

REMEDYING STIGMA-DRIVEN HEALTH DISPARITIES IN SEXUAL MINORITIES

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INTRODUCTION

Sexual minorities (including lesbian, gay, bisexual, and transgender persons) are increasingly recognized as suffering from significant health disparities.² As a collective, sexual minorities experience disparately, higher rates of chronic disease, poor mental health, and sexually transmitted infections and receive less access to preventive care than other populations.³

For the most part, these disparities are avoidable. They are not the result of bad luck or naturally occurring health problems in this population. Instead, they are the consequence of long-standing discrimination and marginalization of sexual minorities in our society. This discrimination can indirectly harm the health of sexual minorities by reducing their access to the social determinants that promote health, like education, safe housing, and high paying jobs. But the experience of living in a society that discriminates against or stigmatizes you has also been shown to directly harm one's health.⁴ When sexual minorities live in communities that more highly discriminate against them, they live twelve years shorter lives than

² Inst. of Med., *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, NAT'L ACAD. SCIENCES (Mar. 31, 2011), <http://www.nationalacademies.org/hmd/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx> [hereinafter IOM 2011].

³ *Id*; see also *Lesbian, Gay, Bisexual, and Transgender Health*, HEALTHY PEOPLE, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited July 25, 2017) [hereinafter Healthy People].

⁴ Maureen R. Benjamins & Steve Whitman, *Relationships Between Discrimination in Health Care and Health Care Outcomes Among Four Race/Ethnic Groups*, 37 J. BEHAV. MED. 4012 (2014).

those sexual minorities living in less discriminatory communities.⁵ They are more likely to engage in self-harming behaviors,⁶ to suffer significant stress that further deteriorates their health,⁷ and to avoid seeking medical attention for these health issues out of a fear of being discriminated against. While public opinion on sexual minorities has improved nationwide,⁸ there is still much room for improvement in providing legal remedies to combat sexual minority discrimination in a variety of settings from employment to education to healthcare.

The healthcare system can play a central role in helping to mitigate the wider social harms of stigma. So long as stigma exists, our healthcare system is the place where harmful effects of stigma will be identified and treated. Educating providers on the effects of stigma on health will allow them to screen for stigma and potentially prevent some of its resulting harms.

But stigma also occurs in, or is perpetuated by, the healthcare system. For example, some sexual minorities complain of discrimination by providers which leads them to not disclose their sexual status,⁹ or to avoid seeking medical care in the future in order to avoid further negative experiences.¹⁰ Discrimination in this setting, whether intentional or unthinking, can amplify the harms of stigma. Not only does it mean more experience of stigma by sexual minorities,

⁵ See Mark L. Hatzenbuehler et al., *Structural Stigma and All-Cause Mortality in Sexual Minority Populations*, 103 SOC. SCI. & MED. 33 (2014) [hereinafter Hatzenbuehler All-Cause Mortality].

⁶ See Mark L. Hatzenbuehler, et al., *Structural Stigma and Cigarette Smoking in a Prospective Cohort Study of Sexual Minority and Heterosexual Youth*, 47 ANN. BEHAV. MED. 48 (2014) [hereinafter Hatzenbuehler Youth].

⁷ See Mark L. Hatzenbuehler & Katie A. McLaughlin, *Structural Stigma and Hypothalamic-Pituitary-Adrenocortical Axis Reactivity in Lesbian, Gay, and Bisexual Young Adults*, 47 ANN. BEHAV. MED. 39 (2014) [hereinafter Hatzenbuehler Hypothalamic].

⁸ See generally *Gay and Lesbian Rights*, GALLUP POLL, <http://www.gallup.com/poll/1651/gay-lesbian-rights.aspx> (last visited July 25, 2017) [hereinafter Gallup] (showing marked improvement in public opinion of gay and lesbian rights since the 1970s).

⁹ See Kyle T. Bernstein et al., *Same-Sex Attraction Disclosure to Health Care Providers Among New York City Men Who Have Sex with Men: Implications for HIV Testing Approaches*, 168 ARCH. INTERN. MED. 1458 (2008).

¹⁰ *When Healthcare Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV*, LAMBDA LEGAL, <http://www.lambdalegal.org/publications/when-health-care-isnt-caring> (last visited July 25, 2017).

but it reduces the chance that this or any other experience of stigma will be appropriately attended to by the healthcare system.¹¹

This paper is the first in the law review literature to explore the impact of stigma on the health of sexual minorities and the role of the healthcare system and its laws in reducing it. Particularly, this Article focuses on the promising new civil right to healthcare, Section 1557 of the Affordable Care Act (ACA).¹² Section 1557 wields enormous power to tackle discrimination on many fronts,¹³ but as the first civil right to reach sex discrimination in healthcare, it holds special meaning. While Section 1557, like other healthcare laws, may at any point be under threat from various attempts by political forces to reform our healthcare system, it will always stand as the first law of its kind and thus as a model for future regulatory reforms at the federal or state level to guarantee broader protections for sexual minorities in healthcare.

This Article seeks to put stigma on the map as worthy of more legal scholarship and it begins a larger project of exploring how law interacts with stigma in this and other health disparate populations. But it also functions to celebrate a major civil rights breakthrough in healthcare. Never before have we seen a law like Section 1557, specifically designed to level the playing field in healthcare and redress long-standing health disparities and stigma.¹⁴

This article will proceed in Part I by briefly describing some of the health disparities experienced by sexual minorities, before turning to stigma as an important contributor to these disparities. Part II explores the wider social stigmas that affect sexual minorities, how stigma specifically affects their health, and what the healthcare system can do to prevent and treat the attending health harms of stigma. Part III argues that stigma also occurs within the healthcare system. It explores the health harms of stigma in both patient-provider relationships and health insurer arrangements, before turning to legal

¹¹ *Id.*

¹² Patient Protection and Affordable Care Act, 42 U.S.C. § 18116(a) (2012).

¹³ Section 1557 reaches race, gender/sex, age, and disability discrimination. *Id.*

¹⁴ See Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 859 (2012) (observing that Section 1557 is the first health-specific civil right).

solutions to combat healthcare discrimination on the basis of sex. It argues that Section 1557 is aptly designed to remedy stigma against sexual minorities in healthcare and has already done significant work to that end. This article ends with a warning in Part IV. Section 1557 and the ACA may be at risk and a variety of harms to sexual minority health may result. If these laws are repealed in name or function, we may need to rethink other approaches to arguing on behalf of the rights of sexual minorities in healthcare.

I. SEXUAL MINORITIES, HEALTH DISPARITIES, AND STIGMA

About 3.2% of the US populations identifies as lesbian or gay, and another 7.5% identify as bisexual.¹⁵ There are many terms used frequently and interchangeably to encompass this population, including “LGBT,”¹⁶ “LGBTQ,”¹⁷ “sexual minorities,” or “sexual and gender minorities.” For purpose of this article, I will focus on “sexual minorities” which I define as “lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity and expressions . . . varies from traditional, societal, cultural, or physiological norms.”¹⁸ For this paper, “transgender” means “persons whose gender identity or expression (masculine, feminine, other) is different from their sex (male, female) at birth.”¹⁹ I define “gender identity” as “one’s internal understanding of one’s own gender, or the

¹⁵ In the survey, 1.3% of women identified as lesbian, and 1.9% of men identified as gay. 5.5% of women and 2.0% of men identified as bisexual. The survey did not capture those who identify as transgender. The percentage of people who reported some experience of same-sex relations is higher: 17.4% of women and 6.2% of men. Casey E. Copen, et al., *Sexual Behavior, Sexual Attraction, and Sexual Orientation Among Adults Aged 18–44 in the United States: Data From the 2011–2013 National Survey of Family Growth*, 88 NAT’L HEALTH STAT. REP. 1 (2016).

¹⁶ This stands for lesbian, gay, bisexual, and transgender.

¹⁷ This acronym includes people who identify as “queer,” which is a general term for people who do not identify as being heterosexual.

¹⁸ This is an adaptation of the definition regularly used by the National Institute of Minority Health and Health Disparities (NIMHD). *Director’s Message*, NAT’L INST. ON MINORITY HEALTH & HEALTH DISPARITIES, <http://www.nimhd.nih.gov/about/directors-corner/message.html> (last visited Apr. 13, 2017) [hereinafter NIMHD].

¹⁹ *HIV Among Transgender People*, CTR. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/hiv/group/gender/transgender/> (last visited Apr. 13, 2017) [hereinafter CDC].

gender with which a person identifies.”²⁰ Gender expression is “people’s outward presentation of their gender.”²¹

It is important to note that while I speak of sexual minorities as a cohesive group, like any subpopulation, they are not so easily categorized. Members of this group share common categorization around sexuality, but may differ in other ways. Some may represent several minority identities at once, for example, racial minority or disability.²² Some may represent multiple sexual minorities at once, for example being transgender and also being gay. Others may not self-identify as being part of a sexual minority, their sexual identity might be fluid, or they might identify as being part of a sexual minority under some definitions but not others. While the empirical literature studies sexual minorities as a discrete population, they are not so easily defined and may not always share common or collective interests with individual identities occurring across a spectrum.

This article does not contemplate women or gender minorities (people who are intersex or born with sex organs that vary from physiological norms).²³ Sex antidiscrimination law typically addresses these populations alongside sexual minorities and Section 1557 may mean major breakthroughs for this group too, but the different groups may merit independent consideration about how health disparities and stigma apply. Much of the health disparities and stigma literature this article contemplate focuses predominantly on LGBT persons or some variation of that group, which is a significant reason why I focus only on sexual minorities in this particular article.²⁴

At various points in the paper I may refer to a specific subset of the sexual minority population, for example if the research data only

²⁰ *Id.*

²¹ *Id.*

²² For foundational writings on intersectionality, see Kimberl Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 149 (1989).

²³ NIMHD contemplates sexual and gender minorities collectively, defining gender minorities as those for whom “reproductive development varies from traditional, societal, cultural, or physiological norm.” See NIMHD, *supra* note 18.

²⁴ Future work might focus on whether stigma, health disparities, and related legal remedies for women and gender minorities are unique or comparable to that of LGBT persons.

supports a finding of a health disparity in lesbians but not gay men. Otherwise, I will use the umbrella term of sexual minority.

With this background in mind, sexual minorities, as a class, experience significant health disparities. Most health disparities in the sexual minority population are not natural or unavoidable. Instead, they are a result of inequities in the distribution of social and economic resources and the harms caused by long-standing discrimination against sexual minority communities. This section briefly describes significant health and healthcare disparities experienced by sexual minorities before turning to an account of stigma and its role as a major driver of health disparities in this population.

A. Health Disparities and Sexual Minorities

In 2011, the Institute of Medicine (IOM) at the behest of National Institutes of Health (NIH) undertook the first major federal study on the health needs of sexual minorities.²⁵ Available research was limited because of a lack of federal surveys on sexual minority health²⁶ and inherent limitations to studying this population.²⁷ But the findings

²⁵ IOM 2011, *supra* note 2 (focusing on lesbian, gay, bisexual, and transgender persons); ANDREA L. SOLARZ, LESBIAN HEALTH: CURRENT ASSESSMENT AND DIRECTIONS FOR THE FUTURE (Inst. of Med. 1999), <https://www.nap.edu/read/6109/chapter/1>.

²⁶ Sexual minorities are frequently excluded from regular health data gathering. For example, the CDC does not include sexual orientation in its Behavioral Risk Factor Surveillance System. This is a telephone health data collection that is currently the largest gathering of health information in the world and a major resource for those studying population-level health disparities. *Behavioral Risk Factor Surveillance System*, CTR. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/brfss/>; see also IOM 2011, *supra* note 2. States have the option of including sexual orientation in their own surveys, but currently a majority of states do not. Grant W. Farmer et al., *Gay Acres: Sexual Orientation Differences in Health Indicators Among Rural and Nonrural Individuals*, 32 J. RURAL HEALTH 321 (2016).

²⁷ There are a number of challenges inherent to studying sexual minorities as a population. Sexual minority identities can be fluid or can overlap, and studies rely on individuals to self-identify, making it hard to have a single consistent standard that captures all possible participants. IOM 2011, *supra* note 2; see also Bethany G. Everett et al., *Examining Sexual Orientation Disparities in Unmet Medical Needs Among Men and Women*, 33 POP. RES. & POL'Y REV. 553, 555 (2014). For example, a transgender man and transgender woman in a relationship would not likely identify as being in a same sex relationship. Alternatively, studies may prompt participants for whether they are "LGBT" as a collective, but each is a distinct population with its own specific health needs that are worthy of independent study. Other barriers include reluctance by some LGBT individuals to discuss their sexuality. Further, recruiting sexual minorities to studies can be challenging, as they represent a small

were startling. There was a group with significant and unmet health and healthcare disparities across a variety of conditions.²⁸ Since then, other agencies, including the NIH, have begun to recognize sexual minorities as an important health disparities population meriting further research and remedies.²⁹

Health disparities are wide-ranging in sexual minorities and include disparities in access to care and in rates of chronic disease, mental health, and sexual health.

1. Preventive Care and Chronic Disease

Sexual minorities suffer from disparate rates of a number of life-threatening and non-life-threatening chronic diseases. LGB people are collectively more likely to have asthma and respiratory diseases, headaches, allergies, osteoarthritis, and serious gastrointestinal problems than non-LGB people.³⁰ Some sexual minorities, including lesbians and bisexual women, are more likely to be overweight or obese.³¹

Sexual minorities experience higher rates of some types of cancer.³² They also suffer greater morbidity and mortality from

portion of the population. IOM 2011, *supra* note 2, at 2.

²⁸ Health and healthcare disparities are terms used to indicate when a particular social group is collectively less healthy than others. Health disparities are variations of health and well-being in populations that are influenced by “culture, lifestyle, socioeconomic status, and accessibility of resources.” Healthcare disparities are a type of health disparity caused by variations in “access to and quality of healthcare” that are often linked to the social and economic positions of groups and individuals. Michelle A. Meade et al., *The Intersection of Disability and Healthcare Disparities: A Conceptual Framework*, 37 *DISABILITIES & REHABILITATION* 1, 3–4 (2014).

²⁹ NIMDH officially recognized LGBT populations as a health disparities populations in 2016, pointing to their current health disparities, their unique healthcare needs, and the impact of overall discrimination on their health as major reasons to *further* understand and study their well-being. NIMHD, *supra* note 18.

³⁰ Farmer et al., *supra* note 26, at 322.

³¹ IOM 2011, *supra* note 2, at 4; Healthy People, *supra* note 3.

³² Farmer et al., *supra* note 26, at 322 (noting that some studies attribute these higher rates of cancer to smoking and substance abuse, diet, and HIV); *see also* Gwendolyn P. Quinn et al., *The Importance of Disclosure: Lesbian, Gay, Bisexual, Transgender/Transsexual, Queer/Questioning, and Intersex Individuals and the Cancer Continuum*, 121 *CANCER* 1160, 1160 (2015).

cancers due to a lower likelihood of early detection owing to a lack of access to and uptake of cancer screenings.³³

Some sexual minorities may be less likely to use preventive care generally³⁴ and are more likely to report longstanding and unaddressed physical and emotional problems.³⁵ Adult and elderly LGBT have been less likely to have children who can take care of them as they age,³⁶ which may exacerbate the ability of these individuals to seek preventive care and manage chronic conditions.

2. Mental Health

Sexual minorities are at greater risk for a number of mental health disorders including suicidal ideation and suicide attempt, self-harm, depression, anxiety, and substance abuse.³⁷ Similar findings arise in studies of sexual minority teenagers.³⁸ LGB teens are two or

³³ Quinn et al., *supra* note 32; *see also* Healthy People, *supra* note 3 (describing lesser access to cancer preventive care for lesbians).

³⁴ *See* IOM 2011, *supra* note 2; *see also* Healthy People, *supra* note 3 (providing evidence of less use of preventive care by lesbians and bisexual women).

