

1-1-2013

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Travis F. Chance

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Recommended Citation

Travis F. Chance, *"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 (2013).
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“GOING TO PIECES” OVER LGBT HEALTH DISPARITIES: HOW AN AMENDED AFFORDABLE CARE ACT COULD CURE THE DISCRIMINATION THAT AILS THE LGBT COMMUNITY*

TRAVIS FRANKLIN CHANCE**

Minority groups, especially those defined along racial and ethnic lines, frequently suffer from health care disparities that non-minority populations do not.¹ In addition to racial and ethnic disparities in health care, disparities are also evident in the lesbian, gay, bisexual and transgender (LGBT) community.² The LGBT community has higher-than-average rates of uninsured persons and experiences barriers to high quality care that non-LGBT persons do not, such as being denied health services outright based upon their LGBT status and, in some cases, physical altercations with discriminatory health care providers.³ The primary cause of these gaps in access to quality medical services is the social stigma associated with a

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* These phrases are in reference to a scene from *THE BIRDCAGE* (United Artists 1996) in which one of the main characters, Armand, is trying to encourage his life partner Albert, to be less hysterical when minor issues arise by telling him that the important thing to remember is “not to go to pieces,” but to act nonchalantly.

** JD Candidate 2014, University of Maryland Carey School of Law (Baltimore, MD). BS Biochemistry, Georgia Institute of Technology (Atlanta, GA). I would like to thank all members of the editorial board of the *Journal of Health Care Law & Policy* who were involved in refining this comment and my family, for showing me that all people deserve to be treated with respect and dignity.

1. Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 *PUB. HEALTH REP.* 293, 294 (2003).

2. See, e.g., U.S. DEPT. OF HEALTH & HUMAN SERVS., *Fact Sheet—The Affordable Care Act and LGBT Americans*, HEALTHCARE.GOV (last updated Feb. 17, 2012), <http://www.healthcare.gov/news/factsheets/2011/01/new-options-for-lgbt-americans.html> (stating that evidence shows disproportionately low rates of insurance in the LGBT community).

3. LAMBDA LEGAL, *WHEN HEALTH CARE ISN’T CARING: LAMBDA LEGAL’S SURVEY OF DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE WITH HIV 5–6* (2010), available at <http://www.lambdalegal.org/health-care-report> [hereinafter *Lambda Legal Study*] (describing unique barriers to LGBT health care, such as past experiences of harsh treatment, discrimination, and bias).

patient's LGBT status, which in turn causes LGBT Americans to delay seeking health care when needed or to avoid it altogether.⁴

There is little doubt that the Patient Protection and Affordable Care Act (the ACA) is one of the most significant pieces of legislation in recent decades, and both opponents and proponents agree that its breadth is sweeping.⁵ Both sides of the political firestorm surrounding the ACA likewise cannot dispute with any force that the United States' health care system was in dire need of reforms and regulatory changes—as of 2010, 45,000 Americans died annually without health insurance and two million cancer patients annually declined health care out of an inability to meet skyrocketing treatment costs.⁶ These gaps in coverage are exacerbated when aspects such as race or other minority status are considered.⁷

Two of the major purposes behind the enactment of the ACA are to increase access to and improve the quality of health care for all Americans.⁸ This paper argues that because the ACA's reformatory focus is on increasing access to care,⁹ which will likely work to remedy some of the discrimination that results in the LGBT community's disparate access to care,¹⁰ it fails to comprehensively combat broader LGBT health care discrimination because it will do nothing to remedy the stigma that results in lower quality care.¹¹ As a result, the ACA fails to address the specific needs of the LGBT community and will not, as it stands, close the gap in any meaningfully significant way between LGBT health care and that of non-LGBT persons.¹² Policy suggestions aimed at eliminating the disparate health status of LGBT Americans intensify this concern because they, like the ACA, focus on

4. See, e.g., *id.* at 9–11 (describing unique barriers to LGBT health care, such as disrespectful attitudes, discriminatory treatment, inflexible or prejudicial policies, and refusals of essential care due to social stigma associated with the patient's status as LGBT, affecting the quality of care received).

