country would receive conversion therapy from a religious or spiritual advisor before the age of eighteen.[4]

How did we get here? What does it really mean to experience conversion therapy? Two very short videos help to illuminate this question. They cover one conversation which was broken into two halves. The speaker is a young man from Iowa named Samuel Brinton. During the videos, he discusses his family's reaction when he realized as a child that he was attracted to other boys.[5] Specifically, he reveals the physical abuse he suffered after sharing this information with his father; his parents' decision to send him to conversion therapy; his therapist's use of both emotional manipulation and behavioral modification techniques which linked same-sex desire to excruciating pain; a suicide attempt; his decision to return to the closet in order to

3. Mallory et al., *supra* note 1, at 1. In January 2018, The Williams Institute estimated that, in the states which did not prohibit licensed mental health professionals from providing conversion therapy services, approximately 20,000 LGBT youth between the ages of 13 and 17 would receive such services prior to the age of 18. *Id*. Since then, six more states have passed statutes prohibiting licensed professionals from providing these services to minors; therefore, that estimate is likely lower at this time. This fact notwithstanding, the majority of individuals providing these services are unlicensed faith advisors. *See id.* (noting that approximately 57,000 youths between the ages of 13 and 17 would receive conversion therapy from such individuals as compared to the estimated 20,000 youths who would receive it from licensed professionals).

4. *Id.*

5. *See* I'm From Driftwood, *Sam Brinton (I'm From Perry, IA) Part 1 – True LGBT Stories*, YOUTUBE" (Oct. 1, 2010), https://www.youtube.com/watch?v=USGKHdC19Mo; I'm From Driftwood, *Sam Brinton (I'm From Perry, IA) Part 2 – True LGBT Stories*, YOUTUBE (Oct. 5, 2010), "'https://www.youtube.com/watch?v=15M-BlUUc5k.

restore family relations; and a new experience of family rejection when he came out to them again in college.[6] This conversation was filmed in 2010; the forms of therapy Brinton experienced, which he has described as torture,[7] occurred in the early 2000s. Despite the recent nature of those events, they hearkened back to earlier points in history when members of the healthcare profession used multiple techniques to try to change their patients' sexual orientations.

Conversion therapy as we currently understand it can trace its origins to late nineteenth century Europe[8] and later spread to the United States. Physicians in the United States initially viewed homosexuality as a medical problem, so they implemented medical solutions in order to try to "cure" individuals.[9] These interventions included castration, testicle implants, bladder washing, and rectal massage.[10] Doctors would "wash a bladder" by inserting a catheter and flushing the bladder with a silver or nitrate solution; rectal massage was exactly what it sounded like – a small device would go into the rectum, and it would be used to massage the prostate.[11] By 1913 though, doctors started to realize that these techniques did not work.[12]

As psychotherapy became more prominent, the mental health profession began to take the lead in administering conversion therapy.[13] This fact notwithstanding, physical interventions did not end as the efforts to change sexual orientation became increasingly prominent during the mid-twentieth century.[14] Psychiatrists and psychoanalysts recommended and implemented techniques like electroshock

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6. *Id*.

7. Sam Brinton, Editorial, *I Was Tortured in Gay Conversion Therapy. And It's Still Legal in 41 States*, N.Y. TIMES (Jan. 24, 2018), https://www.nytimes.com/2018/01/24/opinion/gay-conversion-therapy-torture.html.

8. *See* TOMMY DICKINSON, CURING QUEERS: MENTAL NURSES AND THEIR PATIENTS, 1935—74 20 (2015) (discussing the use of hypnotherapy as a "cure" for homosexuality by a German psychotherapist in 1889).

9. *See* J. Seth Anderson, *Why We Still Haven't Banished Conversion Therapy in 2018*, WASH. POST (Aug. 5, 2018), https://www.washingtonpost.com/news/made-by-history/wp/2018/08/05/why-we-still-havent-banished-conversion-therapy-in-2018/?utm_term=.d0ce86aa4b8e (providing an overview of the history of conversion therapy in the United States).

10. *Id*.

11. *Id*. Anderson noted in the article that at least one doctor believed that rectal massage would be effective because it would "'kill the homosexual cells' in the prostate so that 'heterosexual cells' could take their place." *Id*.

12. *Id*.

13. *Id*.

14. *Id*; *see also* Kenji Yoshino, *Covering*, 111 YALE L.J. 769, 790 (2002) (describing the period from 1938-1969 as the era when conversion therapy became entrenched).

therapy and lobotomies, in addition to talk therapy.[15] The techniques were not simply torturous; they did not work.

Physically invasive interventions did not cease despite their failure to alter the sexuality of the affected patients but behavioral therapy techniques became more prominent, especially in the 1960s.[16] Behavioral therapy often focused on the application of aversive techniques like inducing nausea or paralysis in response to homoerotic imagery and instructing patients to snap their wrists with a rubber band any time they were aroused by homoerotic images.[17] Therapists tried non-aversive techniques as well. They included attempts to improve patients' dating skills with members of the opposite sex; assertiveness training for men (the need for which was often rooted in a belief that weak fathers and dominant mothers produced gay sons); teaching stereotypically masculine and feminine behaviors; orgasmic reconditioning; and, among other techniques, using hypnosis in order to shift the direction of arousal and desire.[18]

As the "gilded age"[19] of conversion therapy ended in the late 1960s, a profession-wide shift in the view of both the effectiveness and propriety of conversion therapy began to take shape among psychotherapists. In 1968, the American Psychiatric Association published the Diagnostic and Statistical Manual-II ("DSM-II"), substantially echoing its view from the DSM-I by classifying homosexuality as a form of sexual deviation.[20] This fact notwithstanding, research in the field was increasingly successful in challenging the notion of homosexuality as a mental disorder.[21] In addition, early gay rights pioneers like Frank Kameny were modestly successful in persuading government and civic actors that gay men and lesbians should receive civil rights protection.[22] As a result of these and other pressures, the American Psychiatric Association declassified homosexuality as a mental disorder in 1973 and consequently removed it as such from the

15. *See, e.g.,* JONATHAN KATZ, GAY AMERICAN HISTORY: LESBIANS AND GAY MEN IN THE U.S.A. 170-73, 191-93 (1976) (excerpting medical treatment records discussing a gay cross-dresser who was subjected to serial electroshock treatments, as well as several psychiatric patients who received lobotomies as a way to control their behavior, including manifestations of same-sex desire).

16. AM. PSYCHOLOGICAL ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 22 (2009), ""https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf.

17. *Id*.

18. *Id*.

19. *See* JACK DRESCHER ET AL., SEXUAL CONVERSION THERAPY: ETHICAL, CLINICAL AND RESEARCH PERSPECTIVES 11 (2001) (using the "gilded age" language to describe the period between the 1940s and 1960s as the height of conversion therapy practices).

20. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1968).

21. *See* AM. PSYCHOLOGICAL ASS'N, *supra* note 16, at 22.

22. *Id*. at 22-23.

DSM-II.[23] Over the next few decades, the American Medical Association, The American Psychiatric Association, The American Psychological Association, and other associations of healthcare professionals begin issuing statements which rejected conversion therapy on the grounds that it harmed the patients and largely did not produce the desired results.[24] Today, there are no longer any major healthcare professional associations which support the practice of conversion therapy.[25]

While the debate over conversion therapy was happening in the healthcare field, the broader movement for LGBTQ equality was taking place in legislatures and courts around the country. In particular, activists in the early part of the twenty-first century focused significant attention, of course, on relationship recognition and marriage equality. Conversion therapy, however, was increasingly a matter of concern that lawmakers wished to address, especially in California. Acting in response to multiple statements from healthcare associations outlining the risks inherent in conversion therapy – which were pronounced for minors – California became the first state in the nation to prohibit licensed mental health practitioners from offering conversion therapy services to minors.[26] Since 2012, seventeen additional states, the District of Columbia, and forty-one local and county governments have done the same.[27]

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23. *Id*. at 23.

24. *Id*.

25. *See* NAT'L CTR. FOR LESBIAN RIGHTS, BORN PERFECT: THE FACTS ABOUT CONVERSION THERAPY, http://www.nclrights.org/bornperfect-the-facts-about-conversion-therapy/ (last visited June 17, 2019) (stating "[a]ll of the nation's leading professional medical and mental health associations have rejected conversion therapy as unnecessary, ineffective, and dangerous").