³⁵ This finding comes from a study in England that found that sexual minorities were two or three times more likely to reporting having longstanding physical and emotional problems than their heterosexual counterparts. Marc N. Elliott et al., *Sexual Minorities in England Have Poorer Health and Worse Health Disparities: A National Survey*, 30 J. GEN. INTERN. MED. 9, 9 (2014).

³⁶ IOM 2011, *supra* note 2, at 4.

³⁷ These disparities are not just US-bound, but exist at the global level. For a systematic review of LGB mental health disparities across North America and Europe, *see* Michael King et al., *A Systematic Review of Mental Disorder, Suicide and Deliberate Self Harm in Lesbian, Gay and Bisexual People*, 8 BMC PSYCHIATRY 1, 4 (2008). Studies on depression, suicidality, and mood disorder show higher rates in LGB populations, but more research is needed in transgender populations. More studies on drug and alcohol abuse are also needed in gay male adults, as most studies in the US have been conducted on lesbian populations. IOM 2011, *supra* note 2, at 4.

³⁸ *See* IOM 2011, *supra* note 2, at 4 (finding increased risk for suicidal ideation and depression among lesbian, gay, and bisexual teens, with small studies suggesting the same for transgender teens). IOM also found rates of increased substance abuse in lesbian, gay, and bisexual teens, though more research is needed on transgender teens. *See also* Michael P. Marshal et al., *Substance Use and Mental Health Disparities among Sexual Minority Girls: Results from the Pittsburgh Girls Study*, 25 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 15, 15 (2012) (finding that “sexual minority girls reported higher past-year rates of cigarette, alcohol, and heavy alcohol use, higher rates of suicidal ideation and self-harm, and higher average depression, anxiety.”).

three times as likely to commit suicide as other teens,³⁹ and are at a disproportionate risk of being homeless.⁴⁰

The topic of mental health and sexual minority must be handled with care. First, sexual minority status has itself been wrongfully treated as a mental health disorder in the past, sometimes generating stigma against these groups. For example, being gay was, for decades, wrongfully viewed as a diagnosable mental disorder until homosexuality was removed from the second edition of the *Diagnosics and Statistics Manual of Mental Disorders (DSM)* in 1973.⁴¹ A similar and controversial debate now wages over whether being transgender should be viewed as within the purview of mental health professionals.⁴²

In addition to wrongly portraying sexual minority status as an illness, those who seek to discriminate against this population might be inclined to portray mental health challenges as somehow endemic to, or part of, sexual minority status.⁴³ Instead, research indicates that stress and discrimination from being part of a socially marginalized group are the drivers behind increased mental health disorders in this population.⁴⁴

³⁹ Healthy People, *supra* note 3.

⁴⁰ See IOM 2011, *supra* note 2; see Healthy People, *supra* note 3.

⁴¹ Gregory M. Herek, *Confronting Sexual Stigma and Prejudice: Theory and Practice*, 63 J. SOC. ISSUES 905, 915 (2007).

⁴² While many view it as a victory that the DSM recently changed “gender identity disorder” to “gender dysmorphia” thus reducing any “disorder” stigma, some feel that it is inappropriate to view transgender status as a diagnosable mental health issue at all. Others believe this medicalization has an advantage if it leads to greater justification for insurance coverage of gender transition services. Jordan Aiken, *Promoting an Integrated Approach to Ensuring Access to Gender Incongruent Health Care*, 31 BERKELEY J. GENDER L. & JUST. 1, 6-7 (2016).

⁴³ Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129 PSYCHOL. BULL. 674, 674 (2003).

⁴⁴ *Id.* at 674-75 (emphasizing that the long history of using mental disorders to stigmatize gays and lesbians calls for a need to emphasize the root cause of heightened mental disorders in these populations).

3. HIV and Sexual Health

HIV continues to be a significant health disparity for sexual minorities, with gay men being collectively at a higher risk of contracting HIV.⁴⁵ Rates of HIV are particularly high in young black men who have sex with men⁴⁶ and in the transgender community.⁴⁷ Gay men and transgender individuals are also at a higher risk of contracting other sexually transmitted infections.⁴⁸

B. Social Determinants of Health in Sexual Minorities

What is behind these health disparities for sexual minorities? Some health disparities are determined by an individual's health behaviors.⁴⁹ And some health issues may be endemic to some sexual minorities; for example, while data suggests increasingly that extended hormone use is harmful to health, some transgender people may knowingly and gladly accept this risk in order to live in the gender of their preference.⁵⁰ However, the vast majority of health disparities in sexual minorities cannot be explained by individual behaviors or choices and are better laid at the feet of inequities in the allocation of power, money, and other valuable resources that determine health outcomes.⁵¹ These contributors to health disparities are social determinants of health, or the social and environmental constructs shaped by our economic and political systems that shape who is more or less healthy.⁵²

Social determinants of health in sexual minorities have been well studied. Like other minorities, sexual minorities are more likely to be

⁴⁵ See Healthy People, *supra* note 3.

⁴⁶ See IOM 2011, *supra* note 2.

⁴⁷ CDC, *supra* note 19 (noting that, in 2013, this population experienced the largest percentage of new cases of HIV of any US population).

⁴⁸ See Healthy People, *supra* note 3.

⁴⁹ See IOM 2011, *supra* note 2.

⁵⁰ *Id.* (mentioning that the NIH has flagged this as an area where additional research is needed); see also NIMHD, *supra* note 18.

⁵¹ NCHHSTP *Social Determinants of Health*, CTR. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html> (last updated Mar. 21, 2014).

⁵² *Id.*

uninsured and may live in social conditions that are less conducive to leading healthy lives.⁵³ For example, sexual minorities are more likely to live in low-income homes and have less education.⁵⁴ They may also experience inequalities at work that can, in turn, affect their economic well-being and access to social determinants of good health like safe neighborhoods, quality food, and adequate exercise.⁵⁵

Along with other determinants of health, stigma is an important contributor to health disparities that has gone under-recognized in the law literature.⁵⁶ Stigma takes its toll on the health of discriminated populations, particularly for sexual minorities who continue to experience significant social stigmatization and inadequate legal protections. This Article seeks to put stigma on the map alongside other social determinants as a serious contributor to health disparities worthy of further legal scholarship. In doing so, this Article does not mean to suggest that stigma prevails as the most important issue, or any more important than other determinants of health. Indeed, “identifying determinants of population health inequalities is [not] a zero-sum game. Introducing stigma as a fundamental cause of population health inequalities does not prevent the field from simultaneously addressing other social causes of poor health.”⁵⁷

⁵³ Everett et al., *supra* note 27.

⁵⁴ In a recent Gallup poll, LGBT families more frequently reported living in the lowest income households that make \$24,000 or less per year. Additionally, LGBT were more likely to report being in households with no college education or with less than a four-year degree. Vanessa G. Rodriguez, *Gallup: LGBT Income & Education Lower Than Previously Thought*, CHRISTIAN EXAMINER (Feb. 10, 2015), <http://www.christianexaminer.com/article/will-profile-of-gays-change-as-americans-increasingly-accept-gays-lesbians/48348.htm>. Data has been mixed on the educational levels of LGTB persons. IOM shows studies suggesting higher education levels in gays and lesbians than heterosexuals but suggests such findings may reflect a great likelihood of more educated sexual minorities to report their sexuality. IOM 2011, *supra* note 2.

⁵⁵ Alexandra Brandes, *The Negative Effect of Stigma, Discrimination, and the Health Care System on the Health of Gender and Sexual Minorities*, 23 TUL. J. L. & SEXUALITY 155, 157-58 (2014) (arguing that sexual minorities are inadequately protected from discrimination in the labor market which affects their income and benefits).

⁵⁶ See Scott Burris, *Disease Stigma in U.S. Public Health Law*, 30 J. L. MED. & ETHICS 179 (2002) (one of the predominant legal scholars exploring stigma, mainly focusing on stigmatized diseases like HIV). See also Jasmine E. Harris, *Processing Disability*, 64 AM. U. L. REV. 457 (2015) (considering stigma literature in the context of disability antidiscrimination).

⁵⁷ Mark L. Hatzenbuehler et al., *Stigma as a Fundamental Cause of Population Health Inequalities*,

However, given the importance of stigma, legal scholars should consider whether legal remedies adequately address stigma and its harms to health.

C. Stigma and Health Disparities

Stigma creates its own harms on human health at a variety of levels. Any efforts to address sexual minority health disparities must consider and tailor remedies to take into account stigma as a direct and primary driver of poor health in sexual minorities, in addition to the indirect role stigma may have in reducing their access to social determinants of health. The following sections describe the sociological account of stigma, how such stigma affects health, and how these factors particularly apply to sexual minorities.

1. *Introducing Stigma*

Erving Goffman, a sociologist, coined the term “stigma” to study the lived experience and wider effects of certain types of discrimination on vulnerable populations.⁵⁸ Goffman defined stigma as “an attribute” that makes a person different and less desirable, leading other people to reduce the person “from a whole and usual person to a tainted, discounted one.”⁵⁹ For purposes of this Article, I distinguish stigma from prejudice, although the concepts are quite similar.⁶⁰

103 AM. J. PUB. HEALTH 813 (2013) [hereinafter Hatzenbuehler Fundamental].

⁵⁸ See ERVING GOFFMAN, *STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY* (1963).

⁵⁹ *Id.* at 3.

⁶⁰ Gordon Willard Allport, a psychologist who studied personality psychology raised similar concepts in his works on prejudice in 1958. GORDON WILLARD ALLPORT, *THE NATURE OF PREJUDICE* (1958). Allport’s concepts of prejudice were similar to stigma. He defined prejudice as a “hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group.” A comparison of the various studies on stigma and prejudice shows that they are, in fact, similar concepts often interchangeably used in the literature. See Jo C. Phelan et al., *Stigma and Prejudice: One Animal or Two?*, 67 SOC. SCI. & MED. 358 (2008). See also Jennifer Stuber et al., *Stigma, Prejudice, Discrimination, & Health*, 67 SOC. SCI. & MED. 351 (2008) (arguing that “the differences between the research traditions of stigma as compared to that of prejudice and discrimination have more to do with different subjects of interest rather than any real conceptual difference.”). Stigma research has traditionally emphasized studying people with “unusual” conditions such as facial disfigurement, HIV/AIDS, short stature and

Link and Phelan describe five components that must be present for stigma.⁶¹ First, individuals must recognize and label a socially relevant human condition that differs among the population (for example, skin color or sexual orientation).⁶² Next, society must engage in some level of stereotyping where the population links the now-labeled person to undesirable characteristics.⁶³ In other words, the public must begin to think that all people of a particular group share that trait.⁶⁴ From there, individuals begin to sort people according to “us” versus “them”; that is, the undesirables all have one trait and are different from the desirables who do not have that trait.⁶⁵ As a result of this sorting, now stigmatized persons suffer some loss of status.⁶⁶ Finally, power is exercised over the stigmatized group.⁶⁷ Because the stigmatized groups are outsiders with an undesirable trait, the public justifies treating them differently and with less respect and privilege.⁶⁸

Stigma is more than discrimination.⁶⁹ Discrimination is to “[r]ecognize a distinction” or treat two groups differently from one another.⁷⁰ Not all discrimination is unlawful or problematic, or in violation of civil rights laws, which typically deal with discrimination against protected classes. Stigma is discrimination that plays on power, using us versus them to exert control over a group or to deprive them of certain rights and interests.⁷¹ Moreover, the act of stigma is not

mental illness. By contrast, researchers focused on prejudice and discrimination tend to focus on the far more ordinary, but clearly powerful implications of gender, age, race and class divisions.” A full review of how prejudice literature might apply to the concepts in this paper is beyond its scope, though future work might warrant a distinct examination of prejudice literature on the health of sexual minorities and possible legal remedies.

⁶¹ Bruce G. Link & Jo Phelan, *Stigma and Its Public Health Implications*, 367 LANCET 528 (2006).

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Burris, *supra* note 56, at 180–81.

⁷⁰ *Discriminate*, OXFORD ENGLISH DICTIONARY (2017), <https://en.oxforddictionaries.com/definition/discriminate>.

⁷¹ Burris emphasizes this point by using the example of lawyers. While lawyers can be viewed

just to differentiate that person from you, but to make them feel badly for that difference. “When you stigmatize someone, your aim is not merely to respond to a trait that you find undesirable but to mark that person in such a way that they find the trait undesirable.”⁷² According to Goffman, stigmatizing a group amounts to giving them a spoiled identity on the basis of their membership in some group or because of their having a particular attribute.⁷³

Minorities are often the prime target of stigma, for example racial minorities and sexual minorities.⁷⁴ However, this is not always true, as majority traits can also sometimes be stigmatized.⁷⁵ For example, women can be stigmatized, as can overweight or obese people, despite these groups occupying a large sector of the population.⁷⁶ Ultimately, the question is not about the particular trait in question or its prevalence. Instead, it is the situating of that trait within a given society, and the meaning it holds therein.⁷⁷ Early work

negatively and may even suffer discrimination, they are not stigmatized because they have power to challenge this discrimination. Burris, *supra* note 56. A similar distinction can be seen in the goals of civil rights laws. Some view civil rights law as playing an anti-classification role only. That is, they make it unlawful to treat one group differently based solely on the basis of being a member of a protected group. In contrast, anti-subordination focuses on using law to alter power structures. The purpose of antidiscrimination is to prevent harm to social standing. Jessica L. Roberts, *The Genetic Information Nondiscrimination Act as an Antidiscrimination Law*, 86 NOTRE DAME L. REV. 597 (2010). Anti-classification mirrors concepts of discrimination for purposes of this paper. They are confined to categorization of people. Anti-subordination speaks more to stigma—that it is the outcome of discrimination, through loss of power, that matters.

⁷² Andrew M. Courtwright, *Justice, Stigma, & the New Epidemiology of Health Disparities*, 23 *BIOETHICS* 90, 91 (2009).

⁷³ GOFFMAN, *supra* note 58, at 107–08.

⁷⁴ Benjamins & Whitman, *supra* note 4, at 407.

⁷⁵ Bernice A. Pescosolido et al., *Rethinking Theoretical Approaches to Stigma: A Framework Integrating Normative Influences on Stigma*, 67 *SOC. SCI. & MED.* 431 (2008).

⁷⁶ *Id.*

⁷⁷ The whole point of stigma is that one group wrongfully dismisses and stereotypes another group. Yet another society might equally prize that trait. For example, while sexual minority is sometimes dismissed in American culture, gender nonconformity is prized and rewarded in Native American culture because of beliefs that such people have healing powers. Michael D. Mink et al., *Stress, Stigma, and Sexual Minority Status: The Intersectional Ecology Model of LGBTQ Health*, 26 *J. GAY & LESBIAN SOC. SERVS.* 502 (2014). Another example that Goffman provides in his leading book on stigma is that those who are expected to have a college degree in their job, and do not, may hide this fact. However, in other work settings where few have

on stigma focused on discredited stigma, or stigmatized traits that were visible and could not be concealed, for example race or gender.⁷⁸ Stigma research increasingly focuses on discreditable stigma, or stigmatized traits that can be concealed, like sexual minorities or mental illness.⁷⁹

What motivates stigma? Researchers have identified three overarching motivations: keeping people out, keeping people in, and keeping people away – all of which hold importance in healthcare.⁸⁰ In the first, stigma is motivated by a desire to keep certain groups subjugated so those in control can have a greater hold on power, class, or wealth.⁸¹ For example, keeping sick people uninsured may mean better insurance rates for the healthy. Keeping people in has to do with enforcing social norms by ensuring that those who stray from a custom or way of life are punished, thereby discouraging others from following suit.⁸² Keeping people away is motivated by a desire to avoid sickness.⁸³ Disease, illness, or other physical and behavioral traits that vary from the norm may be stigmatized in an effort to quarantine real or perceived harmful conditions.⁸⁴

Stigma operates on several levels. At the structural level it creates structural barriers in the form of norms and policies that disenfranchise and dismiss certain groups.⁸⁵ A ban on transgender people using the bathroom of their choice would be an example of

a higher education, the college degree holder might hide the degree. GOFFMAN, *supra* note 58.