5. See David M. Herszenhorn & Robert Pear, *Final Votes in Congress Cap Battle Over Health*, N.Y. TIMES, Mar. 26, 2010, at A17 (quoting Senate Majority Leader Harry Reid's assertion that the legislation will affect health care, jobs, economic recovery, the federal deficit, and expansion of antidiscrimination provisions); MICHAEL D. TANNER, CATO INST., *BAD MEDICINE: A GUIDE TO THE REAL COSTS & CONSEQUENCES OF THE NEW HEALTH CARE LAW 1* (2011), available at <http://www.cato.org/pubs/ftp/papers/BadMedicineWP.pdf> (indicating that the sheer size of the legislation itself—2,500 pages and 500,000 words—is indicative of its impact).

6. JOHN GEYMAN, *HIJACKED: THE ROAD TO SINGLE PAYER 205* (2010).

7. U.S. CENSUS BUREAU, *INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009 23* (2010), available at <http://www.census.gov/prod/2010pubs/p60-238.pdf>.

8. GEYMAN, *supra* note 6, at 2.

9. See *infra* Part III.D. For example, the individual mandate is a primary regulatory pillar upon which the ACA rests and is aimed at increasing the national insurance coverage rate by encouraging uninsured Americans to purchase health insurance or pay a tax. See 26 U.S.C. § 5000A (2011). Another key provision of the ACA is the expansion of Medicaid eligibility, which will further increase access to health care. See 42 U.S.C. § 1396d(y)(1) (2011).

10. See *infra* Part II.A.

11. See *infra* Part III.D.

12. See *infra* Part III.D.

ensuring equal access to care between LGBT and non-LGBT individuals, rather than the broader effects of discriminatory attitudes and behaviors.¹³

This comment argues that without shifting the policy and regulatory focus towards the significant improvement of the *quality* of care for LGBT Americans, efforts to increase *access* to health care in that community will prove to be futile.¹⁴ Part I will provide a substantial overview of the current status of LGBT health in the context of access to and quality of health care services, framing those issues through the lens of discriminatory attitudes and behaviors. Part II will review current policy suggestions for remediation of the LGBT community's disparate health care status, explaining why those suggestions are unworkable and concludes that cultural competency training is an effective solution to combat discrimination in LGBT health care. Part III provides a brief history of American health reform, a summary of the ACA's goals and methodology, and describes the relationship between the ACA and the specific health care needs of the LGBT community. Part IV will then provide a practical proposal as to how the ACA can be amended to provide cultural competency training to health care providers, resulting in a reduction in discriminatory attitudes and a meaningful change in the health of LGBT Americans. Part IV will also explain why the ACA is a better choice for such reform than other avenues.

I. DISCRIMINATION: THE ROOT OF ALL LGBT HEALTH CARE EVILS

The LGBT community experiences substandard access to health care, as well as substandard provision of health care services, as compared to non-LGBT individuals.¹⁵ American society still engages in persistent bias and hostility towards homosexuality and transgenderism, despite increasing acceptance in recent times.¹⁶ The medical community is not insulated from these pervasive social stigmas. Health care providers' discriminatory policies and practices are the genesis of LGBT health disparities.¹⁷ For example, Lambda Legal, a public interest group dedicated to advocating for LGBT rights, conducted a recent survey in which it found that fifty-six percent of lesbian, gay, and bisexual (LGB) respondents, seventy percent of transgender respondents, and sixty-three percent of HIV-positive

13. See *infra* Part II.A–C.

14. See *infra* Part III.D.

15. Emily Kane-Lee & Carey Roth Bayer, *Meeting the Needs of LGBT Patients and Families*, NURSING MGMT., Feb. 2012, at 43, 43–44.