26. S.B. 1172, 2011-12 S., Reg. Sess. (Cal. 2012) (codified at CAL. BUS. & PROF. CODE § 865-865.2 (West 2019)).

27. In addition to California's, the statutes which have banned licensed and regulated healthcare workers from using conversion therapy techniques on minors include the following: COLO. REV. STAT. § 12-245-224(1)(t)(V) (2019); CONN. GEN. STAT. § 19a-907-19a-907c (2017); S.B. 65, 149th Gen. Assemb., (Del. 2018); D.C. CODE §§ 7-1231.02(25A), 7-1231.14a (2014); HAW. REV. STAT. § 453J-1 (2018); 405 ILL. COMP. STAT. ANN. 48/20 (West 2016); MD. CODE ANN., HEALTH OCC. § 1-212.1 (West 2018); ME. REV. STAT. ANN. tit. 32, § 2112 (2019); MASS. GEN. LAWS ANN. ch. 112, § 275 (West 2019); NEV. REV. STAT. ANN. § 629.600 (West 2018); N.H. REV. STAT. ANN. §§ 332-L:1–332-L:3 (2019); N.J. STAT. ANN. §§ 45:1-54–45:1-55 (West 2013); N.M. STAT. ANN. § 61-1-3.3 (West 2017); N.Y. EDUC. LAW § 6509-e (McKinney 2019); OR. REV. STAT. ANN. § 675.850 (West 2015); 23 R.I. GEN. LAWS ANN. §§ 23-94-1–23-94-5 (West 2017); VT. STAT. ANN. tit. 18, § 8352 (West 2016); WASH. REV. CODE § 18.130.180 (West 2018); *see also* Family Equality Council, *Conversion Therapy Laws* (June 2018), https://www.familyequality.org/resources/conversion-therapy-laws/ (providing a list of cities and counties around the country that have implemented prohibitions on conversion therapy). In Puerto Rico, Governor Ricardo A. Rossello signed an executive order requiring licensed medical institutions to certify that they will not engage in the practice of conversion therapy. Concepción de León, *Governor of Puerto Rico Signs Executive Order Banning 'Conversion*

The California statute became the model that other states followed when passing their own conversion therapy statutes. As a general proposition, the laws prohibit licensed or otherwise regulated healthcare workers from administering conversion therapy to minors. In addition, they define conversion therapy as efforts to change not just sexual orientation but also gender identity or gender expression. The prohibitions do not extend to therapeutic efforts designed to assist a person who is undergoing gender transition; similarly, they do not cover therapy supporting people who are seeking greater understanding of their identity or who wish to develop coping mechanisms, as long as the intervention is neutral and does not attempt to alter the identity.[28]

The statutes, however, are not identical; important differences exist among these laws. By way of example, Maryland and Rhode Island prohibit the use of state funds for the purpose of providing health care coverage for conversion therapy.[29] Since the prohibition extends only to minors, these provisions ensure that adults who seek conversion therapy will have to pay for it out of pocket. This structural barrier likely limits the ability of practitioners to offer the service, unless they are prepared to offer it for free to those who otherwise would not be able to afford it. In addition, Nevada, New Hampshire, and Washington have created explicit carve-outs for religious and spiritual advisors who provide conversion therapy services, stating that the regulations do not cover their activities.[30] Nevada takes the extra step of noting

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Therapy' for Minors, N.Y. TIMES (Mar. 27, 2019), https://www.nytimes.com/2019/03/27/us/puerto-rico-conversion-therapy.html.

28. *See generally* CAL. BUS. & PROF. CODE § 865-865.2 (2012); CONN. GEN. STAT. § 19a-907-19a-907c (2017); DEL. CODE ANN. tit. 24, § 3510 (West 2018); D.C. CODE §§ 7-1231.02(25A), § 7-1231.14a (2014); HAW. REV. STAT. § 453J-1 (2018); 405 ILL. COMP. STAT. ANN. 48/20 (West 2016); MD. CODE ANN., HEALTH OCC. § 1-212.1 (West 2018); MASS. GEN. LAWS ANN. ch. 112, § 275 (West 2019); NEV. REV. STAT. ANN. § 629.600 (West 2018); N.H. REV. STAT. ANN. §§ 332-L:1– 332-L:3 (2019); N.J. STAT. ANN. §§ 45:1-54–45:1-55 (West 2013); N.M. STAT. ANN. § 61-1-3.3 (West 2017); N.Y. EDUC. LAW § 6509-e (McKinney 2019); OR. REV. STAT. ANN. § 675.850 (West 2015); 23 R.I. GEN. LAWS ANN. §§ 23-94-1–23-94-5 (West 2017); VT. STAT. ANN. tit. 18, § 8352 (West 2016); WASH. REV. CODE § 18.130.180 (West 2018).

29. MD. CODE ANN., HEALTH OCC. § 1-212.1(d)(2) (West 2018); 23 R.I. GEN. LAWS ANN. § 23-94-4 (West 2017).

30. NEV. S.B. 201, 79th Sess. (Nev. 2017) ("[T]here is nothing in this bill that regulates or prohibits licensed health care professionals from engaging in expressive speech or religious counseling with such children if the licensed health care professionals: (1) are acting in their pastoral or religious capacity as members of the clergy or as religious counselors; and (2) do not hold themselves out as operating pursuant to their professional licenses when so acting in their pastoral or religious capacity."); N.H. REV. STAT. ANN. § 332-L:3 (2019) ("Nothing in this chapter shall be construed to infringe on any constitutional right, including the free exercise of religion."); WASH. REV. CODE § 18.130.180 (2018) ("This act may not be construed to apply to . . . [r]eligious practices or counseling under the auspices of a religious denomination, church, or organization

that licensed practitioners who would otherwise be covered may still provide conversion therapy services to minors if they are doing so in a religious counseling or pastoral capacity and make clear that they are not operating under their professional licenses.[31] Delaware prohibits covered practitioners from referring minors to conversion therapy practitioners who are out of state.[32] The distinctions among the states highlight the underlying dynamics at play, as well as the way in which those dynamics differ across the country. In some states, there is a clear desire to eliminate conversion therapy as far as reasonably possible, even for adults. In other states, legislators made the explicit decision to signal that regulation of conversion therapy operating within the context of religious advising was off limits. While the states all shared the overarching goal of protecting minors from the harms of conversion therapy, state legislators were also attuned to their unique concerns about potential evasion, effectuation of a more widespread rejection of the practice, and shielding themselves from the possibility of litigation through a First Amendment challenge.

The majority of the country is not covered by conversion therapy prohibitions, and this raises important questions that are worth consideration while activists try to persuade legislators to follow the path of the other states. By way of example, what ethical constraints should guide healthcare practitioners in the non-prohibition states, especially for those who *do* provide conversion therapy services to minors? Multiple scholars have referenced using fraud or consumer protection models to regulate bad actors; is there any value in exploring a malpractice angle as well? The latter question is especially important when considering adults who seek conversion therapy services in states where public funds, especially Medicaid, cannot be used to cover the costs of therapy. If there are religious adults who hope to change their orientation or gender identity – regardless of the likelihood of success – should the state impose wealth barriers effectively preventing them from seeking the assistance? The answer to the question may well be yes, but if the answer is no, does a malpractice framework offer protection for these individuals that consumer fraud statutes lack? These and other questions highlight the challenges that exist as more legislatures grapple with the desire to limit the impact of conversion therapy.

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that do not constitute performing conversion therapy by licensed health care providers on patients under age eighteen . . . .").

31. Nev. S.B. 201.

32. DEL. CODE ANN. 24 § 3510(d).

LGBTQ+ INDIVIDUALS, HEALTH INEQUITIES, AND POLICY IMPLICATIONS

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I. INTRODUCTION

When the Office of Disease Prevention and Health Promotion ("ODPHP") released its Healthy People 2020 goals and objectives, it recognized the public health needs of the lesbian, gay, bisexual, and transgender ("LGBT") community for the first time.[1] The stated goal of Healthy People 2020 is to "improve the health, safety, and well-being of [LGBT] individuals."[2] One barrier to obtaining the needed information for achieving this goal is a lack of necessary data collection, particularly as it regards the LGBTQ+ community. This paper will provide a basic overview of health inequities experienced by the LGBTQ+ community and introduce interventions of interest to the legal and public health communities.

II. DESCRIPTION OF LGBTQ+ COMMUNITY

A. ALL COMMUNITIES ARE NOT THE SAME

While the LGBTQ+ community is frequently discussed as one community, it is actually a collection of unique communities. The LGBTQ+ community is inclusive of both sexual orientation and gender identity ("SOGI") minorities. It is important to note both the similarities and the differences between the groups in order to adequately examine health inequities in a way which meaningfully provides avenues to lower the impact of marginalization and increase wellbeing. The discussion of the LGBTQ+ community as a whole, without considering the unique differences among the groups, can gloss over mean-

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1. *Lesbian, Gay, Bisexual, and Transgender Health*, OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health (last visited June 30, 2019).

2. *Id.*

ingful differences, both in gender experiences and sexual orientation. Additionally, there are those whose attraction and behaviors encompass same-sex persons but who do not define themselves as nonheterosexual.[3][4] Despite the need to engage in a discussion regarding the distinctions between the groups within the LGBTQ+ collective, Ilan H. Meyer notes that "LGBT people share remarkably similar experiences related to stigma, discrimination, rejection, and violence across cultures and locales."[5]

1. Lesbian

The term lesbian generally refers to women who are romantically or sexually attracted to other women.[6] These women include all female-identified individuals. For example, a transgender woman[7] who is attracted to women could be a lesbian, although she may identify as queer or pansexual. Likewise, women who like women ("WLW") may prefer to be called gay or queer instead.[8]

2. Gay

The term gay generally refers to persons who are attracted to members of the same sex.[9] This includes transgender men who like men and transgender women who like women. Recently, the term gay has been applied most commonly to men, though some WLW prefer the term gay rather than lesbian.[10]

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3. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING (2011).