⁷⁸ Stephenie R. Chaudoir et al., “Discredited” Versus “Discreditable”: Understanding How Shared and Unique Stigma Mechanisms Affect Psychological and Physical Health Disparities, 35 BASIC APPLIED SOC. PSYCHOL. 75 (2013).

⁷⁹ *Id.*

⁸⁰ Bruce G. Link & Jo Phelan, *Stigma Power*, 103 SOC. SCI. & MED. 24 (2014). See also Hatzenbuehler Fundamental, *supra* note 57 (arguing that these three varying motivators for stigma can help us to better understand how to address stigma through public policy).

⁸¹ Link & Phelan, *supra* note 80, at 25; see also GOFFMAN, *supra* note 58 (describing stigma as keeping people inferior or giving them a spoiled identity).

⁸² GOFFMAN, *supra* note 58.

⁸³ Link & Phelan, *supra* note 80, at 26.

⁸⁴ *Id.*

⁸⁵ Laura M. Bogart et al., *Introduction to the Special Section on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Disparities: Where We Are and Where We’re Going*, 47 ANN. BEHAV. MED. 1 (2014).

structural stigma that can serve to dismiss individual rights and interests. Stigma can also operate at the interpersonal level, affecting how individuals, families, and communities interact with each other.⁸⁶ Hate crimes and violence, or family disputes over sexual orientation, are examples of stigma operating at this level.⁸⁷ Lastly, stigma operates at the individual level, in how the individual processes and responds to stigma.⁸⁸

Individuals can experience stigma as enacted stigma, where an individual experiences actual discrimination, such as when an individual is a victim of a hate crime or harassment.⁸⁹ Individuals can also experience anticipated stigma, where an individual expects future discrimination, based on past personal experience or generalized expectations about how society treats people like them.⁹⁰ For example, a person who knows a victim of a hate crime might fear that such a crime would also happen to them.⁹¹ Individuals can also experience internalized stigma, where individuals self-stigmatize because they feel shame from being a member of a stigmatized group.⁹² Those close friends and family members of sexual minorities may even feel “courtesy stigma,” or stigma by association.⁹³

2. *Stigma and Health Disparities*

Experiencing stigma is bad for your health. The phenomenon has been shown at various points in history where groups were subjected to widespread social inequalities and isolation.⁹⁴ For example, African American populations during the era of Jim Crow exhibited significant health disparities beyond what this population

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ Chaudoir et al., *supra* note 78, at 79.

⁹⁰ *Id.* at 78-79.

⁹¹ *Id.*

⁹² *Id.* at 5.

⁹³ Herek, *supra* note 41, at 909.

⁹⁴ Hatzenbuehler Fundamental, *supra* note 57.

experiences today.⁹⁵ Interestingly, there is a correlation—though not necessarily causation—between high stigma communities and higher mortality for the majority populations, as well. Data supports increased mortality for all populations in areas that had significant racism, sexism, and other forms of discrimination.⁹⁶

The study of stigma as it contributes to health disparities began in the 1980s with the AIDS epidemic.⁹⁷ The AIDS epidemic represented stigma on several levels.⁹⁸ First, a stigmatized group of sexual minorities were at greater risk for the disease.⁹⁹ Second, the disease itself was highly stigmatized, in part because of its link to sexual orientation and in part because of people's fear of a deadly infectious disease.¹⁰⁰ Since then, stigma has been attributed to health disparities for a number of different groups including racial minorities, sexual and gender minorities, the obese, and others.¹⁰¹ Discrimination is associated with worse mental and physical health, unhealthy behaviors, and decreased longevity.¹⁰² Various studies link expectation of devaluation or past perceptions of discrimination to increased stress and poor health.¹⁰³

One reason for the link between stigma and health may be stress.¹⁰⁴ Under the minority stress theory, stress is harmful to health and minorities experience "excess stress to which individuals from stigmatized social categories are exposed."¹⁰⁵ Under this theory,

⁹⁵ *Id.*

⁹⁶ Hatzenbuehler All-Cause Mortality, *supra* note 5, at 33, 39.

⁹⁷ Ronald Bayer, *Stigma and the Ethics of Public Health: Not Can We But Should We*, 67 SOC. SCI. & MED. 463, 464–65 (2008).

⁹⁸ *Id.* at 464.

⁹⁹ *Id.* at 465.

¹⁰⁰ *Id.* at 465–66.

¹⁰¹ Hatzenbuehler Fundamental, *supra* note 57.

¹⁰² Benjamins & Whitman, *supra* note 4, at 410–11.

¹⁰³ See Chaudoir et al., *supra* note 78, at 3.

¹⁰⁴ Meyer, *supra* note 43, at 674–75, 678.

¹⁰⁵ *Id.* (explaining that in this theory, minority stress is moderated and influenced by broader environmental circumstances. For example, socioeconomic status interacts with minority status. Low socioeconomic status hurts the ability of individuals to cope and handle stress, while adding additional stress and challenges. Particular instances of discrimination can

stigma plays an important role in stress-inducement.¹⁰⁶ Minorities “learn to anticipate—indeed, expect—negative regard from members of the dominant culture” and must be on guard, or vigilant, to this negative feeling.¹⁰⁷ This need for hyper-vigilance is its own form of stress that can harm health.¹⁰⁸

Beyond creating stress, stigma can influence health at structural, interpersonal, and individual levels.¹⁰⁹ At the structural level, health policies can lead the stigmatized population to have reduced access to the healthcare system.¹¹⁰ At the interpersonal level, stigma can affect the way individuals interact with the medical system and the way providers interact with them.¹¹¹ People who perceive stigma in a healthcare setting are less likely to trust providers, follow their recommendations, or to be satisfied with the care they receive and are more likely to avoid or delay medical care.¹¹² At the individual level,

influence this stress—for example experiencing a specific act of violence. Additionally, how much someone identifies as a minority (minority identity) can both help them if it means they connect socially with others, or hurt them if it leads people to conceal their identities or to self-efface); see MICHAEL MARMOT, *THE STATUS SYNDROME: HOW SOCIAL STANDING AFFECTS OUR HEALTH AND LONGEVITY* 104–137 (2004).

¹⁰⁶ Meyer, *supra* note 43, at 674–75, 678.

¹⁰⁷ *Id.* at 680.

¹⁰⁸ *Id.* at 676 (discussing four ways in which stigma interacts with stress. Stigmatized individuals have to guard against being pegged as belonging to a stigmatized group in cases where being so characterized is harmful. For example, a lesbian may not want to be viewed as a lesbian if it affects her ability to be promoted at work. Yet, the stigmatized also have to worry about people dismissing their identity, for example if a family member repeatedly refuses to acknowledge that her daughter is a lesbian and tries to set her up on dates with men. They have to worry about how people view their values, such as people attributing certain values or lack thereof to social groups, like competence or morality. And they have to worry about broader acceptance or lack thereof); see also Nyla R. Branscombe et al., *Perceiving Pervasive Discrimination Among African Americans: Implications for Group Identification or Well-Being*, 77 J. PERSONALITY & SOC. PSYCHOL. 135, 135–36 (1999).

¹⁰⁹ Bogart et al., *supra* note 85, at 1.

¹¹⁰ Healthy People, *supra* note 3, at 2 (stating that legal discrimination in “access to health insurance, employment, housing, marriage, adoption, and retirement benefits” as structural problems contribute to disparities in sexual minorities).

¹¹¹ Bogart et al., *supra* note 85, at 1.

¹¹² Benjamins & Whitman, *supra* note 4; see also Chaudoir et al., *supra* note 78, at 403 (citing studies that stigma correlates with decreased adherence to mental illness treatment and to regular access to physicians generally).

stigma can lead individuals to adopt unhealthy or risky behaviors¹¹³ or affect an individual's self-worth and willingness to seek medical help.¹¹⁴

Stigma against sexual minorities is known as sexual stigma or "the negative regard, inferior status, and relative powerlessness that society collectively accords to . . . [sexual minority] . . . behavior, identity, relationship, or community."¹¹⁵ Sexual stigma can be seen as a "cultural phenomenon that exists independently of the attitudes of any one individual. It creates the social context in which such attitudes are formed, maintained, expressed, and changed."¹¹⁶ Herek observes that sexual minorities face two layers of structural stigma.¹¹⁷ First, society is "hetero-normative" meaning that the assumption is that all people are heterosexual, rendering sexual minorities often invisible from policy considerations.¹¹⁸ Second, when they are considered, they are problematized and considered to be abnormal or inferior.¹¹⁹

Stigma appears to play an important role in the health of sexual minorities. The next sections describe how stigma affects the health of sexual minorities and what, specifically, our healthcare system can do about it.

II. REMEDYING SEXUAL MINORITY STIGMA THROUGH THE HEALTHCARE SYSTEM

To the extent that sexual minorities suffer ill health as an effect of wider social stigma, the healthcare system can respond. While it alone cannot eliminate the laws, policies, and public behaviors that lead to such stigmatization, it can be at the frontline in preventing and treating the attending harms of that wider stigma. This section

¹¹³ For example, see Chaudoir et al., *supra* note 78 (discussing evidence that stigma increases drug and alcohol consumption, poor diet, and risky sexual behavior).

¹¹⁴ Bogart et al., *supra* note 85, at 2.

¹¹⁵ Herek, *supra* note 41, at 906-07.

¹¹⁶ *Id.* at 907.

¹¹⁷ *Id.* at 906.

¹¹⁸ *Id.* at 907.

¹¹⁹ *Id.* at 906-07.

explores the role of the healthcare system in addressing wider societal stigma, before turning to how the healthcare system can address healthcare-specific acts of stigma.

A. General Stigma against Sexual Minorities and Health Effects

Discrimination against sexual minorities has declined in recent decades as sexual minority status gains broader social acceptance, but there is still much room for improvement.¹²⁰ In a recent Gallup poll, 28% of Americans agreed that gay and lesbian relations between consenting adults should be illegal,¹²¹ while 37% of the population viewed same-sex relations as “morally wrong.”¹²² Views on same-sex marriage have improved but 37% of the population still thinks it should be forbidden,¹²³ and 35% of those polled thinks that gay and lesbian couples should not be permitted to adopt children.¹²⁴ A majority (50%) believe transgender people should use the bathroom of their birth gender as opposed to the gender they identify as (40%).¹²⁵ And 13% of Americans would prefer to see gays and lesbians be less socially accepted than they currently are.¹²⁶

Sexual minorities are commonly the targets of violence and harassment. Sexual orientation ranked second highest for motivating hate crimes (18.7%), only behind race (48.3%), according to a 2014 Federal Bureau of Investigations hate crimes report.¹²⁷ In a study of

¹²⁰ Gallup, *supra* note 8.

¹²¹ *See id.* (stating that this is an improvement over the results from years prior. For example, the same question posed in 1977 was split, with 43% agreeing it should be illegal and 43% stating that it should not be illegal).

¹²² *Id.*

¹²³ *Id.* (comparing 1996 data in which 68% thought it should not be valid).

¹²⁴ *Id.*

¹²⁵ Gallup, *supra* note 8.

¹²⁶ *Id.*

¹²⁷ The report cited 1,248 hate crimes based on sexual orientation in 2014. Of these, 56.3% were motivated by anti-gay bias, 24.4% from mixed group bias (anti-gay, bisexual, transgender, or lesbian), 13.9% from anti-lesbian bias, and 3.8% from anti-bisexual bias. 2014 *Hate Crime Statistics*, FED. BUREAU INVESTIGATION, https://ucr.fbi.gov/about-us/cjis/ucr/hate-crime/2014/topic-pages/victims_final (last visited July 25, 2017).

adult LGB persons, 13% reported having objects thrown at them, 23% reported being threatened with violence, and almost half were targets of verbal abuse.¹²⁸ 21% reported violence or a property crime based on sexual minority status.¹²⁹

Sexual minority adults may experience discrimination in public accommodations¹³⁰ and employment,¹³¹ among other settings, while sexual minority youth experience significant harassment in American schools.¹³² A majority of sexual minority students reported feeling unsafe because of sexual orientation.¹³³ Almost three-quarters of these student experienced verbal abuse, one-half experienced online abuse, and over one-third reported physical abuse.¹³⁴ Expected and anticipated discrimination is also present in higher education.¹³⁵

Related to these public opinions, of course, are a host of laws and policies that permit discrimination against sexual minorities, some of which are ongoing and some of which have only recently been overturned. Examples include same-sex marriage bans, the “Don’t Ask Don’t Tell” policy that required gay military members to keep their sexual orientation silent, bans on gay people adopting, bans on transgender people using bathrooms of choice, and adoption agencies that refuse to allow gay people to adopt children. These experiences of

¹²⁸ Herek, *supra* note 41, at 109.

¹²⁹ *Id.*

¹³⁰ See *Masterpiece Cake Shop*, AM. CIV. LIBERTIES UNION, <http://aclu-co.org/court-cases/masterpiece-cakeshop/> (last visited Aug. 21, 2017) (noting that litigation often centers around refusals by cake bakers and others to facilitate same-sex weddings. For just one example of this type of litigation, see *id.*).

¹³¹ *What You Should Know About EEOC and the Enforcement Protections for LGBT Workers*, EQUAL EMP. OPPORTUNITY COMMISSION, https://www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm (last visited Aug. 21, 2017) (summarizing recent cases).

¹³² *The 2013 National School Climate Survey*, GAY LESBIAN & STRAIGHT EDUC. NETWORK (2013), http://www.glsen.org/sites/default/files/2013%20National%20School%20Climate%20Survey%20Full%20Report_0.pdf (studying LGBT youth between the ages of 13–21, and covering a variety of school settings ranging from junior high school to early college).

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ Kelly Strader et al., *An Assessment of the Law School Climate for GLBT Students*, 58 J. LEGAL EDUC. 214 (2008) (discussing LGBT experiences of discrimination in law schools).

widespread social discrimination that sexual minorities face from childhood into adulthood lead to overall poorer health.

While sexual minorities experience significant health disparities, these appear to worsen when sexual minorities live in more stigmatizing environments.¹³⁶ Sexual minorities living in communities with high prejudice against them were at higher risk of mortality than others who lived in less stigmatizing communities.¹³⁷ This experience of stigma contributed to a shorter life expectancy of as much as twelve years in those highly prejudicial communities.¹³⁸ Suicide, violence, and cardiovascular disease were all elevated among sexual minorities in these communities.¹³⁹ The average age of suicide was eighteen years earlier in high stigma areas than in low stigma areas, while death by violence occurred four years younger for people in high stigma areas than low stigma areas.¹⁴⁰ All of these experiences of stigma can create high-stress environments for sexual minorities, contributing to their poorer health.¹⁴¹

In a related study, LGB young adults living in highly discriminatory environments exhibited similar neurological responses to stress as those with post-traumatic stress disorder and severe

¹³⁶ Hatzenbuehler All-Cause Mortality, *supra* note 5, at 33.

¹³⁷ A number of studies examine the effect of these “high prejudice communities” on health. Studies use slightly different methodology to define such communities. The general strategy in defining these communities was to use a combination of measures. Community members were typically polled for anti-sexual minority sentiment using a specifically developed measure. Laws might also be evaluated for whether the community or the state had laws that were anti-sexual minority, for examples laws against gay marriage or laws against allowing transgender people to use the bathroom of their choosing. Taking these measures together, the top quartile exhibiting anti-sexual minority sentiments were then defined as high prejudice, and health status of the sexual minorities in that community was then examined. Again, methods for the different studies varied slightly, so each study should be examined in more detail for specific methods. *See generally* Hatzenbuehler All-Cause Mortality, *supra* note 5; Hatzenbuehler Youth, *supra* note 6, Hatzenbuehler Hypothalamic, *supra* note 7.