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

17. See COMM. ON LESBIAN, GAY, BISEXUAL & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, INST. OF MED., *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 14, 211–13 (2011), available at <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx> (providing a detailed account of societal stigma attached to the LGBT community); see also Dean et al., *supra* note 16, at 103 (stating that in addition to society at large, medical providers themselves also engage in discriminatory practices against LGBT persons that impact receipt of medical services).

respondents had experienced discriminatory practices, including refusal of needed services, refusals to touch the patient, use of excessive precautions, harsh language from providers, being blamed for health problems, or physical abuse in their health care.¹⁸ This differential treatment, as compared to non-LGBT persons, results from strongly held societal views on gender roles and bias towards minority sexual orientations and identities that then manifest in providers' discriminatory behaviors and practices.¹⁹

Disparities in health care, as well as in life experiences, for LGBT persons are widespread. For example, the LGBT community sees higher incidences of particular disorders and diseases, suicidal ideation, violence, obesity, substance abuse, and discrimination.²⁰ Laws also rarely protect the LGBT community from discriminatory practices and policies.²¹ For example, the health insurance industry frequently discriminates against LGBT persons and many are also excluded from qualifying for certain Social Security and Medicare benefits based on their sexual orientation or gender identity.²² Providers' discriminatory practices and policies affect two primary facets of health care delivery in the context of LGBT persons: access to and quality of health care services.²³ After discussing the broader

18. See Lambda Legal Study, *supra* note 3, at 5.

19. *Id.* at 12; see also Dean et al., *supra* note 16, at 103 (framing the health disparities in the LGBT population as primarily a function of social stigma).

20. See Dean et al., *supra* note 16, at 111, 113–16, 118, 120–23, 127, 129–30. Lesbians, for example, are at a higher risk for contracting breast cancer, while gay men see higher incidences of the tumor Kaposi's sarcoma related to disproportionate rates of HIV infection. *Id.* at 111.

21. See *id.* at 104 (describing how LGBT persons are frequently excluded from public entitlement programs based on that status).

22. *Id.* The issue of exclusion from federal social programs arose from Section 3 of the Defense of Marriage Act ("DOMA"), which defined "marriage," for all federal purposes, including the provision of benefits, as the union of one man and one woman and "spouse" as a person of the opposite sex to whom one is married. 1 U.S.C. § 7 (2011), *invalidated by* U.S. v. Windsor, 570 U.S. ____ (2013). Section 3 of DOMA was declared unconstitutional as a violation of the Fifth Amendment's due process and equal protection guarantees by the Supreme Court on June 26, 2013. U.S. v. Windsor, 570 U.S. ____ (2013). However, the decision was "confined to those lawful marriages" under state law. *Id.* Currently, only twelve other states and the District of Columbia provide for lawful same-sex marriages, leaving the overwhelming majority of states with some form of prohibition of lawful same-sex marriages, either in the form of a statute or a constitutional amendment. See *id.* Because the federal government's social programs may now only recognize valid, lawful same-sex marriages as defined by each of the fifty states, only those gay couples living in one of the thirteen jurisdictions recognizing same-sex marriages will have increased access to health services that those programs provide. Moreover, the remaining provisions of DOMA are still in full force and effect, including Section 2, which allows states to refuse to recognize a validly performed same-sex marriage from another jurisdiction. See 28 U.S.C. 1738C (2011). Thus, although it was an immeasurably important advancement toward achieving full equality for LGBT persons, it is not entirely clear that the invalidation of Section 3 of DOMA will result in an immediate, positive change in the health status of the LGBT community.

23. See Dean et al., *supra* note 16, at 106–08 (discussing the bias present in health insurance and government programs that prevent many LGBT persons from accessing affordable health treatments and how physicians' adherence to social stigma associated with LGBT persons can cause them to provide substandard care, in turn affecting health outcomes); see also Lambda Legal Study, *supra* note 3 and

instances and implications of discrimination against the LGBT community as a whole, its effect on LGBT persons' access to and quality of health services will be discussed.