4. The communities of men who have sex with men ("MSM") or women who have sex with women ("WLW") but do not adopt a non-heterosexual identity will not be explicitly discussed in this paper. It is important to note that some of the public health implications here (medical knowledge and treatment) may be applicable to these groups, but some of the issues around stigma and even inclusion as a part of the LGBTQ+ community are beyond this paper's scope.

5. Ilan H. Meyer, *Why Lesbian, Gay, Bisexual, and Transgender Public Health?*, 91 AM. J. PUBLIC HEALTH 856 (2001).

6. *Glossary of Terms*, HUMAN RIGHTS CAMPAIGN, http://www.hrc.org/resources/glossary-of-terms/ (last visited Apr 15, 2019).

7. *See infra* Section II(A)(4).

8. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

9. HUMAN RIGHTS CAMPAIGN, *supra* note 6.

10. *Id.*; INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

3. Bisexual

The bisexual community is diverse. It generally includes those who are attracted to more than one sex.[11] Some use this term only for those who identify within the gender binary,[12] while others prefer the term pansexual for those who are attracted to a person regardless of gender identity or sex. Most data collection processes will include in the term bisexual anyone attracted to more than one sex or gender. The term is about the attraction, not the current relationship.[13] So, even if a person is currently in a heterosexual relationship,[14] that person may still identify as bisexual.

4. Transgender and Nonbinary

Transgender is a broad term for those whose gender identity does not comport with their assigned sex at birth ("ASAB"). Persons who are transgender may identify as a man or woman, or they may find their gender identity does not fit on the gender binary and identify as nonbinary. Nonbinary identities include anyone who does not identify as exclusively male or female, including those who identify as genderqueer or gender fluid. Transgender and nonbinary identities are about gender and not sexual orientation. Persons who are transgender or nonbinary may identify as straight, gay, lesbian, bisexual, pansexual, etc. in terms of their sexual orientation. Sexual orientation will be in reference to their gender identity, not their ASAB. For example, transgender women who are attracted to women identify as lesbians.[15]

5. The Q+ in LGBTQ+

The Q in LGBTQ+ can stand for queer or questioning. For purposes of this paper, Q+ is inclusive of the many SOGI minorities in addition to the definitions above. Examples may include those who are questioning their sexual or gender identity. While queer has had a controversial history as a slur, as well as an empowered reclaimed term, a resurgence of individuals are identifying as queer or pansexual because they are sexual identities that are inclusive of many genders, including transgender and nonbinary. Others who do not identify within a specific group on the LGBT spectrum and do not fit

11. Wendy B. Bostwick & Brian Dodge, *Introduction to the Special Section on Bisexual Health: Can You See Us Now?*, 48 ARCHIVES SEXUAL BEHAV. 79 (2019).
12. Those who are attracted to men and women.
13. HUMAN RIGHTS CAMPAIGN, *supra* note 6.
14. A relationship with a person of the opposite gender.
15. HUMAN RIGHTS CAMPAIGN, *supra* note 6.

into the cisgender, heterosexual framework, such as the asexual and intersex communities, also fit under the Q+ umbrella term.[16]

6. Intersectional Identities Within the LGBTQ+ Community

The LGBTQ+ community is wildly diverse in age, race, ethnicity, gender, geography, and other demographics. Although the community is often seen as monolithic with white cisgender gay men front and center, the community is far more diverse than it is often represented. Despite this diversity, studies rarely explore comparisons between intersectional identities, particularly concerning intersections between sexual orientation, gender, race, and ethnicity.[17] Studying intersectional identities,[18] particularly studying gender along with race and ethnicity,[19] could increase understanding of within-group (e.g., by age, race, ASAB)[20] and between-groups (e.g., binary transgender and nonbinary)[21] comparisons.

A recent article advocates for LGBTQ research to be conducted with an intersectional approach that explores the differences between sexual orientation, gender, and the identities within each group.[22] Such an intersectional approach is crucial because when between-groups comparisons are included, unique experiences can be under-

16. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

17. Anneliese A. Singh et al., *"I Am My Own Gender": Resilience Strategies of Trans Youth.*, 92 J. COUNSELING & DEV. 208 (2014); Anneliese A. Singh & Vel S. McKleroy, *"Just Getting Out of Bed Is a Revolutionary Act": The Resilience of Transgender People of Color Who Have Survived Traumatic Life Events*, 17 TRAUMATOLOGY 34 (2011).

18. Stephanie L. Budge et al., *Coping and Psychological Distress Among Genderqueer Individuals: The Moderating Effect of Social Support.*, 8 J. LGBT ISSUES IN COUNSELING 95 (2014); Jessica Domm, Minority Stress, Sexual Minorities and Psychological Wellbeing: Implications for Positive Psychology (Feb. 2, 2017) (unpublished Psy.D. thesis, Victoria University) (on file with the Victoria University Research Repository); Chassitty N. Whitman & Kevin L. Nadal, *Sexual Minority Identities: Outness and Well-Being Among Lesbian, Gay, and Bisexual Adults*, 19 J. GAY & LESBIAN MENTAL HEALTH 370 (2015).

19. Z. Nicolazzo, *'It's a Hard Line to Walk': Black Non-Binary Trans* Collegians' Perspectives on Passing, Realness, and Trans*-Normativity*, 29 INT'L J. QUALITATIVE STUD. IN EDUC. 1173 (2016); Ellen D.B. Riggle et al., *The Positive Aspects of a Transgender Self-Identification*, 2 PSYCHOL. & SEXUALITY 147 (2011).

20. Hélène Frohard-Dourlent et al., *"I Would Have Preferred More Options": Accounting for Non-Binary Youth in Health Research*, 24 NURSING INQUIRY 1 (2017).

21. Budge et al., *supra* note 18; Riggle et al., *supra* note 19; Stephanie L. Budge et al., *The Work Experiences of Transgender Individuals: Negotiating the Transition and Career Decision-Making Processes*, 57 J. COUNSELING PSYCHOL. 377 (2010); Bonnie Moradi et al., *Counseling Psychology Research on Sexual (Orientation) Minority Issues: Conceptual and Methodological Challenges and Opportunities*, 56 J COUNSELING PSYCHOL. 5 (2009).

22. Shanna K. Kattari et al., One Size Does Not Fit All: Differential Transgender Health Experiences by Gender Identity and Sexual Orientation (2019) (on file with author).

stood which serve to inform policy and practice. A statewide study of transgender and nonbinary individuals in Colorado conducted a differential analysis between gender identity, sexual orientation, and age. The study found individuals who were older and heterosexual were less likely to delay care due to anticipated discrimination[23] as compared to young and queer individuals. Compared to transfeminine respondents, transmasculine respondents were twice as likely to delay care and nonbinary individuals were 25% less likely to delay care.[24] A similar study exploring the intersectional identities of gender and LGB on outness and well-being found that those who identify as a gender minority scored significantly lower on well-being and thriving scales than those who identified as cisgender and LGB.[25] Recent studies that have focused on intersectional identities within the LGBTQ+ community have demonstrated a need within the scientific and medical communities to view gender from a multi-dimensional and intersectional perspective.[26]

In addition to experiencing homophobia and racism from society at large, LGBTQ people of color ("POC") may experience intragroup marginalization, such as racism within an LGBTQ community or homophobia within an ethnic community.[27] Research has shown that Black LGBTQ people experience a disproportionate level of disapproval for their sexual identity, which may lead to a conflict of identity.[28] However, presence and awareness of LGBTQ POC has been shown to ameliorate conflict between LGBTQ and racial and ethnic identities.[29] Acceptance plays a key role in a person's ability to remove competition between their sexual identity and racial identity.[30] When a person does not feel a sense of belonging as part of a minority group, it can lead to further self-marginalization.[31] Findings from another study exploring the tacit and implicit self-marginalization of black nonbinary students emphasized the invisibility of nonbinary identities, and even more so black nonbinary individuals, not only

23. *Id.*

24. *Id.*

25. Whitman & Nadal, *supra* note 18.

26. Nicolazzo, *supra* note 19.

27. Kimberly F. Balsam et al., *Measuring Multiple Minority Stress: The LGBT People of Color Microaggressions Scale*, 17 CULTURAL DIVERSITY & ETHNIC MINORITY PSYCHOL. 163 (2011); Angelique Harris et al., *The Sociopolitical Involvement of Black, Latino, and Asian/Pacific Islander Gay and Bisexual Men*, 21 J. MEN'S STUD. 236 (2013); Mignon R. Moore, *Articulating a Politics of (Multiple) Identities: LGBT Sexuality and Inclusion in Black Community Life*, 7 DU BOIS REV. 315 (2010).