¹³⁸ Hatzenbuehler All-Cause Mortality, *supra* note 5, at 33.

¹³⁹ Of high stigma deaths in the research sample, 6.25% were attributed to suicide, 6.25% were due to violence or murder, 25% were attributed to cardiovascular deaths, and 27.45% deaths were cancer-related. The findings were not generalizable, but they did indicate higher rates of mortality across these areas for individuals in high stigma living conditions versus low stigma living conditions. *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

trauma.¹⁴² Other studies show that LGB populations experienced higher rates of preventable illness and poorer outcomes therein, which may be further evidence that stigma and discrimination are at the heart of their health disparities.¹⁴³ LGB health disparities appear to vary over the course of life, being worst during adolescent and early adulthood, which suggests a high exposure to minority stress during that time.¹⁴⁴

B. The Healthcare System as a Gatekeeper to Redress Harms of General Stigma

Our healthcare system is not generally responsible for, nor capable of, eliminating the wider stigmas experienced by sexual minorities. Broader social change and regulation are needed to address

¹⁴² Participants had cortisol levels measured through saliva samples and participated in a highly stressful public speaking event. Like teens exposed to other traumatic events, LGB teens in the study showed lower cortisol levels during the stressful public speaking. Lower cortisol response during times of stress is associated with psychiatric disease and poor physical health, including cardiovascular disease. The researchers view it as a possible clear link between structural discrimination and poor physical health of LGB populations. Hatzembuehler Hypothalamic, *supra* note 7, at 7.

¹⁴³ In a study of 2001 to 2011 morbidity data from the Stockholm Public Health Cohort, there were no differences in rates of illness between sexual minorities and majorities when looking at diseases that are not easily prevented. But with diseases that are easily prevented, sexual minorities were at greater risk of morbidity, suggesting that “unequal distribution of health-protective resources, including knowledge, prestige, power, and supportive social connections” may be at the heart of their health disparities. Richard Branstrom et al., *Sexual Orientation Disparities in Preventable Disease: A Fundamental Cause Perspective*, 106 AM. J. PUB. HEALTH 1109 (2016).

¹⁴⁴ Richard Branstrom et al., *Sexual Orientation Disparities in Physical Health: Age and Gender Effects in a Population-based Study*, 51 SOC. PSYCHIATRY EPIDEMIOL 289 (2016). This study was one of the first to compare health disparities of LGB people across age groups to determine where age affects health disparities in this population. The study of stigma and health disparities in sexual minorities is limited in that it often lumps LGBT people into a single collective, when experiences with stigma and with healthcare providers may vary based on the individual and the sexual minority category they identify with. For example, transgender status may be less familiar to some providers than being gay or lesbian, and it also may be important for many clinical encounters. And some sexual minorities may simply experience greater discrimination due to greater social stigma against that group in current political and social climates. For example, bisexual people appear to experience more stigma than gays and lesbians. Some studies suggest more significant health disparities for bisexual women as a result of such stigma. “[S]tigma faced by bisexual people may lead to them hiding their sexuality, in turn resulting in social isolation and negative mental health outcomes.” Tonje J. Persson et al., *Explaining Mental Health Disparities for Non-Monosexual Women: Abuse History and Risky Sex, or the Burdens of Non-Disclosure?*, 128 SOC. SCI. & MED. 366e (2015).

issues like interpersonal violence, anti-LGBT policies, and problems in our educational and employment systems.

But because one of the resulting harms of stigma is health disparities, our healthcare system can, and must, play a central role in reducing these harms or disparities in health among sexual minorities will only heighten. To reduce the harms of stigma-driven health disparities, healthcare providers can be more attentive to the health effects of stigma and can screen to prevent patient harm, while also advocating for social changes where policies clearly harm the health of sexual minorities.

1. Healthcare Professionals as Frontline Workers that Identify and Prevent Stigma Harms

Many of the health harms caused by stigma are preventable. For example, by knowing that sexual minorities who live in highly discriminatory communities face increased risk of suicide, cardiovascular disease, drug addiction, and other issues, providers can screen for experiences of discrimination and can be more attentive about screening for signs of mental health and substance abuse issues.¹⁴⁵

Training of healthcare providers on the needs of sexual minorities can be improved. While medical students are frequently trained on assessing sexual identity, they are not trained on the “medical and social factors affecting LGBT patients, despite the demonstrated impact of these factors on health outcomes.”¹⁴⁶ Deans of medical schools have reported student dissatisfaction with the amount and degree in which they cover sexual minority status and related health disparities in their medical school curricula.¹⁴⁷

Improved education at undergraduate, graduate, and continuing education levels about not just sexual minority health, but

¹⁴⁵ See *supra* notes 135-142.

¹⁴⁶ Jessie V. Ford et al., *Sexual Health Training and Education in the U.S.*, 128 PUB. HEALTH REP. 96, 96-101 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3562751/>.

¹⁴⁷ In one study only a quarter of medical school deans called their LGBT curriculum good or very good, while the average school had five hours of LGBT-related content in the curriculum. Juno Obedin-Maliver et al., *Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education*, 306 JAMA 971, 974 (2011).

stigma-related disparities, may help providers to ensure that their patients' stigma does not translate into medical harms.¹⁴⁸

2. *Advocating Against Harmful Social Policies*

In addition to preventing the harms associated with stigma, healthcare providers may also play a role in reducing stigma. They can do this by helping to explain to the public how laws and policies translate into health harms and by advocating against policies that are proven to cause stigma and health harms.

For example, many organized medical societies advocated against "Don't Ask Don't Tell" on the basis that it was harmful to the health of sexual minorities.¹⁴⁹ Delegates to the American Medical Association (AMA) argued that the policy compromises the physician-patient relationship and the medical care of sexual minority patients who serve in the military. Because the military can inspect medical records of its members, the policy discouraged patients from disclosing their sexual identity to their physicians, leaving physicians without full and necessary information about their patients.¹⁵⁰

In another example, the American College of Obstetricians and Gynecologists (ACOG) introduced a committee opinion in 2013 in support of marriage equality for same-sex couples on the basis of harms of the policy to health. ACOG argued that "[l]ack of marriage equality has a negative effect on the health and well-being of women in same-sex relationships and their families."¹⁵¹ ACOG observed that a number of other institutions, including the AMA and the American

¹⁴⁸ See Mary Butler et al., *Improving Cultural Competence to Reduce Health Disparities*, COMP. EFFECTIVENESS REV. No. 170 (Mar. 2016) (chronicling efforts on this front).

¹⁴⁹ For example, the AMA put forth resolutions for its organization to lobby against this policy. See *Policy H-65.972, Repeal of "Don't Ask Don't Tell,"* AM. MED. ASS'N (2009), <http://archive.li/iwGYL>.

¹⁵⁰ As one delegate said, the "Don't Ask, Don't Tell" law is "hurting people, it's making doctors lie, it's having patients not get proper care and it's hurting the military." *AMA Meeting: "Don't Ask Don't Tell" Said to Hurt Patient Care; Repeal Urged*, AM. MED. ASS'N NEWS (Nov. 23, 2009), <http://www.amednews.com/article/20091123/profession/311239970/7/>.

¹⁵¹ *Marriage Equality for Same-Sex Couples*, ACOG COMMITTEE ON HEALTHCARE FOR UNDERSERVED WOMEN (Sept. 2013), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Marriage-Equality-for-Same-Sex-Couples> (citing to the health and economic benefits of marriage and to data showing poorer health for sexual minorities in states with marriage bans).

Psychiatric Association, had also supported marriage equality for healthcare reasons.

One obvious area where this may be important in the future is for healthcare providers to educate the public and advocate for the need for expansive health services and insurance regulations to protect sexual minorities' access to the healthcare system. Many professional medical groups came out in support of the ACA, but more work is needed to explain the link between health reform and sexual minorities' health disparities, particularly if and when the ACA and other health reforms are under threat.

III. REMEDYING HEALTHCARE SEXUAL MINORITY STIGMA

In addition to the roles that the healthcare system can play in treating and preventing the health harms of general societal stigma, more attention needs to be paid to how the healthcare system itself perpetuates stigma against sexual minorities. If sexual minorities are skeptical of the healthcare system and its providers, and if they believe that these people too will discriminate against them, then the healthcare system will be of little help in treating wider harms of stigma in health. This section describes possible experiences of stigma that sexual minorities might encounter with two key stakeholders: healthcare providers and health insurers, and legal remedies for this stigma.

It is important to emphasize that this section explores the antidiscrimination law approach to fighting stigmatizing practices in healthcare. In stressing antidiscrimination law, I do not mean to suggest that this is the only approach to tackling discriminatory practices. Many of the actions by healthcare providers and insurers that sexual minorities view as stigmatizing would not rise to a level of implicating antidiscrimination law and would be better approached by educational and other efforts. If healthcare providers and insurers are made more aware of stigma and its harms, they may be more sensitive to these issues and less likely to accidentally or intentionally behave in ways that can be perceived as stigmatizing to sexual minorities. But the legal remedies set a basement for the minimum level appropriate conduct and send a powerful message about how healthcare entities ought to behave.

A. Stigma in the Healthcare Context

This section describes two ways in which sexual minorities may encounter real or perceived stigma in the healthcare arena: at the provider level in how providers treat and interface with sexual minorities and at the insurance level in what benefits are or are not covered for sexual minorities.

1. Patient-Provider Relationships

Stigma within the patient-provider relationship can contribute to health disparities in sexual minorities. Such stigma can sometimes be intentional; for example, healthcare is sometimes overtly denied to patients on the basis of sexual orientation or other protected basis.¹⁵² Overt stigma seems to be particularly problematic in the transgender population.¹⁵³

Stigma against sexual minority patients can also be a result of implicit bias, or a result of a lack of provider knowledge and training about how to treat and interact with sexual minority patients.¹⁵⁴

¹⁵² See IOM 2011, *supra* note 2, at 4.

¹⁵³ Transgender patients in the VA system receive significant protections. “Doctors and staff are responsible for treating patients with respect, addressing and referring to transgender and gender nonconforming patients by their self-identified gender and name, and providing room assignments and access to restrooms based on self-identified genders, “irrespective of appearance and/or surgical history” and “in a manner that respects the privacy needs of transgender and non-transgender patients alike.” See *VHA Directive 2013-003, Providing Health Care for Transgender and Intersex Veterans*, DEP’T VETERAN AFF. (2013), http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2863 [hereinafter *VHA Directive 2013-003*]; See also Aiken, *supra* note 42 (discussing the VA’s efforts to prevent discrimination against transgender patients).

¹⁵⁴ See IOM 2011, *supra* note 2, at 4; see also Kim D. Jaffee et al., *Discrimination and Delayed Health Care Among Transgender Women and Men*, 54 *MED. CARE* 1010, 1111 (2016). A large portion of physicians (ranging from 63–92%) report not having knowledge about the health needs of sexual minority patients. Many physicians (44–63%) also report not being aware of the sexual minority status of patients. R. Dahan et al., *Is Patients’ Sexual Orientation a Blind Spot of Family Physicians?*, 55 *J. HOMOSEX.* 524 (2008); A. Westerstahl et al., *GPs and Lesbian Women in the Consultation: Issues of Awareness and Knowledge*, 20 *SCAND. J. PRIM. HEALTH CARE* 203 (2002). New efforts by CMS to include sexual minority status in electronic medical records may help provider awareness. Electronic medical records that are approved for the meaningful use incentive program must “have the capacity to collect sexual orientation and gender identity (SO/GI) information from patients” for the purpose of . . . identifying interventions and treatments most helpful to the particular patient . . . sexual orientation and gender identity can be relevant to individual treatment decisions; for example, transgender men who were

Furthermore, uncertainty is a central focus with respect to provider discrimination. A line of research suggests that disparities heighten when the physician is no longer objectively certain about a clinical case and instead has to rely on subjective influences.¹⁵⁵ Uncertainty may particularly be a concern in transgender patients. For example, 50% of transgender patients reported having to teach medical providers about their particular medical needs based on their transgender status.¹⁵⁶

IOM in its 2011 report found evidence of enacted stigma against LGBT individual including “refusal of treatment by health care staff, verbal abuse, and disrespectful behavior, as well as many other forms of failure to provide adequate care.”¹⁵⁷ In other studies, 11% of LGB people felt providers were avoiding touching them or using excess precautions in the clinic.¹⁵⁸ In a study of black sexual minority women, over one-third reported a negative experience with a healthcare provider in the last five years.¹⁵⁹ LGBT patients have also faced stigma

assigned female at birth should be offered a cervical exam, as appropriate.” Sean R. Cahill et al., *Inclusion of Sexual Orientation and Gender Identity in Stage 3 Meaningful Use Guidelines: A Huge Step Forward for LGBT Health*, 3 LGBT HEALTH 100 (2016).

¹⁵⁵ “[A]mbiguity as to the diagnostic implications of clinical symptoms, signs and laboratory tests; incomplete information about the efficacy of diagnostic and therapeutic interventions; and unresolved differences of opinion about how to value potential clinical outcomes . . . create wide space for clinical discretion. Subjective influences, including unfavorable stereotypes and attitudes about social groups, shape the exercise of this discretion.” The authors argue that uncertainty and a need for clinician judgment also means a heightened need for patient-doctor communications which can be tempered when a clinician is not comfortable or familiar with a particular group. Uncertainty also means greater trust by patients in doctor’s judgment which can be problematic in groups who are skeptical of medicine. Ana I. Balsa et al., *Clinical Uncertainty and Healthcare Disparities*, 29 AM. J.L. & MED. 203, 204 (2003).

¹⁵⁶ JAMIE M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 6 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

¹⁵⁷ See IOM 2011, *supra* note 2.

¹⁵⁸ LAMBDA LEGAL, *supra* note 10, at 5.

¹⁵⁹ Patients attributed this discrimination to race (70.4%), to gender (58.2%), and to sexual orientation (46.2%). See Li Chien-Ching et al., *Predictors and Consequences of Negative Patient-Provider Interactions Among a Sample of African American Sexual Minority Women*, 2 LGBT HEALTH 140, 140 (2015). In another study, 85% of sexual minority women left a primary care setting with unmet healthcare needs and they were 50% less likely to receive basic screenings, for example pelvic and cervical cancer screenings. See also J. E. Heck et al., *Health Care Access Among Individuals Involved in Same-Sex Relationships*, 96 AM. J. PUB. HEALTH 1111, 1112-1113 (2006).

in the past by not being permitted to have their partners function as surrogates, sometimes even being denied basic access to medical information of their loved ones because they were unable to get married.¹⁶⁰

Transgender patients experience the greatest discrimination in clinics according to most surveys. About one-fifth of transgender patients have experienced denial of services because of their gender identity.¹⁶¹ About 20% of transgender patients reported being spoken to with harsh language in a healthcare setting and 8% reported being handled with physical roughness or abuse.¹⁶² In another study, about 25% of transgender (or gender nonconforming) people reported being denied equal treatment in a doctor's office or hospital.¹⁶³ One in three reported delays in care that were a consequence of discrimination,¹⁶⁴ and over 40% of transgender men have reported "verbal harassment, physical assault, or denial of care in a doctor's office or hospital."¹⁶⁵

Such stigma, or expectation of that stigma, can lead patients to experience anticipatory stigma, fearing more stigma in the future.¹⁶⁶ This can lead them to delay seeking care, or to avoid it altogether.¹⁶⁷ In a study of black sexual minority women who reported negative experiences with healthcare providers, about a third of these patients responded to this event by not seeing a doctor the next time they were sick (or reducing access to healthcare in some other way).¹⁶⁸ Over half of transgender patients in one study (and 9% of LGB) believed they

¹⁶⁰ Efforts by DHHS and President Obama in 2011 sought to redress this issue. A. Nicole Kwapisz, *In Times of Medical Crisis: Inadequacy of Legal Remedies Available to Sexual Minorities*, 14 SCHOLAR 447, 465-467 (2011). *Obergefell* also helps to redress this problem. See generally *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).