A. Discrimination Against the LGBT: Specific Examples and Its Impact on LGBT Health Care

The discrimination facing LGBT individuals typically permeates almost every facet of their lives.²⁴ One major area in which LGBT persons experience outright discrimination is in the context of employment.²⁵ This discrimination can manifest in many different ways, including exclusion from employee benefit programs, verbal and physical harassment, negative performance evaluations, and termination of employment based upon LGBT status.²⁶

The effects of discrimination against LGBT individuals are unfortunately not reserved to adulthood, but rather begin at an early age.²⁷ Approximately sixty-one percent of the student respondents, aged thirteen to twenty, of a 2011 study conducted by the Gay, Lesbian and Straight Education Network stated that they heard the derogatory use of "gay" frequently, while roughly forty-four percent of respondents heard other homophobic remarks by other students (such as "fag" or "dyke") used frequently in schools.²⁸ Sixty percent of the student respondents to this same study felt unsafe at school because of their sexual orientation.²⁹ This is for good reason, as eighty percent of respondents reported experiencing verbal assaults because of their LGBT status, while forty percent reported being physically assaulted.³⁰ School officials often choose not to intervene when they hear such language, intensifying the plight of LGBT youth.³¹ The impacts of such blatant homophobia and transphobia on our nation's LGBT youth are serious, and

accompanying text (describing providers' uniquely discriminatory treatment of LGBT persons during provision of care).

24. Lambda Legal Study, *supra* note 3, at 12 (discussing the effects of negative societal and provider biases against LGBT individuals on LGBT health care).

25. Jennifer C. Pizer et al., *Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People: The Need for Federal Legislation Prohibiting Discrimination and Providing for Equal Employment Benefits*, 45 LOY. L.A. L. REV. 715, 720–21 (2012).

26. *Id.* at 725.

27. See generally GAY, LESBIAN & STRAIGHT EDUC. NETWORK, THE 2011 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH IN OUR NATION'S SCHOOLS (2012), available at http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/002/2105-1.pdf [hereinafter GLSEN Study] (describing the unique LGBT-discriminatory and homophobic experiences of our nation's youth).

28. *Id.* at xiv, 14.

29. *Id.* at 19.

30. *Id.* at 23.

31. See *id.* at 17 (finding that school administrations never intervened in such instances 42.5% of the time).

include missing multiple days of school, lower grades, self-destructive behaviors and, in the worst of cases, suicide.³²

In addition to the situation of LGBT youth, the current state of the LGBT elderly plainly illustrates the essentially life-long discriminatory and homophobic/transphobic treatment the LGBT community experiences.³³ Most of the current LGBT elderly grew up at the forefront of the modern LGBT rights movement as a whole and personally experienced many of the adverse repercussions of the movement itself.³⁴ Additionally, many modern day practices and policies disproportionately discriminate against elderly LGBT.³⁵ Most of the federal social programs are distinctly heteronormative and do not extend benefits to many same-sex elderly couples.³⁶ Additionally, there are few legislative protections against discrimination in elderly housing on the basis of LGBT status.³⁷ These modern experiences, coupled with the long history of homophobia and transphobia to which LGBT elders have been subjected, underscore the extent of the stigma LGBT persons experience. The persistence of homophobia and transphobia in our society serves as the vehicle through which the health care industry exhibits both direct and indirect discrimination towards LGBT patients, affecting LGBT persons' access to health care and quality of received services.³⁸

B. The Effects of Discrimination on LGBT Access to Health Care

Accessing health care as a member of the LGBT community comes with numerous unique obstacles.³⁹ Members of the LGBT community are more likely to be uninsured than the non-LGBT, and these low insurance rates are a primary barrier to care.⁴⁰ The disproportionate rate of insurance in the LGBT community compared to non-LGBT persons is mainly due to employers' discriminatory

32. *Id.* at 21, 39; *see also* CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT: SEXUAL IDENTITY, SEX OF SEXUAL CONTACTS, AND HEALTH-RISK BEHAVIORS AMONG STUDENTS IN GRADES 9–12—YOUTH RISK BEHAVIOR SURVEILLANCE, SELECTED SITES, UNITED STATES, 2001–2009 14 (2011), *available at* <http://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf> (finding that LGB youth are four times more likely than non-LGB peers to attempt suicide).