28. Balsam et al., *supra* note 27; Moore, *supra* note 27.

29. Moore, *supra* note 27.

30. *Id.*

31. Harris et al., *supra* note 27.

within the larger society but also within transgender spaces.[32] Feeling connected to the LGBTQ community is the strongest predictor of involvement within both LGBT communities and POC communities.[33]

Understanding intersectionality of LGBTQ identities can be aided through an approach rooted in anti-oppressive theory ("AOT"), which posits that individuals and their experiences are intersectional and fluid because their experiences and individuality are inextricable from their identities.[34] Exploring how these identities interact together can aid in understanding oppression, how oppression is experienced, and discovering different methods of disrupting oppression.

III. HEALTH INEQUTIES DESCRIBED

A. Behavioral Health

Members of the LGBTQ community have an enormous risk of health inequities in the field of behavioral health. Overall, the community experiences an increase in the incidence of mental health challenges, especially suicide when compared to their cisgender and heterosexual counterparts.[35] A systematic review of mental health disorders among LGB individuals showed that depression, anxiety, and substance misuse were at least one-and-a-half times more common among sexual minorities compared to their heterosexual peers.[36] While the LGB community experiences a suicide attempt rate of two to three times that of the general population, the transgender community experiences suicide attempts at nine times the rate of the general population.[37] Additionally, studies of gender minorities have shown extremely high rates of suicidal ideation,[38] with suicidal ideation as high as 51% and attempted suicide rates as high as 30% among trans-

32. Nicolazzo, *supra* note 19.

33. Juan Battle & Angelique Harris, *Connectedness and the Sociopolitical Involvement of Same-Gender-Loving Black Men*, 16 Men & Masculinities 260 (2013).

34. Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, in Violence Against Women: Classic Papers 282 (Raquel Kennedy Bergen et al. eds., 2005) (1994); Mehmoona Moosa-Mitha, *Situating Anti-Oppressive Theories Within Critical and Difference-Centered Perspectives*, in Research as Resistance: Critical, Indigenous and Anti-Oppressive Approaches 37 (Leslie Brown & Susan Strega, eds., 2005).

35. Michael King et al., *A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People*, 8 BMC Psychiatry, Aug. 18, 2018, at 1.

36. *Id.*

37. Nat'l Ctr. for Transgender Equal., The Report of the 2015 U.S. Transgender Survey (2016) 1-298, https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

38. Johanna Olson et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. Adolescent Health 374 (2015).

gender youth,[39] compared to the national average of 4.6% for cisgender heterosexuals.[40]

As understood through Minority Stress[41] and an intersectional lens,[42] LGBTQ individuals with multiple marginalized identities are at even higher risk of mental health disparities than those with a single marginalized identity and these experiences may be unique between each subgroup. LGBTQ POC face racism and LGBTQ-based discrimination, the latter sometimes within their own racial and ethnic communities, which contribute to compound adverse effects on mental health that can lead to suicidal ideation.[43] Furthermore, LGBT individuals may be further marginalized and, thus, be at higher risk of suicide due to the additional barriers of homelessness, incarceration (whether in the juvenile justice system or in prison), and mental illness.[44]

Age may also be a consideration for additional behavioral health risks and coping among older LGBTQ adults. Regarding support, older LGBTQ adults may have fewer family connections and rely more on families of choice, such as long-term friends, social organizations, small groups or networks of people,[45] and have less support in illness and disability if they did not raise children.[46] Older LGBTQ+ adults are also at higher risk of poor mental health, smoking, excessive drinking, cardiovascular disease, diabetes, and obesity.[47] Due to historical LGBTQ-based discrimination experienced throughout their lives—perhaps one of the more impactful factors on behavioral

39. *Id.*; JAIME M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY (2011); Jack Harrison et al., *A Gender Not Listed Here: Genderqueers, Gender Rebels, and Otherwise in the National Transgender Discrimination Survey*, 2 LGBTQ POL'Y J. HARV. KENNEDY SCH. 13 (2012).

40. 2015 U.S. Trans Survey, , 2015 U.S. TRANS SURVEY , http://www.ustranssurvey.org/ (last visited Apr 25, 2019).

41. Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129 PSYCHOL. BULL. 674 (2003).

42. Doug Meyer, *An Intersectional Analysis of Lesbian, Gay, Bisexual, and Transgender (LGBT) People's Evaluations of Anti-Queer Violence*, 26 GENDER & SOC'Y 849 (2012).

43. Megan Sutter & Paul B. Perrin, *Discrimination, Mental Health, and Suicidal Ideation Among LGBTQ People of Color*, 63 J. COUNSELING PSYCHOL. 98 (2016).

44. Vincent M.B. Silenzio et al., *Sexual Orientation and Risk Factors for Suicidal Ideation and Suicide Attempts Among Adolescents and Young Adults*, 97 AM. J. PUB. HEALTH 2017 (2007).

45. Richard A. Friend, *Older Lesbian and Gay People: A Theory of Successful Aging*, 20 J. HOMOSEXUALITY 99 (1991).

46. KEVIN L. ARD, NAT'L LGBT HEALTH EDUC. CTR., UNDERSTANDING THE HEALTH NEEDS OF LGBT PEOPLE (2016).

47. Leah Eskenazi, *How to Find Care for LGBT Seniors*, PBS NEWS HOUR (June 11, 2015, 2:41 PM), https://www.pbs.org/newshour/health/lgbt-older-adults-emerging-community.

health—many older adults may be hesitant to disclose their sexual orientation or gender identity and may even become closeted when entering assisted living,[48] with concealment leading to anxiety and depression. This may be especially concerning for older transgender adults whose gender may be exposed during physical assistance.[49]

Higher psychological distress and behavioral problems were reported for youth whose parents rejected their gender nonconformity compared to more accepting parents.[50] In another study, transgender youth reported verbal and physical abuse, high rates of depression, and 47% of respondents reported attempting suicide.[51] Conversely, research continues to reinforce the importance of family acceptance, which has been found to be a protective factor against suicidality[52] that serves to promote positive health outcomes.[53]

Recent studies are replete with the corrosive effects of a hostile environment, such as stigma, prejudice, and discrimination, on LGBTQ individuals' overall health. In addition to the corrosive effects of discrimination on mental health, stigma and oppression may inhibit one's ability to cope and further traumatize individuals.[54] When unique experiences are examined among groups within the LGBT community, the disparities can be even greater, stressing the importance of this information to better serve each population.[55] These findings highlight the important role of mental and physical healthcare providers and organizations to support LGBTQ clients and their families, to provide competent services, and to create inclusive and

48. Iain Johnson, *Gay and Gray: The Need for Federal Regulation of Assisted Living Facilities and the Inclusion of LGBT Individuals*, 16 J. GENDER, RACE, & JUST. 293 (2013); Michael J. Johnson et al., *Gay and Lesbian Perceptions of Discrimination in Retirement Care Facilities*, 49 J. HOMOSEXUALITY 83 (2005).

49. Mo Perry, *The Challenge of Being Transgender in a Nursing Home*, THE ATL. (Aug. 12, 2015), https://www.theatlantic.com/health/archive/2015/08/transgender-nursing-home-aging/400580/.

50. H. A. Bradley, *Transgender Children and Their Families: Acceptance and Its Impact on Well-Being*, 71 DISSERTATION ABSTRACTS INT'L 650 (2010).

51. Kenta Asakura, *It Takes a Village: Applying a Social Ecological Framework of Resilience in Working with LGBTQ Youth*, 97 FAMILIES IN SOC'Y 15 (2016).

52. Caitlin Ryan et al., *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults*, 123 PEDIATRICS 346 (2009).

53. SANDY E. JAMES ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2016); Singh et al., *supra* note 17; ROBB TRAVERS ET AL., IMPACT OF STRONG PARENTAL SUPPORT FOR TRANS YOUTH: A REPORT PREPARED FOR CHILDREN'S AID SOCIETY OF TORONTO AND DELISLE YOUTH SERVICES (2012), https://www.researchgate.net/publication/284988129_Impacts_of_strong_parental_support_for_trans_youth_A_report_prepared_for_Children's_Aid_Society_of_Toronto_and_Delisle_Youth_Services.

54. Lauren Mizock & Kim T. Mueser, *Employment, Mental Health, Internalized Stigma, and Coping with Transphobia Among Transgender Individuals*, 1 PSY. SEXUAL ORIENTATION & GENDER DIVERSITY 146 (2014).