¹⁶¹ See Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 AM. J. PUB. HEALTH e31, e32 (2014).

¹⁶² LAMBDA LEGAL, *supra* note 10, at 5-6. A different study puts verbal harassment even higher, with 28% of transgender patients reporting it. Stroumsa, *supra* note 161, at 32.

¹⁶³ See Jaffee et al., *supra* note 154, at 1111.

¹⁶⁴ See *id.*

¹⁶⁵ *Id.*

¹⁶⁶ See Chadoir et al., *supra* note 78, at 2.

¹⁶⁷ IOM 2011, *supra* note 2. Because of the link between health insurance and employment, some patients may also be sensitive to divulging sexual history if they are not "out" at work.

¹⁶⁸ See Li Chien-Ching, *supra* note 159, at 144.

would face discriminatory care and saw it as a barrier to their seeking healthcare.¹⁶⁹ It may also lead individuals to self-stigmatize and believe that harassment and discrimination in healthcare environments is justified and that they are not worthy of respectful healthcare.¹⁷⁰

Patients who feel stigmatized, or worry about stigma, may also be less likely to disclose important clinical information, which may then contribute to poorer health outcomes and greater disparities. A study of gay men in New York found that 39% did not disclose that they had sexual activity with male partners, despite most having been to see a physician recently.¹⁷¹ The rates were worse among African American and Hispanic patients.¹⁷² Disguising sexual status to avoid stigma can be problematic for health. It has been empirically shown to harm mental health, to increase risk of cancer and infectious disease, and to increase rapidity of HIV symptoms.¹⁷³ Though coming out in an unsafe environment can be harmful too, resulting in “decreased well-being (anger, depression, low self-esteem)” and “increased binge drinking, illicit drug use, and depression.”¹⁷⁴

2. Health Insurers Coverage Decisions

Sexual minorities have also frequently encountered a health insurance system that can at times seem intentionally derogatory to them. In some instances, sexual minorities have not enjoyed access to the same types of benefits, despite these benefits being available to others. Often insurance did not cover benefits that were unique to sexual minorities at all.

¹⁶⁹ See LAMBDA LEGAL, *supra* note 10, at 12. In a different survey, one-third of transgender patients delayed preventive care because of fear of discrimination. See also Stroumsa, *supra* note 161, at 32.

¹⁷⁰ See Chaudoir et al., *supra* note 78, at 2–3.

¹⁷¹ See Bernstein et al., *supra* note 9, at 1461.

¹⁷² *Id.* See also Everett et al., *supra* note 27.

¹⁷³ See Larissa A. McGarrity & David M. Huebner, *Is Being Out About Sexual Orientation Uniformly Healthy? The Moderating Role of Socioeconomic Status in a Prospective Study of Gay and Bisexual Men*, 47 ANN. BEHAV. MED. 28, 28–29 (2014).

¹⁷⁴ *Id.*

For example, transgender persons have frequently been denied services that were medically necessary but were not considered necessary based on the individual's assigned sex at birth, gender identity, or gender as denoted in a medical record or insurance document.¹⁷⁵ For example, insurers might not cover ovarian cancer treatment for a person whose insurance documents identify the person as male, despite the fact that the individual requires medical treatment.¹⁷⁶ Sometimes such refusals of care are truly tragic, as in the case of Robert Eads, a transgender man who died after his treatment for cervical cancer was delayed past the point of his being able to recover.¹⁷⁷

It has been a widespread practice for insurers to refuse to cover any type of gender transition procedures, including surgeries or hormonal therapies.¹⁷⁸ Some may argue that such exclusions are more a form of "healthism" by avoiding an individual because they have a costly medical condition, instead of on the basis of sex.¹⁷⁹ Yet, this may also be a form of transgender bias if the result is that transgender patients pay for insurance that pools resources to cover a host of other healthcare services for DSM diagnosable conditions but leaves out that coverage for transgender people.¹⁸⁰ Though certainly not all transgender individuals are interested in transitioning through

¹⁷⁵ See 45 C.F.R. § 92.206 (2016).

¹⁷⁶ Aiken, *supra* note 42, at 4.

¹⁷⁷ See *id.* (noting that Robert Eads was diagnosed with cervical cancer in 1996, but was unable to find treatment for over ten months because providers were uncomfortable with his transgender status and worried treating him would damage their clinics' reputations. Eads died, after finding treatment, because the cancer had spread).

¹⁷⁸ See *id.* ("[M]any health-related insurance plans or other health-related coverage, including Medicaid programs, currently have explicit exclusions of coverage for all care related to gender dysphoria or associated with gender-transition.").

¹⁷⁹ For a discussion of insurers' motivations to avoid high-cost health consumers, see Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (and Isn't) Healthism*, 50 GA. L. REV. 833 (2016).

¹⁸⁰ Sarah E. Gage, *The Transgender Eligibility Gap: How the ACA Fails to Cover Medically Necessary Treatment for Transgender Individuals and How HHS Can Fix It*, 49 NEW ENG. L. REV. 499, 528 (2015) ("The ACA's ability to lower health care costs depends on the individual mandate. Thus, transgender individuals' forced participation subsidizes the cost for others' medically necessary care while being denied insurance coverage for their own medically necessary, gender-confirming care.").

surgery or hormones, for some individuals access to transition options is very important.¹⁸¹

These insurance practices could contribute to enacted stigma for sexual minority patients who experience direct denial of services.¹⁸² It can also lead to anticipated stigma, making individuals expect additional stigma when they interact with health systems in the future.¹⁸³ And it can feed internal stigma, making individuals feel they do not deserve more from the healthcare system.¹⁸⁴

B. The Role of Antidiscrimination Laws in Addressing Health-Related Stigma

Law can combat stigma on a variety of levels. At a structural level, it can prevent or redress acts of discrimination, or it can criminalize violence associated with stigma, for example.¹⁸⁵ Law can explicitly harness “good” stigma, using stigma to maximize public norms in cases where stigmatized behaviors are bad for public health.¹⁸⁶ Likewise, law may serve an expression function of conveying who is in power.¹⁸⁷ At an interpersonal level, law can

¹⁸¹ See, e.g., Dean Spade, *Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates*, 8 SEATTLE J. FOR SOC. POL’Y 497, 499 (2010) (pointing to some research suggesting that lack of insurance coverage for transition was a contributor to increased imprisonment of transgender youth and adults who sometimes have sought out sex work or other illegal activities as a way to pay for hormones).

¹⁸² Chaudoir et al., *supra* note 78, at 77.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 82.

¹⁸⁶ There is some debate about whether stigma can ever be acceptable and harnessed for positive good. For example, some argue that stigmatizing cigarette smoking was a reasonable attempt to improve the public health. Others worry that the severe shame and self-discrimination that is a result of stigma may make it an impermissible “means of social control, even for public-health purposes. Bayer, *supra* note 97.

¹⁸⁷ For example, Scott Burris points to the harnessing of stigma in the Helms amendments, which prohibited the inclusion of homosexual acts from a safe sex brochure as a way of the government indicating that it did not sanction or approve of same sex relationships. Opposition to the Helms Act was, according to Burris, a way of openly disputing such stigma and standing for equality for same sex couples. See Scott Burris, *Stigma and the Law*, 367 LANCET 529, 530 (2006); see also Herek, *supra* note 41, at 919 (discussing how sodomy laws stigmatized sexual minorities until the Court in *Lawrence v. Texas* overturned a Texas anti-

change the way people see each other. Burris proposes expressive theory of law as one way to consider this issue.¹⁸⁸ In the expressive theory, law is a reflection of popular attitude.¹⁸⁹ It sends a message to the public about the underlying value or attitudes of society.¹⁹⁰ Individuals pay attention to these messages and adjust their behavior to gain approval and avoid disapproval.¹⁹¹ With respect to stigma, law can then send messages about what stigma is or is not appropriate, which can then in turn affect people's behavior towards potentially stigmatized groups.¹⁹² For example, law can reject an "us-versus-them" dichotomy.¹⁹³ At an individual level, law can also serve as an instrument to improve individuals' ability to withstand stigma.¹⁹⁴ It can alter the way individuals see themselves and their rights.¹⁹⁵

To a certain extent, though, law is limited in the battle over stigma. Our antidiscrimination laws are heavily fragmented, meaning that only certain individuals are protected and only in certain times and places.¹⁹⁶ Moreover, civil rights laws are often critiqued for not being adequately enforced.¹⁹⁷ With uncertainty of when and if laws will protect them, the stigmatized may be unwilling to out themselves as belonging to a particular group.¹⁹⁸ For some, civil rights focus too much on intentional discrimination, which serves to, in effect, sanction

sodomy law and recognized the liberties of sexual minorities to engage in intimate contact).

¹⁸⁸ Burris, *supra* note 56, at 184.

¹⁸⁹ Richard H. McAdams, *An Attitudinal Theory of Expressive Law*, 79 OR. L. REV. 339, 340 (2000).

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² Burris, *supra* note 56, at 184.

¹⁹³ *Id.*

¹⁹⁴ Burris, *supra* note 187, at 530-31.

¹⁹⁵ *Id.* at 529-30.

¹⁹⁶ Ani B. Satz, *Fragmented Lives: Disability Discrimination and the Role of "Environment-Framing,"* 68 WASH. & LEE L. REV. 187, 191-92 (2011); Burris, *supra* note 187, at 530 ("If a Bible company fires a salesman because he has HIV, that is discrimination under the law. But if customers refuse to deal with him, it is called choice. There is no legal protection against being ostracized by one's family, rejected by one's spouse, shunned by one's neighbours.").

¹⁹⁷ Burris, *supra* note 187, at 530.

¹⁹⁸ *Id.*

all other forms of discrimination or subordination.¹⁹⁹ These laws may not so readily reach implicit bias,²⁰⁰ which plays an important role in perpetuating stigma.²⁰¹ Our antidiscrimination laws tend to conceive of an individual through an overly singular lens. One is injured by being a woman, or a black person, but law has no clear redress for being discriminated on both bases at the same time.²⁰² Lastly, even

¹⁹⁹ For example, “[r]ace,’ ‘disability,’ and ‘HIV-positive’ have all been made into legal categories . . . sometimes for good reasons and sometimes for bad, but always with at least the potential effect of objectifying and validating the notion that the trait is significant under at least some circumstances.” Burris, *supra* note 56, at 183. Particularly, antidiscrimination law’s focus on intent can serve as a barrier to other forms of discrimination, like structural discrimination. Burris points to the continued health disparities of black Americans as an example of the failures of the civil rights movement to reach structural racism, despite its success at tackling and defending against intentional discrimination. *Id.* at 184–85. In reaction to the reality that we may just be trading some forms of discrimination for others, and making discrimination go underground so to speak, some scholars think it’s even more important to focus on resource allocation. Pescosolido et al., *supra* note 75, at 437 (quoting B.F. Reskin, *Including Mechanisms in our Models of Ascriptive Inequality*, 68 AM. SOC. L. REV. 1, 16 (2003) (“[T]he search for understanding and changing attitudes has produced only ‘never-ending and unprofitable debate over the role of unobserved motives.’ . . . [T]he focus needs to shift away from ‘hearts and minds’ to allocation mechanism.”)).

²⁰⁰ See generally Samuel R. Bagenstos, *The Structural Turn and the Limits of Antidiscrimination Law*, 94 CALIF. L. REV. 1 (2006) (discussing the shortcomings of antidiscrimination law with respect to implicit bias and advocating for broad social and not just legal changes to redress it. “Discrimination actuated by implicit bias is not rooted in a set of objectionable values so much as it is built into the structure of how people’s brains make sense of the avalanche of information they must process. If antidiscrimination law is to respond to such bias effectively, the concept of wrongful discrimination must expand to embrace not only the deviant acts of especially immoral people but also the everyday actions of virtually all of us.” Bagenstos advocates for broad social solutions over legal ones to address the harder to reach issue of implicit bias). For more on how antidiscrimination and its predominantly fault based orientation stop short at reaching implicit bias, see Stephen M. Rich, *Against Prejudice*, 80 GEO. WASH. L. REV. 1 (2011).

²⁰¹ Professor Burris explains poignantly how bias operates in stigma: “The power of stigma as a form of social control is that it is decentralized — everyone enforces it — and hidden — it resides in our assumptions about what is real in the world. There is rarely a need for anything so gross as overt, intentional discrimination: stigma can be quite well enforced by those with relative power through the day to day exercise of discretion over matters such as whom to mentor, or stop and frisk — or refer for specialist care.” Scott Burris, *Foreword: Envisioning Health Disparities*, 29 AM. J.L. & MED. 151, 152–53 (2003).

²⁰² For foundational writings on intersectionality, see Kimberly Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 149 (1989).

perfect antidiscrimination laws do “not necessarily change the attitudes that produce the behaviour.”²⁰³

Despite these limitations, if stigma has discriminatory behaviors at its heart, then antidiscrimination law is the natural starting point to provide legal remedies to address this important contributor to health disparities. Particularly, scholars stress the importance of antidiscrimination law as a critical tool in the early movement to reshape a social group’s interests. As discrimination grows more covert, civil rights tools may struggle to reach it. But early on, any tool is important when discrimination is open and active, such as is presently the case with sexual minorities in healthcare.

1. Anti-Stigma Laws Pre-ACA

The civil rights laws enforced by the Department of Health and Human Services’ Office of Civil Rights (DHHS/OCR) serve as an indicator of the relevant laws in the realm of healthcare (or at least the laws that are being enforced).²⁰⁴

The most significant, perhaps, is Title IX, prohibiting sex and gender discrimination in federally-assisted educational programming.²⁰⁵ Title IX has broad reach with respect to discrimination in education including recruitment and admissions of students, financial aid, housing, and sports.²⁰⁶ For purposes of healthcare discrimination, it also reaches student health plans.²⁰⁷ Thus, for example, Title IX could reach a claim that a student health plan discriminated on the basis of gender by failing to adequately cover birth control.²⁰⁸

Beyond Title IX, protections are sparse. Currently, there are sex antidiscrimination laws that attach to the following: training programs

²⁰³ Burris, *supra* note 187, at 529.

²⁰⁴ *Discrimination on the Basis of Sex*, DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html> (last visited Apr. 10, 2017).

²⁰⁵ Title IX of The Education Amendments of 1972, 20 U.S.C. § 1681 (1972).

²⁰⁶ *See id.*

²⁰⁷ *See id.*

²⁰⁸ *See id.*

for healthcare providers,²⁰⁹ homeless transitions programs,²¹⁰ public telecommunications,²¹¹ violence centers,²¹² and home energy programs.²¹³ Most of these do not apply in the context of healthcare. They do not reach provider conduct, or insurer conduct, which as the next sections will suggest, are critical issues with respect to stigma-related health disparities for sexual minorities. The only one of these laws that truly reaches healthcare providers is that which requires nondiscrimination in provider training.²¹⁴ This could indirectly benefit sexual minority patients to the extent that it ensures that sexual minorities become healthcare providers who are presumably more willing and able to treat sexual minority patients.²¹⁵

There are also several block grant programs, meaning that only the program receiving funding has to comply with the nondiscrimination mandates. There are protections against sex/gender discrimination for programs being funded by the Maternal and Child Health Services Block Grant,²¹⁶ the Preventative Health and Health Services Block Grants,²¹⁷ the Community Mental Health

²⁰⁹ Pub. Health Serv. Act §§ 794, 855, 42 U.S.C. §§ 295m, 296g.

²¹⁰ Pub. Health Serv. Act § 533, 42 U.S.C. § 290cc-33.

²¹¹ The Communications Act of 1934, 47 U.S.C. § 398.

²¹² The Family Violence Prevention & Services Act, 42 U.S.C § 10406.

²¹³ The Low-Income Home Energy Assistance Act of 1981, 42 U.S.C. § 8625.

²¹⁴ 42 U.S.C. §§ 295m, 296g.