55. Kattari et al., *supra* note 22.

affirming environments[56] with adaptations to address and ameliorate the increased behavioral health risks due to the unique and marginalized experiences of LGBT individuals.[57]

1. Violent Injury

Andrea L. Roberts reported in a national study that the differences in exposure to violence due to sexual orientation were "striking."[58] LGB populations were almost twice as likely to have been exposed to violence.[59] In fact, a key finding of the study was that "lesbians, gay men, bisexuals, and heterosexuals with same-sex sexual partners—but not heterosexuals with same-sex attraction only—had significantly elevated risk of exposure to nearly every [traumatic] event type except war-related traumas."[60] Sexual orientation minorities are at an increased risk of experiencing intimate partner violence, sexual assault, physical and sexual abuse in childhood, and violence in their communities, including hate crimes.[61]

Violence in the transgender community is particularly concerning. The results of the 2015 U.S. Transgender Survey indicate an increased risk of violence and harm to mental and physical health. Verbal harassment, physical attacks and harassment, and physical or sexual assault accessing bathrooms in the last year were all attributed to reactions to individuals being transgender.[62] Eight percent of survey respondents attributed urinary tract infections, kidney infections, or other kidney problems in the past year to avoiding restrooms for fear of violence.[63]

School is a significant factor for LGBTQ youth. In the 2016 Youth Risk Behavior Survey ("YRBS"), LGBT teens reported being bullied in school, having forced sex, and being victims of sexual and physical vio-

56. Megan E. Gandy, Assessing LGBTQ Youth Cultural Competency in Direct-Care Behavioral Health Workers: Development and Validation of a Measure (Apr. 2015) (unpublished Ph.D. dissertation, Virginia Commonwealth University) (on file with Virginia Commonwealth University); THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH (Harvey J. Makadon et al., 2d ed. 2015); Patricia E. Penn et al., *LGBTQ Persons with Co-Occurring Conditions: Perspectives on Treatment*, 31 ALCOHOLISM TREATMENT Q. 466 (2013).

57. Ann P. Haas et al., *Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations*, 58 J. HOMOSEXUALITY 10 (2011); Silenzio et al., *supra* note 43.

58. Andrea L. Roberts et al., *Pervasive Trauma Exposure Among US Sexual Orientation Minority Adults and Risk of Posttraumatic Stress Disorder*, 100 AM. J. PUB. HEALTH 2433, 2437 (2010).

59. *Id.*

60. *Id.*

61. *Id.*

62. JAMES ET AL., *supra* note 50.

63. *Id.*

lence.[64] Nonbinary students also reported verbal harassment and feeling unsafe in school.[65]

B. Mitigators of Negative Health Outcomes

Acceptance and support have been found to be some of the strongest mitigators to disparate health outcomes for persons in the LGBTQ+ community. As policies are designed, the potential to positively influence acceptance and support may be variables to consider. Below is additional information regarding the kinds of behaviors which mitigate negative health outcomes.

1. Family Support

Research reinforces the importance of family acceptance, a protective factor for LGBTQ youth.[66] Family acceptance has been found to not only be a protective factor against depression, substance abuse, and suicidal ideation and behaviors[67] but also to promote higher self-esteem, social support, and general health status among LGBTQ youth and adolescents.[68] In one of the first studies to assess gender nonconformity among LGB youth, 30% of participants reported negative reactions from parents who discouraged gender atypical behavior through counseling, punishment or restriction, and insistence to change.[69]

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64. Hudaisa Hafeez et al., *Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, 9 Cureus 1184 (2017); Laura Kann et al., *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12 — United States and Selected Sites, 2015*, 65 Morbidity & Mortality Wkly. Rep. (Surveillance Summaries) 1 (2016).

65. Harrison et al., *supra* note 39; Russell B. Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment.*, 46 Developmental Psychol. 1580 (2010).

66. Maria E. Eisenberg & Michael D. Resnick, *Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors*, 39 J. Adolescent Health 662 (2006); Elizabeth M. Saewyc et al., *Protective Factors in the Lives of Bisexual Adolescents in North America*, 99 Am. J. Pub. Health 110 (2009).

67. Ryan et al., *supra* note 44; Caitlin Ryan et al., *Family Acceptance in Adolescence and the Health of LGBT Young Adults*, 23 J. Child & Adolescent Psychiatric Nursing 205 (2010).

68. James et al., *supra* note 50; Ryan et al., *supra* note 65; Anneliese A. Singh et al., *"I am my own gender": Resilience strategies of trans youth.*, 92(2) J. Counseling & Dev. 208, 208-214 (2014); Robb Travers et al., Impact of Strong Parental Support for Trans Youth: A Report Prepared for Children's Aid Society of Toronto and Delisle Youth Services (2012).

69. Anthony R. D'Augelli et al., *Childhood Gender Atypicality, Victimization, and PTSD Among Lesbian, Gay, and Bisexual Youth*, 21 J. Interpersonal Violence 1462 (2006).

2. School Acceptance

School acceptance has been found to be associated with lower anxiety, depression, skipping of classes, and negative coping mechanisms, such as drinking and smoking.[70] In particular, the presence of school GSAs (previously Gay-Straight Alliances, now Gender and Sexuality Alliances) have been shown to have a significant impact on the wellbeing of LGBTQ youth, as well as lower rates of truancy, tobacco use, alcohol use, attempted suicide, and casual sexual behavior.[71] Even without actively participating, the mere presence of a GSA was a strong indicator of well-being as reported by LGBTQ young adults[72] and an official sign of support.[73]

Additionally, GSAs are a meaningful venue for youth to engage in gender and sexual orientation activism.[74] Despite the need for support, research has also shown that LGBTQ youth lack access to such protective resources.[75] In the 2015 National School Climate Survey assessing the experience of LGBTQ youth, 23.1% of youth ages thirteen to twenty-one identified as nonbinary, genderqueer, or another gender.[76] The majority, 56.6% of the sample, reported their school did not have policies that addressed the needs of gender minority students, which were offered as a result of not including nonbinary needs.[77] Furthermore, even when anti-discrimination policies are in place, Jennifer Schindel reported from her fieldnotes that teachers may not know how to proceed with such things as bathroom usage and accepted pronouns with gender minority students.[78] In related findings, transgender and nonbinary high school students reported signifi-

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71. V. Paul Poteat et al., *Gay Straight Alliances Are Associated with Student Health: A Multischool Comparison of LGBTQ and Heterosexual Youth*, 23 J. RES. ON ADOLESCENCE 319 (2013).

72. Russell B. Toomey et al., *High School Gay-Straight Alliances (GSAs) and Young Adult Well-Being: An Examination of GSA Presence, Participation, and Perceived Effectiveness*, 15 APPLIED DEVELOPMENTAL SCI. 175 (2011).

73. Carol Goodenow et al., *School Support Groups, Other School Factors, and the Safety of Sexual Minority Adolescents*, 43 PSYCHOL. IN THE SCHOOLS 573 (2006).

74. Jennifer E. Schindel, *Gender 101 – Beyond the Binary: Gay-Straight Alliances and Gender Activism*, 5 SEXUALITY RES. & SOC. POL'Y 56 (2008).

75. Kenta Asakura & Shelley L. Craig, *"It Gets Better" . . . but How? Exploring Resilience Development in the Accounts of LGBTQ Adults*, 24 J. HUM. BEHAV. IN SOC. ENV'T 253 (2014).

76. JOSEPH G. KOSCIW ET AL. GLSEN, THE 2015 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER YOUTH IN OUR NATION'S SCHOOLS (2016).

77. Such policies include adopting pronouns approved by LGBTQ community members and providing all-gender facilities.

78. Schindel, *supra* note 72.

cantly lower-quality student-teacher relationships compared to their cisgender counterparts.[79]

Although hostile school environments have been found to severely compromise the psychosocial wellbeing of LGBTQ youth,[80] research has found that school-related protective factors against adverse mental health outcomes, such as depression and suicidality, to include perceived school safety and caring adults and teachers.[81]

3. Community Support

In a 2018 report, Andrew R. Flores and Andrew Park examined the link between social acceptance of LGBTQ people and legal inclusion of sexual minorities, such as non-discrimination policies. The study found a strong statistical link between social acceptance and legal inclusion of SOGI.[82] As policies are considered, it may be prudent to examine the impact the policy may have on the LGBTQ community both directly and in terms of societal acceptance.

Research has consistently shown community support to be crucial for wellbeing among transgender and nonbinary adults.[83] Interpersonal relationships that allow LGBTQ individuals to be seen and accepted have been repeatedly found to be influential across the lifespan.[84] Early social development has significant long-term effects on mental health outcomes with social support being necessary for establishing healthy interactions and serving as a protective factor

79. Marla E. Eisenberg et al., *Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents*, 61 J. ADOLESCENT HEALTH 521 (2017).

80. Asakura & Craig, *supra* note 73.

81. Eisenberg & Resnick, *supra* note 64; JOSEPH G. KOSCIW ET AL., GLSEN, THE 2009 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH IN OUR NATION'S SCHOOLS (2010).

82. ANDREW R. FLORES & ANDREW PARK, UCLA SCH. OF LAW, EXAMINING THE RELATIONSHIP BETWEEN SOCIAL ACCEPTANCE OF LGBT PEOPLE AND LEGAL INCLUSION OF SEXUAL MINORITIES (2018).