²¹⁵ See Kenneth DeVille & Loretta M. Kopelman, *Diversity, Trust, and Patient Care: Affirmative Action in Medical Education 25 Years After Bakke*, 28 J. MED. PHILOS. 489, 500 (2003).

²¹⁶ Social Security Act § 508, 42 U.S.C. § 708. This block grant targets infant mortality by providing pre and post-natal care for pregnant women and some preventive services for children like vaccinations. It reaches about 34 million people every year. *Factsheet: Maternal and Child Health*, HEALTH RES. & SERVS. ADMIN., <http://hrsa.gov/ourstories/maternalchild/factsheet.html> (last visited Apr. 25, 2017). Though its focus is somewhat narrow, it could relate to sexual minorities to the extent there is discrimination against eligible participants in pregnancy care.

²¹⁷ Public Health Service Act § 1908, 42 U.S.C. § 300w-7. This block grant provides funds to states to target their greatest public health needs. Examples of programs include tuberculosis reduction in prison programs, programs targeted at preventing skin cancer, or programs to reduce prescription drug abuse. *PHHS Block Grant*, CTR. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/phhsblockgrant/grantehighlights.htm> (last visited Apr. 25, 2017).

Services Block Grant,²¹⁸ and Substance Abuse Prevention and Treatment Block Grants.²¹⁹

Beyond federal laws, other protections are equally inadequate. State public accommodation laws are important in their own right to protect the interests of sexual minorities.²²⁰ But for purposes of health disparities, they prove to be an important forum at the state level to reach insurers and healthcare providers.²²¹ Currently, a majority of

²¹⁸ Community Services Block Grant Act, 42 U.S.C. § 9918. This grant helps to fund improvements for community mental health services, thus ensuring protections against sex discrimination in those forums. *Community Mental Health Services Block Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <http://www.samhsa.gov/grants/block-grants/mhbg> (last visited July 5, 2017).

²¹⁹ Public Health Service Act § 1947, 42 U.S.C. § 300x-57. A related grant program, this helps to fund community efforts to reduce substance abuse and could apply to sexual minorities seeking help through such programs. *Substance Abuse and Mental Health Block Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <http://www.samhsa.gov/grants/block-grants>.

²²⁰ Sari L. Reisner et al., *Legal Protections in Public Accommodations Settings: A Critical Public Health Issue for Transgender and Gender-Nonconforming People*, 93 MILBANK Q. 484, 485 (2015) (surveying Massachusetts transgender individuals and finding that 65% reported discrimination in a public accommodation in 2012. The most prevalent areas of discrimination were transportation (36%), retail (28), restaurants (26%), public events (25%) and healthcare (24%).).

²²¹ State public accommodation laws vary in their reach and in what they define as places of public accommodation. Generally, they prohibit discrimination on the basis of specified protected classes in places that are generally open to the public or may offer services to the public. This may include private facilities, as well as government-owned ones. Some state laws may interpret public accommodation to include the services offered by health insurers or physicians. The failure of federal law to fully and specifically address sexual minority discrimination makes state law all the more important. For an example of the importance of public accommodation law, see Nan D. Hunter, *Accommodating the Public Sphere: Beyond the Market Model*, 85 MINN. L. REV. 1591, 1636 (2001) (describing the critical roles these laws played in the women's rights movement after federal law failed to provide adequate remedy against sex discrimination). *But see* Travis Franklin Chase, "Going To Pieces" Over LGBT Health Disparities: How An Amended Affordable Care Act Could Cure the Discrimination that Ails the LGBT Community, 16 J. HEALTH CARE L. & POL'Y 375, 389 (2013) (arguing that state public accommodation laws do not go far enough to combat healthcare discrimination against sexual minorities because they only prevent intentional discrimination. "[Public accommodation] laws to combat discriminatory attitudes and discriminatory provision of care to the LGBT community may be a start, but cannot unilaterally solve the entire gap in LGBT health care.>").

state public accommodation laws do not ban discrimination on the basis of sexual orientation²²² or gender identity.²²³

Professional society policies might prohibit discrimination, at least by participating healthcare providers. Major organized medical societies like the AMA,²²⁴ American College of Physicians,²²⁵ and ACOG²²⁶ have statements that protect some sexual minorities, but many state medical societies appear to be behind in adopting such protections.²²⁷

²²² Twenty-one states and the District of Columbia currently prohibit discrimination in public accommodations on the basis of sexual orientation. *State Public Accommodation Law*, NAT'L CONF. ST. LEGISLATURES (July 13, 2016), <http://www.ncsl.org/research/civil-and-criminal-justice/state-public-accommodation-laws.aspx>.

²²³ Only eighteen states and the District of Columbia currently forbid discrimination in public accommodation on the basis of gender identity. *Id.* But see Aiken, *supra* note 42, at 16 (arguing that "sex discrimination provisions and public accommodations laws should, by definition, prohibit exclusion of gender incongruent care" despite the fact that most states do not explicitly prohibit on this basis).

²²⁴ *AMA Code of Medical Ethics*, AM. MED. ASS'N, <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf> (last visited Apr. 25, 2017) ("Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care.").

²²⁵ *ACP Ethics Manual Sixth Edition*, AM. COLL. PHYSICIANS, <https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-sixth-edition> (last visited Apr. 25, 2017) ("The denial of appropriate care to a class of patients for any reason is unethical. Importantly, disparities in care as a result of personal characteristics, such as race, have received increased attention and need to be addressed. Physicians should also explore how their own attitudes, knowledge, and beliefs may influence their ability to fulfill these obligations.").

²²⁶ ACOG has special opinions for treating lesbian and bisexual woman and transgender patients and came out in support of gay marriage as an important health issue. *Opinion: Healthcare for Transgender Individuals*, AM. CONG. OBSTETRICIANS & GYNECOLOGISTS (Dec. 2011), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals>; *Opinion: on Healthcare for Lesbians and Bisexual Women*, AM. CONG. OBSTETRICIANS & GYNECOLOGISTS (May 2012), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Lesbians-and-Bisexual-Women>; *Opinion: Marriage Equality*, AM. CONG. OBSTETRICIANS & GYNECOLOGISTS (Sept. 2013), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Marriage-Equality-for-Same-Sex-Couples>.

²²⁷ Elizabeth R. Cayton, *Equal Access to Health Care: Sexual Orientation and State Public Accommodation Antidiscrimination Statutes*, 19 L. & SEXUALITY 193, 197 (2010).

The protections above are minimal when considered in the wider context of healthcare delivery or financing. The block grant protections are significant for those engaging with their local community health centers for drug and alcohol treatment or mental health treatment. States that ban sexual orientation and gender identity discrimination may offer significant protections, and some narrow healthcare environments are treated differently, like student health. However, the sum of these parts does not make up a whole, and significant gaps remained prior to Section 1557 of the ACA. These laws certainly did not afford any type of widespread health-based remedy against healthcare discrimination. And they clearly did not reach most hospitals, most healthcare providers, and health insurers, particularly those operating in the private realm.

2. Section 1557 of the ACA

Prior to Section 1557, there were no widespread protections in healthcare, either private or public, for sex discrimination. Section 1557 thus brings these groups into the fold and offers new and sweeping protections against private and public discrimination in healthcare.²²⁸ It is the first ever civil rights law to specifically extend to healthcare discrimination.²²⁹ And it is also the first law to ever widely address sex and gender discrimination in healthcare.²³⁰

Section 1557 broadly proscribes discrimination “on the basis of race, color, national origin, sex, age, or disability” in healthcare.²³¹ Such individuals may not be “excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination

²²⁸ Watson, *supra* note 14, at 859.

²²⁹ *Id.*

²³⁰ The potential for Section 1557 to redress gender-based discrimination in healthcare is also very significant, but is outside the scope of this paper. For a discussion of the impact of the ACA on gender and healthcare discrimination, see generally Megan Veith, *The Continuing Gender-Health Divide: A Discussion of Free Choice, Gender Discrimination, and Gender Theory as Applied to the Affordable Care Act*, 21 GEO. J. ON POVERTY L. & POL'Y 341 (2014). See also *State of Women's Coverage: Health Plan Violations of the Affordable Care Act*, NAT'L WOMEN'S L. CTR. (2015), <http://www.nwlc.org/sites/default/files/pdfs/stateofcoverage2015final.pdf> (providing a host of areas where gender-based discrimination persists post-ACA and where Section 1557 could provide useful remedies).

²³¹ Patient Protection and Affordable Care Act, 42 U.S.C. § 18116(a) (2012).

under any health program or activity” that receives funding from the federal government.²³² The final rule by DHHS became effective in July of 2016.²³³

Section 1557 applies to any healthcare program or activity²³⁴ receiving federal assistance which it defines as “any grant, loan, credit, subsidy, contract (. . . including a contract of insurance).”²³⁵ Federal financial assistance includes payments from Medicaid, Children’s Health Insurance Program (CHIP), federal premium tax credits (which apply to insurance purchases on the federal and state marketplaces), and some Medicare payments.²³⁶ Most entities receive some form of such funding and thus most healthcare providers and insurers in the US will be covered by Section 1557.²³⁷ Specifically, covered healthcare programs and activities could include hospitals, clinics, physician’s practices, community health centers, nursing facilities, residential treatment centers, insurers and group health plans and entities that provide or administer health insurance or health services.²³⁸ For insurers who are covered by Section 1557, they must comply with Section 1557 not just in their marketplace offerings but all other insurance products they offer including any third party plans they administer (like employment plans).²³⁹ Entities covered by Section 1557 also must not discriminate in their employee health plans.²⁴⁰ For example, an insurer must comply with Section 1557 in its employee

²³² Section 1557 extends several existing civil rights laws: 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 (the Rehabilitation Act which extends to disability discrimination). *Id.*

²³³ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

²³⁴ 42 U.S.C. § 18116 (2017); *see* 45 C.F.R. § 92.4 (2017).

²³⁵ 45 C.F.R. § 92.4 (2017).

²³⁶ DHHS declined to extend Section 1557 to Medicare Part B payments, which could mean that some physicians who accept these payments are excluded. However, DHHS notes that most physicians do not only accept these payments and will be included under Section 1557 because of receiving other funds that are covered. *Id.*

²³⁷ *Id.*

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ 42 U.S.C. § 18116 (2017); *see* 45 C.F.R. § 92.4 (2017).

benefit plan.²⁴¹ State Medicaid programs and CHIP are also covered under this provision.²⁴²

Section 1557 also applies to HHS and other agencies and healthcare programs that they administer.²⁴³ This encompasses Centers for Medicare and Medicaid Services (CMS), IOM, Centers for Disease Control (CDC), and other major health care agencies.²⁴⁴ Lastly, Section 1557 applies to healthcare programs established under Title I of the ACA.²⁴⁵ This includes the federally-facilitated and state-facilitated exchanges, including those who regulate these marketplaces and the plans offered on them.²⁴⁶

DHHS, in its final rule, defined “on the basis of sex” to include but not be limited to “discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.”²⁴⁷ Much of the rule is dedicated to specifically discussing discrimination in the context of transgender patients and insurance, for example a mandate that insurers cover at least some aspect of gender transition and that failure to do so is deemed discrimination on

²⁴¹ 45 C.F.R. § 92.4 (2017).

²⁴² 45 C.F.R. § 92.1 (2017).

²⁴³ 45 C.F.R. § 92.303 (2017).

²⁴⁴ 45 C.F.R. § 92.4 (2017).

²⁴⁵ 45 C.F.R. § 92.1 (2017).

²⁴⁶ *Id.*

²⁴⁷ 45 C.F.R. § 92.4 (2017). Sex stereotypes are defined as “stereotypical notions of masculinity or femininity, including expectation of how individual represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.” Gender identity is defined by the rule makers as an “individual’s internal sense of gender, which may be different from an individual’s sex assigned at birth.” The rule encompasses “transgender status” where a person’s “gender identity is different from the sex assigned to that person at birth.” It also encompasses “gender expression” where a person’s outward expression of their gender “may or may not conform to social stereotypes associated with a particular gender.” Lastly, the definition of gender identity reaches individuals who are non-binary meaning they do not recognize their gender as male or female.

the basis of sex.²⁴⁸ Unsurprisingly, given the major ramifications of this law for sexual minorities, the greater majority of commentators were sexual minority advocates, particularly transgender advocates.²⁴⁹

Despite these fairly broad protections against discrimination on the basis of sex, DHHS stopped short of explicitly prohibiting discrimination on the basis of sexual orientation.²⁵⁰ DHHS supported banning this as a matter of policy, arguing that discrimination on the basis of sexual orientation is harmful to equal access to healthcare and health insurance coverage.²⁵¹ However, DHHS seemed reluctant to extend 1557 to sexual orientation because no federal appellate court has yet to conclude that Title IX clearly reached discrimination on the basis of sexual orientation.²⁵² Instead, they rely on a growing body of case law that nonetheless reaches sexual orientation through the lens of sex stereotyping, including *Price Waterhouse v. Hopkins*, which held that Title VII sex cases encompass sex stereotyping²⁵³ and *Baldwin v. Department of Transportation*,²⁵⁴ which clarifies that sex discrimination

²⁴⁸ 45 C.F.R. § 92.207(b) (3)-(5) (2017).

²⁴⁹ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,376 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

²⁵⁰ See 45 C.F.R. § 92.4 (2017).

²⁵¹ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,389 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

²⁵² *Id.*

²⁵³ *Price Waterhouse v. Hopkins*, 490 U.S. 228, 250-51 (1989) (discussing how a senior manager in an accounting firm sued for discrimination after her bid for partnership at an accounting firm was denied because partners did not believe she acted feminine enough); Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,387 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92). For a broad discussion on conceptualizing stereotyping in employment law, see Kerri L. Stone, *Clarifying Stereotyping*, 59 U. KAN. L. REV. 591, 593-94 (2011) (discussing the conceptualization of stereotyping in employment law). For a discussion of the possibilities of *Waterhouse* for sex stereotyping cases, see Zachary R. Herz, *Price's Progress: Sex Stereotyping and Its Potential for Antidiscrimination Law*, 124 YALE L.J. 396, 402-03 (2014) (discussing the possibilities of *Waterhouse* for sex stereotyping cases). For its implication in sexual minority populations, see Ilona M. Turner, *Sex Stereotyping Per Se: Transgender Employees and Title VII*, 95 CALIF. L. REV. 561, 562-63 (2007) (discussing its implication in sexual minority populations).

²⁵⁴ *Baldwin v. Dept. of Transp.*, E.E.O.C. Appeal No. 0120133080 (2015). The EEOC explained that “[d]iscrimination on the basis of sexual orientation is premised on sex-based preferences, assumptions, expectations, stereotypes, or norms. ‘Sexual orientation’ as a concept cannot be defined or understood without reference to sex. A man is referred to as ‘gay’ if he is physically and/or emotionally attracted to other men. . . . Someone is referred to as ‘heterosexual’ or

protections necessarily must apply to discrimination on the basis of sexual orientation. As such, DHHS argued that OCR will evaluate claims of sexual orientation through the lens of whether they involve claims of sex stereotyping.²⁵⁵ Interestingly, while DHHS was reluctant to discuss sexual orientation as its own independent category for discrimination, based on the fact that Title IX has not done so, it went further than Title IX law with respect to transgender status.²⁵⁶

a. Section 1557 and Patient-Provider Relationships

Prior to the adoption of Section 1557 of the ACA, there were minimal protections to tackle discrimination by healthcare providers. Civil rights laws that attached where federal spending applied were

'straight' if he or she is physically and/or emotionally attracted to someone of the opposite-sex. . . . It follows, then, that sexual orientation is inseparable from and inescapably linked to sex and, therefore, that allegations of sexual orientation discrimination involve sex-based considerations." *Id.* at 6. See also William C. Sung, *Taking the Fight Back to Title VII: A Case for Redefining "Because of Sex" to Include Gender Stereotypes, Sexual Orientation, and Gender Identity*, 84 S. CALIF. L. REV. 487, 493-94 (2011); see also M. Dru Levasseur, *Gender Identity Defines Sex: Updating the Law to Reflect Modern Medical Science is Key to Transgender Rights*, 39 VT. L. REV. 943, 947 (2015) (discussing the importance of including gender identity under sex discrimination).

²⁵⁵ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,390 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

²⁵⁶ Title IX has yet to consider whether gender identity is discrimination on the basis of sex for purposes of Title IX. This issue was to be addressed by the Supreme Court which granted cert to review *Gloucester County* in October of 2016. *G.G. v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709 (4th Cir. 2016), *cert. granted*, 2016 U.S. LEXIS 6408, and *vacated, remanded* 2017 U.S. LEXIS 1626. *Gloucester* is well known as the case in which a transgender high school student is suing his school board who is requiring transgender students to use the bathroom of their sex as assigned at birth rather than based on the gender they identify as. Plaintiff is suing on the basis of equal protection and Title IX. However, the Court vacated and remanded back to the lower courts after the Department of Education and the Department of Justice under the Trump administration, in a "Dear Colleague" letter rescinded Obama-era protections for transgender people under Title IX. *Gloucester County v. G.G.*, SCOTUS BLOG, <http://www.scotusblog.com/case-files/cases/gloucester-county-school-board-v-g-g/> (last visited July 6, 2017). Some Section 1557 claims are at a standstill while waiting to hear whether the Supreme Court holds gender identity as a protected group under Title IX, despite the fact that DHHS has indicated that it should be so for purposes of Section 1557 claims. See *Robinson v. Dignity Health*, No. 16-CV-3035 YGR, 2016 U.S. Dist. LEXIS 168613, at *1, *6 (N.D. Cal. Dec. 6, 2016) ("[A] stay to await the Supreme Court's decision would serve the orderly administration of justice and simplify the issues in the litigation, given the high likelihood that the decision in *Gloucester County* would affect the decision of one or both of Plaintiff's claims.").

typically not interpreted to apply to physicians—leaving plaintiffs with few remedies.²⁵⁷ Plaintiffs were frequently at the mercy of whether their states had adequate protections in place for sexual minorities and how courts would view provider objections that were based on religious objections or conscience.²⁵⁸ Patients also might be reluctant to bring suit for a number of reasons, emphasizing the importance of fair trials in the relatively few cases where they did.²⁵⁹

Section 1557 has the ability to address provider discrimination. For one, Section 1557 requires that “providers of health services may no longer deny or limit services based on an individual’s sex, without a legitimate nondiscriminatory reason.”²⁶⁰ They need not change the services they offer, but for services they do already offer, they must equally provide them to transgender patients, unless they have a nondiscriminatory rationale for refusing.²⁶¹ For example, a

²⁵⁷ Medicare Part B payments were interpreted to not apply to physicians in private offices. “Physicians in private practice have not been subject to federal antidiscrimination statutes regarding race and sex discrimination in their care of patients, and state laws prohibiting such discrimination in physician services, other than in the case of HIV/AIDS, are extraordinarily rare.” Sandra H. Johnson, *The ACA’s Provision on Nondiscrimination Takes Shape*, 46 HASTINGS CTR. REP. 5 (2016).

²⁵⁸ For an example of such a case that involved religious objection and state rights, see *North Coast v. San Diego Cty. Superior Court*, 189 P3d (Cal. Sup. Ct. 2008). In this case, Benitez was part of a lesbian couple seeking IVF from a fertility clinic. The fertility clinic denied services to Benitez because they were devout Christians who objected to providing such services to a same-sex couple. Benitez sued under the California Unruh Civil Rights Act, a state public accommodations law which prohibits discrimination on the basis of sexual orientation. Defendant fertility clinic defended on the basis rights of federal and state religious freedom and free speech. The California State Supreme Court ruled in favor of Benitez. State public accommodation laws governed discriminatory conduct, not free speech or religious beliefs, and the clinic must not behave in a way that its beliefs interfered with the rights of the plaintiff.

²⁵⁹ Mutcherson has studied provider discrimination in the fertility context. She observes that, when faced with discrimination, many patients might not seek legal attention whether because some patients may simply be unaware that they have faced bias, other patients may “shop” around the issue by finding a nondiscriminatory provider, or they might not want the stress and assault on privacy that litigation entails. For these reasons, she emphasizes that “cases that do appear in court are given a fair hearing.” Kimberly M. Mutcherson, *Disabling Dreams of Parenthood: The Fertility Industry, Anti-Discrimination and Parents with Disabilities*, 27 LAW & INEQUALITY 317 (2009).

²⁶⁰ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 96, 31, 455 (proposed May 18, 2016) (to be codified at 42 C.F.R. pt. 92); 45 C.F.R. §92.206.

²⁶¹ *Id.*

gynecological surgeon who “previously declined to provide a medically necessary hysterectomy for a transgender man would have to revise its policy to provide the procedure for transgender individuals in the same manner it provides the procedure for other individuals.”²⁶² Several cases have allowed plaintiffs to state a claim under Section 1557 to date where they allege denial of services on the basis of protected class or changed or lesser services.²⁶³ The state lawsuit challenging Section 1557 argues that this violates provider medical judgment and forces physicians to engage in practices that violate their exercise of conscience.²⁶⁴

Section 1557 may go beyond provider denial of services, to provider harassment, which forms an important part of the stigma that many patients face in healthcare.²⁶⁵ Although Section 1557 does not provide a separate provision regarding patient harassment, DHHS considers the law to currently address it fully based on past interpretations of Title IX and other civil rights laws.²⁶⁶ DHHS views Section 1557 as prohibiting “all forms of unlawful harassments based on a protected characteristic.”²⁶⁷ For sex discrimination, the harassment is unlawful if “harassing conduct creates a hostile environment . . . sufficiently serious [so as to] interfere with or limit an individual’s ability to participate in or benefit from a program.”²⁶⁸ DHHS provides examples of what it views as unlawful harassment: “a

²⁶² *Id.*

²⁶³ For example, see *Tovar v. Essential Health*, 2016 WL 2745816 (D. Minn. 2016) (arguing that plaintiffs did not state a sufficient claim, and comparing with cases that did). See *Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 841-42 (D.S.C.2015) (plaintiff stated ACA claim where CVS denied him the right to have his prescriptions filled at CVS pharmacies because of his race and disability). Finally, *Tovar* does not allege that HealthPartners gave her a different plan or fewer benefits *because* she had a transgender child, which would clearly be discrimination under the ACA. See *Pa. Transp. Auth. v. Gilead Scis., Inc.*, 102 F.Supp.3d 688, 700 (E.D.Pa. 2015) (suggesting what facts might sufficiently allege discrimination under the ACA).

²⁶⁴ *Franciscan Alliance v. Burwell*, No. 7:16-cv-00108-O, 2016 WL 7638311, at *2 (N.D. Tex. Dec. 31, 2016).

²⁶⁵ See *supra* footnotes 155-73.

²⁶⁶ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 96, 31,405-06. (proposed May 18, 2016) (to be codified at 42 C.F.R. pt. 92); 45 C.F.R. §92.206.

²⁶⁷ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 96, at 31,406.

²⁶⁸ *Id.*

provider's persistent and intentional refusal to use a transgender individual's preferred name and pronoun," or a provider using derogative language towards an unmarried person engaging in sexual activity.²⁶⁹

The story of Jakob Rumble and his current litigation against providers for discriminating on the basis of his gender identity is startling anecdotal evidence of the types of behaviors that sexual minorities may face in some healthcare settings and how Section 1557 can apply.²⁷⁰ Rumble is a male transgender patient who saw his primary care doctor complaining of pain in his reproductive organs.²⁷¹ When antibiotics did not improve his pain, he went to the emergency room.²⁷² There, Rumble claims to have experienced harassing treatment from a variety of emergency room and admitted hospital staff that he believes was a result of his transgender status.²⁷³ Among many claims, Rumble says he was wrongfully given a hospital bracelet indicating he was "female," was asked aggressively about his sexual history by a physician, and was subjected to rough physical handling of his genital.²⁷⁴ The district court looked at the totality of the circumstances in determining whether Rumble successfully alleged a claim of discrimination on the basis of sex.²⁷⁵ The court ultimately concluded that Rumble had successfully stated a claim of sex discrimination because "it is plausible that Dr. Steinman mistreated Plaintiff *because* of Rumble's gender identity, and the mistreatment was not 'random poor treatment that anyone might have received.'" ²⁷⁶

²⁶⁹ *Id.*

²⁷⁰ See *Rumble v. Fairview Health Serv.*, No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415 (D. Minn. Mar. 16, 2015).

²⁷¹ Rumble complained of pain in his uterus, vagina, cervix, and labia, and found urinating extremely painful and difficult. *Id.* at *2.

²⁷² *Id.* at *3.

²⁷³ *Id.* at *3, *7.

²⁷⁴ *Id.* at *3-4.

²⁷⁵ Particularly, the Court looked at "(1) the alleged questions that Dr. Steinman asked and the comments he made about Rumble's hormone use, (2) Dr. Steinman's alleged tone during questioning, (3) the alleged "assaultive behavior" Dr. Steinman subjected Rumble to during the physical exam, and (4) the medical bill Rumble received after his hospital visit" (which specifically discussed how the diagnosis was inconsistent with patient's gender). *Id.* at *18.

²⁷⁶ *Rumble v. Fairview Health Serv.*, No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415, *18 (D.

Medicare Conditions of Participation (MCOPs) can likewise play a significant role at the interpersonal level to bolster Section 1557. Centers for Medicare and Medicaid (CMS) has recently put forward proposed changes to the MCOPs to improve protections for sexual minorities against discrimination.²⁷⁷ All providers who participate in Medicare do so with the agreement that they will comply with the MCOPs.²⁷⁸ The proposed MCOP clearly states that all Medicare providers must comply with Section 1557 of the ACA and DHHS's regulations.²⁷⁹ In the MCOP, stigma is explicitly recognized as a major motivator for modifying the rules to explicitly address sex discrimination.²⁸⁰ CMS emphasized findings from the IOM 2011 study on LGBT health that ongoing acts of discrimination persist, noting that "[t]here are many examples of manifestations of enacted stigma against LGBT individuals by health care providers."²⁸¹ CMS emphasizes that patients can experience discrimination that impacts access to care, but likewise that fear of such discrimination can be equally harmful.²⁸² CMS emphasized written policies in hospitals to

Minn. Mar. 16, 2015).

²⁷⁷ Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care, 81 Fed. Reg. 39,448, 39,450 (proposed June 16, 2016) (to be codified at 42 C.F.R. pt. 482) [hereinafter MCOP Rule].

²⁷⁸ 42 C.F.R. § 489.10. Specifically, the MCOPs apply to hospitals that accept Medicare funds, but MCOPs do not apply to the specific physicians providing this care (though hospitals might enforce such provisions on doctors through bylaws and employment contracts).

²⁷⁹ MCOP Rule, *supra* note 277, at 39,450.

²⁸⁰ "We have been made aware that the historic lack of an explicit prohibition within the CoPs, and, in particular, the lack of civil rights protections regarding hospital patients' gender identities, is regarded as having been a barrier to seeking care by individuals who fear such discrimination. Discriminatory behavior, or even the fear of discriminatory behavior, by healthcare providers remains an issue and can create barriers to care and result in adverse outcomes for patients There are many examples of manifestations of enacted stigma against LGBT individuals by health care providers Because discriminatory behavior can affect perceived and actual access to and effectiveness of healthcare delivery, we propose to establish explicit requirements that a hospital not discriminate on the basis of race, color, national origin, sex (including gender identity), age, or disability and that the hospital establish and implement a written policy prohibiting discrimination on the basis of race, color, national origin, sex (including gender identity), age, or disability." *Id.*

²⁸¹ *Id.*

²⁸² *Id.*

implement these antidiscrimination mandates.²⁸³ They explicitly include gender identity in their definition of sex discrimination, and they go beyond DHHS/OCR by also including sexual orientation as an explicit category of protected people.²⁸⁴ By requiring hospitals to address sex discrimination through policies and explicitly banning sex discrimination in Medicare participating hospitals (including discrimination on the basis of gender identity and sexual orientation), the law will be a further mandate for providers to ensure that they engage in fair treatment of sexual minorities both free of harassment and in terms of availability of services.

b. Section 1557 and Health Insurers

Section 1557 explicitly bans sex discrimination by insurers.²⁸⁵ Section 92.206 of the final rule requires “equal access to . . . health programs or activities without discrimination on the basis of sex.”²⁸⁶ Insurers covered by Section 1557 are forbidden from denying, canceling, limiting, or refusing to issue a health plan for a discriminatory reason.²⁸⁷ They are also forbidden from imposing additional cost-sharing or creating benefit designs that discriminate, or marketing in a discriminatory manner.²⁸⁸

Regarding transgender care, insurers are no longer permitted to “deny or limit health services that are ordinarily or exclusively

²⁸³ This is an important development given the findings of a survey which found that, in a poll of 640 hospitals, only 257 policies addressed both sexual orientation and gender identity specifically. Tari Hanneman, *HEI 2014: Healthcare Equality Index*, HUM. RTS. CAMPAIGN 12, http://assets.hrc.org/files/assets/resources/HEI_2014_high_interactive.pdf (last visited Apr. 25, 2017).

²⁸⁴ “In addition, we believe that discrimination by a hospital based on a patient’s . . . sexual orientation can potentially lead to a denial of services or inadequate care . . . which is detrimental to the patient’s health and safety. We are therefore . . . proposing to establish explicit requirements that a hospital not discrimination on the basis of . . . sexual orientation As noted, substantial academic research demonstrates that discrimination on the basis of sexual orientation is inconsistent with the health and safety of patients” MCOP Rule, *supra* note 277, at 39,451. CMS also explicitly banned discrimination based on a patient’s religion, which is an added distinction from Section 1557.

²⁸⁵ 45 C.F.R. §§ 92.206–92.207.

²⁸⁶ 45 C.F.R. § 92.206.

²⁸⁷ 45 C.F.R. § 92.207.

²⁸⁸ *Id.*

available to individuals of one sex . . . based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available."²⁸⁹ Thus, insurers must now ensure that individuals receive medically necessary care regardless of whether that care fits into a clinical binary.²⁹⁰

Insurers are forbidden from "hav[ing] or implement[ing] a categorical cover exclusion or limitation for all health services related to gender transition."²⁹¹ DHHS supports this requirement because it views *systematic denial* of all services for a single condition, gender dysphoria, as "unlawful on its face."²⁹² Insurers are also not allowed to deny or limit coverage, or have additional cost-sharing for gender transition if it results in discrimination against transgender people.²⁹³ Here, OCR is tasked with evaluating the coverage of that service for other non-transgender people to determine whether the denial is legitimate or is a "pretext for discrimination."²⁹⁴ For example, when an insurer denies coverage for an individual where the patient's doctor says the treatment is necessary to treat gender dysphoria, OCR will examine whether the covered treatment is available to other patients in other circumstances.²⁹⁵

²⁸⁹ 45 C.F.R. § 92.207.

²⁹⁰ *See id.*

²⁹¹ *Id.*

²⁹² Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 96, 31, 429 (proposed May 18, 2016) (to be codified at 42 C.F.R. pt. 92). Notably, this was the only example in all of Section 1557 in which DHHS explicitly mandated that coverage denial was per se discriminatory and that some aspect of clinical care must be covered. This is interesting and important given that there are other types of health services frequently excluded from health insurance that DHHS did not mandate be covered, for example infertility treatments, even though one could make a case that failure to cover those was discrimination on the basis of disability.

²⁹³ 45 C.F.R. § 92.207.

²⁹⁴ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 96, 31, 429 (proposed May 18, 2016) (to be codified at 42 C.F.R. pt. 92).