83. Barbara L. Fredrickson, *The Broaden-and-Build Theory of Positive Emotions*, 359 PHIL. TRANSACTIONS OF THE ROYAL SOC'Y B 1367 (2004); Ilan H. Meyer & David M. Frost, *Minority Stress and the Health of Sexual Minorities*, in HANDBOOK OF PSYCHOLOGY AND SEXUAL ORIENTATION 252 (Charlotte J. Patterson & Anthony R. D'Augelli eds., 2013); ELLEN D.B. RIGGLE & SHARON S. ROSTOSKY, A PRIMITIVE VIEW OF LGBTQ: EMBRACING IDENTITY AND CULTIVATING WELL-BEING (2011); MARTIN E.P. SELIGMAN, AUTHENTIC HAPPINESS: USING THE NEW POSITIVE PSYCHOLOGY TO REALIZE YOUR POTENTIAL FOR LASTING FULFILLMENT (2002); Asakura & Craig, *supra* note 77; Riggle et al., *supra* note 19; Megan C. Stanton et al., *Individual, Social and Community-Level Predictors of Wellbeing in a US Sample of Transgender and Gender Non-Conforming Individuals*, 19 CULTURE, HEALTH & SEXUALITY 32 (2017).

84. Riggle et al., *supra* note 19; Michelle D. Vaughan & Eric M. Rodriguez, *LGBT Strengths: Incorporating Positive Psychology into Theory, Research, Training, and Practice*, 1 PSYCHOL. OF SEXUAL ORIENTATION & GENDER DIVERSITY 325 (2014).

against isolation, depression, anxiety, and severe mental health challenges.[85]

C. Health Access

Barriers to healthcare access have a significant impact on mental and physical health for LGBTQ+ individuals. Structural and personal forces can work to either assist in access or make it more difficult. The Institute of Medicine describes four primary areas recognized for negatively impacting health access for the LGBTQ community.

1. Stigma (Personal Level)[86]

Of the many barriers for LGBTQ individuals, stigma[87] is associated with lower levels of health care access. Stigma can be experienced explicitly in the form of slurs or violence ("enacted"), indirectly via conversations not directed at the person but nevertheless harmful or in conversations directed at the person with heteronormative language ("felt"), and via the person's internalized belief learned over time from a society which treats SOGI minorities as others ("internalized").[88] Furthermore, anticipated discrimination is a barrier to accessing healthcare for many sexual and gender minorities.[89] All of these forms of stigma make it more unlikely that the person impacted will trust a health system to be able to meet their needs free of bias. Conversely, a positive LGBTQ identity has been found to bolster resilience and better cope with future minority-related stressors.[90]

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85. Budge et al., *supra* note 18; Cara Jean Hale et al., *Social Support and Physical Health: The Importance of Belonging*, 53 J. Am. C. Health 276 (2005).

86. The Institute of Medicine emphasizes that "[p]ersonal-level barriers are created by the attitudes, beliefs, and behaviors of individuals within the health care system—both providers and patients." Inst. of Med., The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (2011). Structural stigma, or institutional stigma, is the manifestation of stigma within the institutions of society. Patrick W. Corrigan et al., *Structural Stigma in State Legislation*, 56 Psychiatric Services 557 (2005). Structural stigma often perpetuates stigma-based differentials in status and power and may operate even in the absence of prejudice on the part of individual members of an institution. Bruce G. Link & Jo. C. Phelan, *Conceptualizing Stigma*, 27 Ann. Rev. Soc. 363 (2001).

87. Institute of Medicine, *supra* note 84.. The Institute of Medicine defines stigma as: "inferior status, negative regard, and relative powerlessness that society collectively assigns to individuals and groups that are associated with various conditions, statuses, and attributes." *Id.*

88. Inst. of Med. (US) Comm. on Lesbian, Gay, Bisexual, & Transgender Health Issues & Research Gaps & Opportunities, *supra* note 3.

89. Michael L. Hendricks & Ryan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 Prof'l Psychol. 460 (2012).

90. Vaughan & Rodriguez, *supra* note 82.

2. Structural Stigma

Structural stigma impacts access to services whether or not the provider or the individual themselves has perpetrated or experienced stigma. These are institutional policies and/or attitudes adopted by society at large, which fail to support inclusion. For example, hospital rules around visitation of same-sex partners, particularly prior to marriage equality, impact the patient whether or not individual providers act to stigmatize patients. These structural problems leave LGBTQ individuals without needed access to services and support.

3. Professional Knowledge and Training

While the American Medical Association has recommended improved and increased training in LGBTQ care, the lack of cultural competency across healthcare fields impacts the willingness of the LGBTQ community to enter into treatment with those who do not understand their needs.[91] A review of the literature shows a lack of sufficient training in the needs of the LGBTQ communities.[92] Some practitioners report feeling incompetent to work with LGBT clients, which may be due to a lack of personal initiative along with a lack of agency responsiveness to prepare professionals.[93] Research has shown a significant relationship between LGB-competence among mental health practitioners and organizational LGBT-competence, with the latter increasing the former, strengthening the argument for needed LGBT training.[94]

Transgender individuals are particularly impacted in the area of practitioner competence due to the cultural discomfort with those who do not conform to gender norms.[95] A systematic review of literature on mental health providers' attitudes towards transgender people showed more frequent positive attitudes compared to the general population, with most negative attitudes among white, heterosexual men who identified as religious and conservative.[96] However, some mental health professionals report feeling unprepared for working with trans-

91. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

92. Suzanne Brown et al., *Mental Health Practitioners' Attitudes Towards Transgender People: A Systematic Review of the Literature*, 19 INT'L J. TRANSGENDERISM 4 (2018).

93. Carmen Logie et al., *Evaluating the Phobias, Attitudes, and Cultural Competence of Master of Social Work Students Toward the LGBT Populations*, 53 J. HOMOSEXUALITY 201 (2007).

94. David McCarty-Caplan, *LGBT-Competence in Social Work Education: The Relationship of School Contexts to Student Sexual Minority Competence*, 65 J. HOMOSEXUALITY 19 (2017).

95. Frohard-Dourlent et al., *supra* note 20.

96. Brown et al., *supra* note 90.

gender clients, with some holding religious or political-based prejudiced attitudes.[97] A study of attitudes towards transgender people among counseling professionals found that in addition to training and experience, factors related to positive attitudes towards transgender people include personal familiarity with transgender people and belief in a biological or other individual etiology for transgender identities.[98] Despite the expectation that psychologists will engage with transgender clients, little to no training on transgender issues is included during or after their formal education, highlighting the need for cultural competency training,[99] which is arguably also applicable to other professions.

D. Health Insurance

While marriage equality has positively impacted the ability of the LGBTQ community to access employer-sponsored health insurance, disparities in the employment levels of the LGBTQ community, including a lack of anti-discrimination labor laws in many states, still create disparities between the LGBTQ community and the general population in health coverage. Health insurance policies on items such as gender confirmation surgery ("GCS") and hormone replacement treatments ("HRTs") can also create structural barriers to health access.[100] In particular, even those with GCS-inclusive policies continue to be written on the binary spectrum and, thus, exclude nonbinary individuals. For example, someone assigned female at birth ("AFAB") attempting to access top surgery[101] who has an insurance policy that uses the language "to affirm their *male* identity" as a requirement for deeming the surgery medically necessary, therefore, excludes anyone who does not identify their gender as male (e.g., nonbinary individuals). Individually, and especially accumulatively, these barriers create a significant burden to the LGBTQ community as individuals attempt to access health care. Health policy discussions should include these issues if we are to begin to increase health care access for LGBTQ individuals.

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97. Jill M. Chonody et al., *Attitudes Toward Gay Men and Lesbian Women Among Heterosexual Social Work Faculty*, 50 J. Soc. Work Educ. 136 (2014)

98. Emily A. Nisley, Counseling Professionals' Attuitudes Toward Transgender People and Responses to Transgender Clients (Dec. 2010) (unpublished Ph.D. dissertation, Western Michigan University) (on file with Western Michigan University).

99. Am. Psychological Ass'n, Report of the Task Force on Gender Identity and Gender Variance (2008).

100. Inst. of Med. (US) Comm. on Lesbian, Gay, Bisexual, & Transgender Health Issues & Research Gaps & Opportunities, *supra* note 3.

101. The removal of breast tissue and masculinization or neutralization of the chest.

E. Access to Public Spaces

1. Non-Discrimination Legislation

Affirmation and inclusion of sexual and gender minorities seemed to be gaining momentum the early 2000s, as legislative and organizational policies, including the legalization of gay marriage, increased in the inclusion of non-discrimination policies.[102] However, in 2016, the changing sociopolitical climate saw an increase in discriminatory state-level legislation with proposed and passed laws with negative repercussions, particularly for gender minorities. Currently only nineteen states and the District of Columbia have protections against discrimination based on sexual orientation and gender identity concerning statewide public accommodations.[103]

In 2011, the United Nation's General Assembly Report acknowledged the discrimination faced by LGBTQ individuals, as documented over the previous two decades, and has recommended each nation to recognize the rights of transgender individuals.[104] More recently, the European Union's Council of Europe Parliamentary Assembly proposed the transgender-inclusive Resolution 2048. Of the proposed policies, the most nonbinary-applicable were to remove required mental health diagnoses for changing gender markers and to recommend countries include a third gender option.[105] Additionally, research concerning transgender experiences was called for to include discrimination, hate crimes, suicide prevention, and the effectiveness of anti-discrimination legislation.[106]

2. Bathroom Bills

Historically, bathrooms have been the battleground of human rights movements for Blacks, women, people with disabilities, and now for transgender Americans.[107] The collective bathroom bills began in March 2016 when North Carolina passed House Bill 2 ("N.C.

102. Ray Sanchez, *Feds' Transgender Guidance Provokes Fierce Backlash*, CNN (last updated May 14, 2016, 6:44 PM), https://www.cnn.com/2016/05/14/politics/transgender-bathrooms-backlash/.

103. State Maps of Laws & Policies: Public Accommodations, Human Rights Campaign (last updated June 11, 2018), https://www.hrc.org/state-maps/public-accomodations.

104. U.N. Human Rights Council, Rep. of the U.N. High Comm'r for Human Rights, U.N. Doc. A/HRC/19/41 (2011).

105. Discrimination Against Transgender People in Europe, Parl. Eur. Doc. 13742 (2015).

106. *Id.*

107. Alia E. Dastagir, *The Imaginary Predator in America's Transgender Bathroom War*, USA Today (Apr. 28, 2016 5:34 PM), https://www.usatoday.com/story/news/nation/2016/04/28/transgender-bathroom-bills-discrimination/32594395/.

H.B. 2").[108] N.C. H.B. 2 was reportedly a response to several trans-affirming bathroom bills that allowed transgender individuals to use the bathroom according to their gender.[109] Conversely, N.C. H.B. 2 required transgender and nonbinary people to use the bathroom that aligned with their ASAB.[110] Although it has since been repealed, N.C. H.B. 2 ignited sixteen other states to propose similar legislation.[111]

The implications of such requirements placed transgender and nonbinary people at risk of physical and mental health risks as a result of facing daily suspicion, harassment, and hostility. According to the 2015 U.S. Transgender Survey,[112] bathrooms continue to be increasingly dangerous spaces for transgender persons with increasingly harmful legislation. When attempting to use bathrooms, 9% of respondents reported being denied access, 12% reported being verbally harassed, 1% reported being physically attacked or sexually assaulted with the majority, 53%, of nonbinary respondents reporting avoidance of bathrooms sometimes to always in the last twelve months for fear of harassment and other potential invidious forms of discrimination. For fear of confrontation, 59% of respondents avoided public restrooms in the last year and 32% limited fluid intake to limit necessary bathroom use with 8% reporting urinary tract infection or related infections in the past year due to bathroom avoidance.[113] Even more disparaging is the fact that being denied access to bathrooms has been linked to suicide among transgender individuals.[114]

The argument of bathroom bill proponents has focused on the protection of women and children from the perceived threat of transgender sexual predators.[115] Despite the heightened fear, there have been no recorded cases of assault in a bathroom by a transgender person in the United States.[116] Ultimately, the sexual predator argument has been called a *red herring*.[117] The Obama administration took a clear stance on bathroom bills with a statement from the Departments

108. H.B. 2, 2016 Gen. Assemb., 2nd Extra Sess. (N.C. 2016).

109. Kevin Drum, *A Very Brief Timeline of the Bathroom Wars*, MOTHER JONES (May 14, 2016), https://www.motherjones.com/kevin-drum/2016/05/timeline-bathroom-wars/.

110. Joellen Kralik, *"Bathroom Bill" Legislative Tracking*, NAT'L CONF. OF ST. LEGISLATURES (July 28, 2017), http://www.ncsl.org/research/education/-bathroom-bill-legislative-tracking635951130.aspx.

111. *Id.*

112. JAMES ET AL., *supra* note 50.

113. *Id.*

114. Max Kutner, *Denying Transgender People Bathroom Access Is Linked to Suicide*, NEWSWEEK (May 1, 2016, 8:00 AM), http://www.newsweek.com/transgender-bathroom-law-study-suicide-454185.

115. Katy Steinmetz, *Why LGBT Advocates Say Bathroom 'Predators' Argument Is a Red Herring*, TIME (May 2, 2016), http://time.com/4314896/transgender-bathroom-bill-male-predators-argument/.

116. Dastagir, *supra* note 104.

117. Steinmetz, *supra* note 112.

of Education and Justice directing school administrations to ensure that "transgender students enjoy a supportive and nondiscriminatory school environment."[118] At this time, administrative interpretations of these rules have been moving away from including transgender persons from protections.[119] Even if legislation passes to allow individuals to use the bathroom according to gender, nonbinary individuals will continue to be excluded unless all-gender bathrooms are present.

3. The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") provided LGBTQ individuals increased protections and access to services,[120] even though gender diverse individuals still experience gatekeeping, such as required professional letters to validate their gender,[121] and discrimination in health care.[122] With the emergence of the World Professional Association of Transgender Health ("WPATH") standards of care for transgender and gender non-conforming ("SOC") clients, guidelines have been established with the intent to guide practitioners in providing affirmative care.[123] Particular to nonbinary individuals, to the most recent version ("SOC 7") changed from binary to nonbinary language and included a statement to recommend practitioners not impose the gender binary on youth.[124] These modifications evidenced an increasing professional awareness of nonbinary identities and established a need for more inclusive practices.[125]

F. Minority Stress Theory

The minority stress model was developed by Ilan H. Meyer and theorizes that minorities experience diminished mental and physical health as a result of harmful social environments that create stress due to stigma, prejudice, and discrimination.[126] In particular, a higher prevalence of anxiety, depression, and substance use are at-

118. Sanchez, *supra* note 99.
119. For a more detailed discussion, *see infra* Section IV(C).
120. The White House, *Here's How Obamacare Helps the LGBT Community*, Internet Archive (archived Mar. 7, 2015), https://web.archive.org/web/20150307034356/https://www.whitehouse.gov/share/lgbt-aca-benefits.
121. Aiden Collazo et al., *Facilitating Transition Among Transgender Clients: Components of Effective Clinical Practice*, 41 Clinical Soc. Work. J. 228 (2013).
122. Grant et al., *supra* note 39; James et al., *supra* note 50.
123. Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 Int'l J. Transgenderism 165 (2012).
124. *Id.*
125. Frohard-Dourlent, *supra* note 20.
126. Meyer, *supra* note 42.

tributed to minority stress among LGB individuals as compared to heterosexuals. Stigma associated with nonconformity to prevailing sexual orientation and gender norms is a collective experience for LGBT individuals and, therefore, a significant social determinant of health.[127]

Minority stress has been categorized as distal or external[128] and proximal or internal[129] processes.[130] Enacted stigma has been reported to range from seemingly innocuous remarks to physical assault and death threats.[131] Minority stress also results from anticipated discrimination, concealment of identity, and internalized stigma (acceptance and internalization of a negative message about one's identity).[132]

Michael Hendricks and Ryan Testa theorized additional gender identity-specific stressors of *expectations of violence and discrimination* and *internalized transphobia*.[133] Gender nonconformity was found to be a consistent and robust predictor of psychological distress, which was theorized to be in part due to the hypervigilance related to rejection based on perceptions of gender expression.[134] Some transgender and nonbinary individuals report anticipating rejection "anytime they left home and entered a public space."[135]

Another group with unique minority stressors is older, LGBTQ adults. In addition to the barriers to care faced by LGBTQ youth and adults, such as a lack of culturally competent providers and experiences with, and a fear of, discrimination, they face additional barriers because of isolation and a lack of social services specific to their needs.[136] Over 1.5 million LGBTQ people are over sixty-five in the United States, a number expected to double by 2030,[137] and currently

127. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

128. An objective, enacted stigma that is directly experienced.

129. A subjective, felt stigma that is internally experienced.

130. Gregory M. Herek, *Sexual Stigma and Sexual Prejudice in the United States: A Conceptual Framework*, 54 NEB. SYMP. ON MOTIVATION 65 (2009); Graham Scambler & Anthony Hopkins, *Being Epileptic: Coming to Terms with Stigma*, 8 SOC. HEALTH & ILLNESS 26 (1986); Meyer, *supra* note 42.

131. Brian A. Rood et al., *Identity Concealment in Transgender Adults: A Qualitative Assessment of Minority Stress and Gender Affirmation*, 87 AM. J. ORTHOPSYCHIATRY 704 (2017).