²⁹⁵ *Id.* This requirement is very similar to comparability requirements in Medicaid, but it expands this notion to private insurance. For an example of how this type of requirement plays out in the context of transgender care, see *Cruz v. Zucker*, 2016 WL 3660763 (S.D.N.Y. Nov. 14, 2016) in which the Court held that the state Medicaid agency violated Medicaid law when it refused to cover certain cosmetic surgeries for transgender patients that it did for

Note that these provisions do not, however, affirmatively require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude a covered entity from applying neutral standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner.²⁹⁶ Importantly, additional protections against sex discrimination also allow transgender people to sue on that basis, as opposed to on the basis of disability, given that there is some controversy over whether transgender people wish to secure more rights by emphasizing gender dysmorphia as a mental health issue.²⁹⁷

These adjustments to insurance laws by Section 1557 remove clear structural barriers to healthcare for sexual minorities. They allow more individuals to be able to afford access to necessary medical care, like cancer screening and treatment, that were inappropriately denied to them in the past. They reduce economic harms, by preventing these individuals from having to pay out of pocket for healthcare that others may receive through insurance, like infertility coverage or therapies to treat gender dysphoria.

These changes to insurance also hold a more symbolic value with respect to structural barriers. As Deborah Stone emphasizes, our choices in who gets covered by insurance and what gets covered are not coincidental.²⁹⁸ They reflect a willingness on the part of society to shoulder the burdens of that individual, that their misfortune is not just on them, but something that society as a collective is willing to shoulder with them.²⁹⁹ This goes to the heart of the us versus them dichotomy on stigma.³⁰⁰ If insurance covers gender transitions, it is suggesting, at a public policy level, that these individuals are deserving of the same access and the same types of treatments as others, that they have as much of a right to the public coffers of

others. The surgeries in question included breast reconstruction, electrolysis, and others.

²⁹⁶ See 45 C.F.R. § 92.207.

²⁹⁷ See Aiken, *supra* note 42, at 6–7.

²⁹⁸ Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL'Y & L. 287, 287 (1993).

²⁹⁹ *Id.*

³⁰⁰ Link & Phelan, *supra* note 61, at 528.

insurance as everyone else.³⁰¹ In contrast, a failure to cover such services suggests that they are not worthy of collective, social support.³⁰² Moreover, Section 1557 serves an expressive function, sending a message to society at large that stigma against this group is no longer going to be overlooked.

IV. MAINTAINING A FOCUS ON FIGHTING STIGMA-ASSOCIATED HEALTH DISPARITIES

The healthcare system is a central actor in the effort to reduce the health disparities associated with stigma. It can both prevent and treat the health harms that occur because of wider social stigma, and it can help to ensure that healthcare is a safe and non-stigmatizing place for sexual minorities to seek help for the medical issues caused or made worse by stigma.

At the time of writing this Article, several events emphasize the importance of this issue and threaten to worsen the health disparities of sexual minorities. Section 1557 and the wider ACA are both at risk. A major aim of Donald Trump's campaign platform was to repeal and replace the ACA.³⁰³ Both of these efforts could be harmful for sexual minority health.

A. Access to Affordable and Adequate Health Insurance

Because stigma makes sexual minorities sicker as a population, access to the healthcare system is imperative to redress harms of stigma. Yet, pre-ACA, sexual minorities were less likely to have health insurance.³⁰⁴ This may be in part due to the fact that, up until

³⁰¹ See Stone, *supra* note 298, at 289.

³⁰² See *id.* at 291.

³⁰³ Chris Donovan & Adam Kelsey, *Fact-checking Trump's 'Repeal and Replace' Obamacare Timeline*, ABC NEWS (Mar. 24, 2017, 8:07 PM), <http://abcnews.go.com/Politics/fact-checking-trumps-repeal-replace-obamacare-timeline/story?id=46360908>.

³⁰⁴ Transgender individuals are less likely to have health insurance than heterosexual or LGB individuals. See Healthy People, *supra* note 3, at 2. For example, 19% of transgender patients reported being uninsured at a time when 15% of the general population was. Stroumsa, *supra* note 161, at 32. See also Courtwright, *supra* note 72, at 90 (describing health insurance as a health disparities issue).

legalization of gay marriage by *Obergefell v. Hodges* in 2015, same-sex couples were not able to cover their partners under employer-sponsored health plans. Employer-sponsored healthcare accounts for about half of all health insurance, and without it, same sex couples who did not qualify for Medicaid or Medicare were forced to pay for costly individual insurance or go uninsured.³⁰⁵ High rates of uninsured in sexual minorities may also be attributed to a lesser likelihood of sexual minorities having the full-time, higher paying jobs that provide employer sponsored insurance in the first place.³⁰⁶

The Affordable Care Act overhauled the private insurance industry. Particularly, it focused on eliminating health-status based discrimination by insurers. Under the ACA, insurers are no longer permitted to exclude people with preexisting conditions from coverage³⁰⁷ or to vary premiums based on gender, race, disease-status, and a host of other factors.³⁰⁸ Insurers also have to be more standardized in the benefits they cover, removing the ability of insurers to reduce certain benefits in a way that discourages enrollment by people with high health needs.³⁰⁹ Sexual minorities benefited from these changes like everyone else, perhaps more so. More individuals on the lower income spectrum were eligible for Medicaid, and just like everyone else, sexual minorities could no longer be charged more or excluded from coverage when they were sick.³¹⁰

³⁰⁵ The first relevant case to extend protections for same sex couples with employer health insurance was *United States v. Windsor*. See *United States v. Windsor*, 133 S. Ct. 2675 (2013). After that case, employers were required to extend employer health insurance to same-sex partners in states that recognized marriage equality. With *Obergefell v. Hodges*, employers in all states must now extend these benefits to same sex couples. See *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015). See Angela K. Parone, *Health Implications of the Supreme Court's Obergefell vs. Hodges Marriage Equality Decision*, 2 LGBT HEALTH 196, 197 (2015) (explaining the law only applies to fully-insured employer sponsored health plans, and self-insured plans are exempt from the requirement).

³⁰⁶ One study reports that transgender people experience significant amounts of bias and job loss in the workplace, which they also attribute to lower rates of employer-sponsored insurance in this population. Stroumsa, *supra* note 161.

³⁰⁷ Patient Protection and Affordable Care Act, §§ 2702–2705, 42 U.S.C. § 18001 et seq. (2010).

³⁰⁸ Patient Protection and Affordable Care Act, § 2701, 42 U.S.C. § 18001 et seq. (2010).

³⁰⁹ Patient Protection and Affordable Care Act § 1302(b)(1), 42 U.S.C. § 18022 (2012).

³¹⁰ Gage, *supra* note 180 (“[T]he expansion of state-administered Medicaid paired with ACA’s

Yet the ACA, public health insurance programs, and even the idea of government regulation of health insurers are coming under threat. In the coming years, it will be important to consider the effects of health reform on sexual minorities and their health disparities. Efforts to repeal or replace the ACA, specifically, or to reduce government regulation of healthcare generally will have harmful effects for sexual minorities both (1) in terms of impeding their access to healthcare and (2) reducing coverage for the benefits they particularly need.

First, maintaining a healthcare system that offers expansive access to lower income people is imperative for sexual minorities who, as a class, more frequently live in lower income homes and have less education and thus may rely heavily on government programs or subsidization of private insurance.

Second, a roll-back on consumer protections in health insurance will differentially harm sexual minorities. The healthcare conditions in which sexual minorities experience greater health disparities (mental health conditions, sexually transmitted diseases) are precisely the same conditions that insurers discriminated against pre-ACA. In one experiment conducted by Kaiser Family Foundation prior to the adoption of the ACA, insurers in the individual insurance market were asked for quotes on a woman with "situational depression."³¹¹ Insurers rejected coverage altogether in 23% of cases, half of the insurers who decided to cover her excluded depression from coverage, and about half of the insurers imposed an increased premium.³¹² A second hypothetical client with HIV was rejected by all insurers for a total of sixty denials.³¹³

individual mandate means that many transgender individuals will have medical insurance for the first time.").

³¹¹ Karen Pollitz et al., *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?*, KAISER FAM. FOUND., June 2001, at 15, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf>.

³¹² *Id.*

³¹³ *Id.*

Efforts by the ACA³¹⁴ and the Mental Health Parity Act³¹⁵ to assure adequate coverage for mental health services and HIV (and other sexual health services) are critical to combatting health disparities in sexual minorities. Regulatory roll-backs of consumer protections will be lethal for this group.

B. Section 1557: Losing a Very New, Very Meaningful Right

Section 1557 is one of the most promising tools to combat health effects of sex stigma as the first ever health-specific civil right and the first civil right to clearly reach sex-based discrimination in that context. Not only does it incentivize entities to make changes to protect sexual minorities, but for sexual minorities, the law can have great meaning with respect to individual identity. It serves to clarify for individuals that discrimination on the basis of their sex is not appropriate in healthcare and that they have clear rights in this arena.

While President Trump may not repeal Section 1557 specifically, other aspects of a repeal could have a ripple effect on the enforcement of the law. First, the law's reach depends on federal spending in healthcare. Section 1557 only applies to entities that are receiving federal healthcare dollars, healthcare agencies, and entities regulated by the ACA.³¹⁶ One of the novelties of the law was that it finally reached private health insurers and some physicians because the private industry now widely accepted federal money through enrollee's paying premiums and cost-sharing via subsidies and credits.³¹⁷ A repeal and replacement of the ACA may mean the repeal of those subsidies and, in turn, a dwindling of the reach of Section 1557.³¹⁸ This may prove fatal for sexual minorities' rights, given that they have little protection currently beyond Section 1557.

³¹⁴ The ACA mandates coverage of mental health and addiction services as part of its ten essential health benefits. *See* Patient Protection and Affordable Care Act § 1302(b)(1). It also bans preexisting condition discrimination. *Id.*

³¹⁵ Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343.

³¹⁶ Department of Health and Human Services, Nondiscrimination in Health Programs and Activities, 45 C.F.R. §92.1 (2016).

³¹⁷ Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 BOST. J.L. & SOC. JUST. 235 (2016).

³¹⁸ With loss of subsidies and credits, many private insurers and providers may no longer satisfy

Section 1557 is also facing threat in the courts. Recently, a court has nationally enjoined Section 1557's enforcement with respect to protections on the basis of gender identity, thus making many of the transgender protections discussed in prior sections, at least for now, moot.³¹⁹ States and providers claim that the transition mandate interferes with medical judgment and with providers' and other institutions' religious freedoms.³²⁰ States also object that the mandate to cover some form of gender transition will be too costly for state budgets.³²¹ The case serves as a reminder that broadened protections for sex discrimination face frequent challenge from religious groups under religious freedom claims.³²² Section 1557 does not have its own religious exemption, but other religious exemption laws apply.³²³

Even more, Section 1557 as a statute itself is fairly hollow, and the meaning is more in the rules crafted by DHHS only last year. DHHS, under the new presidency, has signaled an interest in overhauling the regulations set forth during the Obama

the definition of being in receipt of federal financial assistance. *See id.* (citing Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (2012)).

³¹⁹ *Franciscan Alliance, Inc. vs. Burwell*, 2016 WL 7638311 (holding that "the regulation violates the Administrative Procedure Act (APA) by contradicting existing law and exceeding statutory authority, and the regulation likely violates the Religious Freedom Restoration Act (RFRA) as applied to Private Plaintiffs.").

³²⁰ *Id.*

³²¹ Several states (Texas, Wisconsin, Nebraska, Kentucky, and Kansas) have brought this suit in a jurisdiction that appears friendly to claims against broadened transgender rights. Timothy Jost, *Plaintiffs Say ACA Equity Rules Illegally Require Abortion, Gender Transition Services*, HEALTH AFF. BLOG (Aug. 24, 2016), <http://healthaffairs.org/blog/2016/08/24/plaintiffs-say-aca-equity-rules-illegally-require-abortion-gender-transition-services/>.

³²² For more on religious freedom challenges and Section 1557, see Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L.J. 2470 (2015). For a discussion of how religious freedom cases interact with sexual minorities, see Aglae Eufrazio, *Venturing into a Minefield: Potential Effects of the Hobby Lobby Decision on the LGBT Community*, 18 ST. MARY'S L. REV. & SOC. JUST. 107 (2016). *See also* Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516 (2015) (discussing complicity based conscientious objections in healthcare).

³²³ 45 C.F.R. § 92.2 ("[I]nsofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required").

administration. DOJ specifically requested that the litigation regarding Section 1557 be stayed while DHHS considers the regulation.³²⁴

Without Section 1557 or something like it, ridding healthcare of stigma against sexual minorities will be challenging if not impossible. An erosion of Section 1557 at any level should not go unnoticed. Though the protections are new, they are powerful, and they were overdue.

But if Section 1557 were to be repealed, or altered, or simply unenforced, we may need to turn to other forums to argue on behalf of these rights for sexual minorities in healthcare. As the last section suggests, Section 1557 is by no means the only approach. Healthcare entities and providers can chip away at the harms of stigma in a variety of ways: they can educate themselves, they can educate the public, and they can advocate for reforms that end harmful social practices.

And other legal approaches may need to be more fully considered for their merits and their reach. For example, more consideration could go into the role of employment law and Title IX to tackle stigma-related health disparities.³²⁵

State public accommodation laws are one forum where there is much room to grow since many currently do not have sufficient protections on their books for sex discrimination. More research may be useful in the barriers to implementing such laws and solutions, given that some state legislators and governors may be highly combative to expanding the rights of sexual minorities.³²⁶ Public accommodation laws could potentially reach harmful discrimination by both health insurers and providers.

Another forum to consider that can help to bolster the potential absence of strong federal law is medical professional societies. Medical professional societies can be more aggressive in creating and enforcing

³²⁴ Jost, *supra* note 321.

³²⁵ Baldwin v. Dept. of Transp., E.E.O.C. Appeal No. 0120133080 (2015); G.G. v. Gloucester Cnty. Sch. Bd., 822 F.3d 709 (4th Cir. 2016), *cert. granted*, 2016 U.S. LEXIS 6408, and *vacated, remanded* 2017 U.S. LEXIS 1626.

³²⁶ Indeed, a number of states have been going in the opposite direction, advocating for anti-LGBT laws. For examples of these laws and how they affect health care discrimination in the LGBT population, see Fenway Inst., *What the New Affordable Care Act Nondiscrimination Rule Means for Providers and LGBT Patients*, FENWAY HEALTH, <http://fenwayhealth.org/wp-content/uploads/ACA-1557-Non-Discrimination-LGBTs-Brief-v2.pdf>.

sex antidiscrimination policies against their member physicians, through recognizing the long line of scientific literature on stigma and its impact on patients. This could address provider behavior and, to some degree, the individual's experiences of stigma to the extent individuals are aware of such professional codes and see them as a signal that they, as individuals, have rights and deserve protections in the patient-provider encounter.

CONCLUSION

Sexual minorities, like other minority groups, suffer from significant and unmet health disparities. Stigma is at the heart of these health disparities. Any effort to redress these disparities must take into account and reduce stigma.

Broader legal remedies must seek to address the larger issue of stigma against sexual minorities in employment, education, and other settings. But, because stigma leads to healthcare problems, our healthcare system can play a critical role, as well. Healthcare entities can be more aware of the health effects of stigma and the many ways that providers can screen for and prevent resulting harms of stigma. Healthcare providers can also help to educate the public on why stigmatizing social practices are expensive and are harmful for patient health, public health, and our healthcare system as a whole.

But healthcare can also do its part by making sure that stigma is not perpetuated within the healthcare system. Provider and insurer discrimination can directly harm sexual minorities and can make them lose trust in a healthcare system that they must rely on if they are to prevent and treat their stigma-related health disparities.

The Affordable Care Act has done much to help sexual minorities gain access to affordable and adequate health benefits. Additionally, Section 1557 of the ACA, as the first health-specific civil right, and the first to reach sex discrimination in healthcare, can be a powerful tool in the battle over healthcare stigma. Both may be under threat in ways that could prove harmful to sexual minority health, and more exploration is needed into the best and most viable approaches to eliminating the harms of stigma-driven disparities in the future.