132. Meyer, *supra* note 42.

133. Hendricks & Testa, *supra* note 87.

134. Domm, *supra* note 18.

135. Brian A. Rood et al., *Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals*, 1 TRANSGENDER HEALTH 151, 156 (2016).

136. The White House, *supra* note 117.

137. Perry, *supra* note 48.

only seven LGBTQ+ retirement communities exist in the U.S.[138] Some older, LGBTQ adults are reluctant to share their sexual or gender identity, becoming closeted when entering assisted living.[139] Assisted living can be a stressful environment for older transgender adults due to sex-segregated spaces, such as housing, bedrooms, bathrooms, and potentially exposing their gender identity by receiving physical assistance.[140] Furthermore, decades of chronic stress may lead to adverse health effects.[141] In particular, survivors of the 1980s and 1990s HIV/AIDS crisis may still be hesitant to engage with medical care and service providers.[142]

IV. LEGAL & PUBLIC HEALTH APPROACHES

A. Data Collection

Public health relies heavily on data collection to consider both what interventions are needed to protect a population's health and to determine whether such interventions are effective. Unfortunately, it is difficult to use these methodologies for the LGBTQ population as data collection for this population is scarce and utterly lacking in resources Healthy People 2020, an initiative of ODPHP, created goals for increased data collection for the LGBTQ community as a necessary step to increase the public health community's ability to serve this population better. Recommendations included extensive surveys on the demographic and social characteristics of the SOGI community; data gathering on LGBTQ household composition; surveys of income and education in the SOGI community, including comparisons of partnered and unpartnered persons; examination of impact of barriers to care; and studies of the impact of stigma at personal and structural levels on LGBTQ health.[143] Without this baseline data, it will be challenging to move forward in determining the best ways to serve the LGBTQ community. It will be important to understand the impact of policy on this community in addition to traditional public health data

138. *LGBT Resources, LGBT Senior Housing*, Gay & Lesbian Ass'n of Retiring Persons, Inc., http://www.gaylesbianretiring.org/lgbt-resources.html (last visited Aug. 24, 2019).

139. Johnson, *supra* note 47; Johnson et al., *supra* note 47.

140. Perry, *supra* note 48.

141. Movement Advancement Project & Servs. & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders, Improving the Lives of LGBT Older Adults (2010).

142. Friend, *supra* note 44.

143. *Lesbian, Gay, Bisexual, and Transgender Health,* Office of Disease Prevention & Health Promotion, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health (last visited Feb 13, 2019).

statistics because policies alone can be social determinants of health for the LGBTQ community.[144]

B. EDUCATION

Despite the American Medical Association's recommendation for more considerable training on LGBTQ topics, there exists a lack of cultural competency in the field, which impacts the willingness of the LGBTQ community to enter into treatment with those who do not understand their needs.[145] The medical community continues to need training regarding the needs of the LGBTQ community. Providers report discomfort or feeling unprepared when taking histories and understanding the treatment needs of the LGBTQ community.[146] Transgender individuals are particularly impacted by this area. Conversely, having "transgender-inclusive" primary care practitioners has been found to significantly reduce the likelihood that transgender and nonbinary individuals will experience depression or suicidal ideations, as well as a strong predictor that transgender and nonbinary individuals will seek medical interventions and not delay care due to fears of discrimination.[147]

Recent studies in the field speak to the need for an ongoing commitment for competency training for working with LGBTQ clients. Education for health care providers that are culturally responsive across sexual orientation and gender identity is extremely important.[148] In addition to the medical field, LGBTQ individuals would benefit from professionals in all social service professions receiving LGBTQ education, especially in schools. Formal LGBTQ education plays an essential role in removing the onus on the marginalized population to be educators. Furthermore, priority LGBTQ education can contribute to a more welcoming and affirming environment for recruiting and retaining LGBTQ professionals.

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144. Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 UNIV. PA. L. REV. 1649 (2011); Scott Burris et al., *Better Health Faster: The Five Essential Public Health Law Services*, 131 PUB. HEALTH REP. 747 (2016).

145. Greta R. Bauer, *"I Don't Think This Is Theoretica; This Is Our Lives": How Erasure Impacts Health Care for Transgender People*, 20 J. ASS'N NURSES IN AIDS CARE 348 (2009); Luisa Kcomt, *Profound Health-Care Discrimination Experienced by Transgender People: Rapid Systematic Review*, 58 SOC. WORK IN HEALTH CARE 201 (2019).

146. R.E. Knight et al., *Exploring Clinicians' Experiences Providing Sexual Health Services for LGBTQ Youth: Considering Social and Structural Determinants of Health in Clinical Practice*, 29 HEALTH EDUC. RES. 662 (2014).

147. Shanna K. Kattari et al., *Exploring the Relationship Between Transgender-Inclusive Providers and Mental Health Outcomes Among Transgender/Gender Variant People*, 55 SOC. WORK IN HEALTH CARE 635 (2016).

148. Kattari et al., *supra* note 22.

C. Statutes and Regulations

The federal landscape under which the LGBTQ+ population lives and accesses health services has been changing. The transgender community, in particular, has seen a number of changes to administrative rules and the interpretation of administrative rules which have made it more difficult to live free from stress and stigma and to access services.

The PPACA nondiscrimination language under section 1557 created an opportunity to expand access to health care for the LGBTQ+ population. Section 1557 prohibited discrimination on the basis of race, color, national origin, sex, age, or disability in health programs receiving federal funding.[149] The definitions for protected groups incorporated pre-existing laws rather than enumerating new protected groups with definitions. In 2016, the administration promulgated an administrative rule specifically directing that Title IX was to be interpreted to include sexual orientation and gender identity under sex discrimination.[150] Within months, a lawsuit on behalf of Catholic health care providers and physicians, *Franciscan Alliance v. Burwell*,[151] challenged the rule and the court issued a nationwide injunction.[152]

In 2017, President Trump issued Executive Order 13765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal."[153] The order allowed for the Department

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149. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 119 (codified at 42 U.S.C. § 18116). Section 1557 provided:

> Except as otherwise provided for in this title? (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title? (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

Id.

150. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

151. 227 F. Supp. 3d 660 (N.D. Tex. 2016).

152. Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

153. On January 20, 2017, the President issued Executive Order 13765 "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal," that requires, among other things, "[t]o the maximum extent permitted by law, the Secretary of Health and Human Services . . . shall exercise all authority and discretion available to [ ] waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [PPACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of

of Health and Human Services to waive requirements of the PPACA which would cause fiscal or administrative burdens to states or individuals. This order, in addition to the court's injunction, effectively undermined the goals of the rule interpreting section 1557 to include sexual orientation and gender identity. In May 2019, the administration set forth a new proposed rule for comment.[154] This proposed rule explicitly changes the administrative interpretation of sex discrimination to be a binary one, allowing states to determine for themselves whether or not to include protections for sexual orientation and gender identity.[155]

The next year will be a pivotal one for those seeking to ensure access and non-discrimination for the LGBTQ community. The Supreme Court has granted certiorari to three cases, which will examine whether Title VII workplace discrimination protections apply to sexual orientation and transgender individuals.[156] While these cases are based on Title VII, the Court's interpretation of sex in under Title VII will have an impact on Title IX and other civil rights laws where the term "sex" is used. The 2019 Supreme Court Term will have significant implications for LGBTQ access to health care in the future.

V. CONCLUSION

It is important to note that, as discussed above, it was not until the Healthy People 2020 initiative that the LGBTQ community was included in this prominent national public health objective. Though the LGBTQ community has been with us from the beginning, it has only relatively recently received attention for the pertinent health disparities and inequities the community experiences. As the public health community continues to improve its ability to work with and for this community, the legal and policy-making community would do well to increase its understanding of the impact of policy on the community. The next few years will be critical for this work, as all three branches of government continue to grapple with the best ways to

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health insurance, or makers of medical devices, products, or medications." Exec. Order No. 13,765, 82 Fed. Reg. 8,351 (Jan. 24, 2017).

154. Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) (to be codified at 45 C.F.R. pt. 438).

155. *Id.* See the rule's description of the interpretation to include sexual orientation and gender identity described as a "novel" definition: "The Department proposes to repeal the novel definition of "sex" in the Section 1557 regulation in order to make the Department's regulations implementing Title IX through the Section 1557 Regulation more consistent with the Title IX regulations of other Federal agencies." *Id.*

156. Bostock v. Clayton Cnty., 723 F. App'x 964 (11th Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. Apr. 22, 2019) (No. 17-1618); Zarda v. Altitude Express, Inc., 883 F.3d 100 (2d Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. Apr. 22, 2019) (No. 17-1623); EEOC v. R.G. & G.R. Harris Funeral Homes, Inc., 884 F.3d 560 (6th Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. Apr. 22, 2019) (No. 18-107).

work with this community. Importantly, there is some suggestion that the decision may be made to move away from helping this community that continues to face pervasive health inequities. The legal community has a role to play in working to decrease the health disparities of the LGBTQ community. It would be well served to do so.