33. *See* Nancy J. Knauer, *LGBT Elder Law: Toward Equity in Aging*, 32 HARV. J. L. & GENDER 1, 49–50 (2009) (describing the unique experiences of the current elderly LGBT in growing up and forming their sexual identity as part of the Stonewall generation).

34. *Id.*

35. *See id.* at 45–49 (describing the effects of government LGBT discrimination against LGBT elderly, including financial insecurity, property rights, Social Security, and Medicare/Medicaid benefits).

36. *Id.* at 47–49; *see also supra* text accompanying note 22.

37. *See* Knauer, *supra* note 33, at 51 (arguing that amendment of the Fair Housing Act is needed to protect LGBT elders from discrimination in terms of housing).

38. *See infra* Part I.B–C (detailing LGBT persons' experiences of discriminatory treatment in accessing and receiving health care services).

39. *See* Dean et al., *supra* note 16, at 106 (discussing provider opinions, treatment relationship communication barriers and financial issues as examples of barriers to care).

40. Pizer et al., *supra* note 25, at 766.

policies against those individuals.⁴¹ Employers are the largest sources of insurance coverage in the United States—eighty percent of non-elderly persons are insured through their employer or that of a family member.⁴² Few of these employers, however, extend benefits to non-married partners of their employees and LGB persons are excluded from a huge potential source of insurance as a result.⁴³ Transgender persons are also virtually excluded from accessing employer-sponsored health plans because those plans rarely cover transgender-specific medical needs, such as transitioning hormones and operations, or because insurers unilaterally refuse to issue coverage based on gender identity.⁴⁴ There are currently no federal laws prohibiting employment discrimination on the basis of sexual orientation or gender identity, much less any prohibition of discriminating in the provision of employee benefits, which lessens the ability of LGBT persons to access employer-sponsored health care.⁴⁵

Another barrier to LGBT person's access to health care is provider bias against those in the community.⁴⁶ Providers' discriminatory behaviors mainly result from subscription to stereotypes and social biases and can take many forms, such as refusing outright to care for a LGB person; the likelihood of being refused care more than triples for transgender patients.⁴⁷ In a recent survey by Lambda Legal, almost eight percent of LGB respondents and almost twenty-seven percent of transgender respondents said they were denied medical care outright based on their actual or perceived orientation or identity.⁴⁸ This same study found that nineteen percent of respondents that were HIV positive had been refused medical treatment based on that status alone.⁴⁹ Higher gynecological cancer mortality rates in lesbians versus heterosexual women aptly illustrate the effects of providers' LGBT bias, which causes lesbians to habitually avoid seeking preventive care and screenings to avoid discriminatory attitudes and behaviors and results in poorer gynecological cancer prognoses.⁵⁰

41. See Dean et al., *supra* note 16, at 106 (describing employers' denial of the benefits extended to heterosexual married couples to unmarried partners of employees in same-sex relationships).

42. Pizer et al., *supra* note 25, at 765–66.

43. *Id.* at 766.

44. *Health Insurance Discrimination for Transgender People*, HUMAN RIGHTS CAMPAIGN, www.hrc.org/resources/entry/health-insurance-discrimination-for-transgender-people (last visited June 5, 2013).

45. Pizer et al., *supra* note 25, at 742 (describing the legal landscape regarding sexual orientation discrimination as “incomplete at the federal level” in proposing the Employment Non-Discrimination Act as a remedy).

46. See Lambda Legal Study, *supra* note 3, at 8 (characterizing providers' discriminatory behaviors towards LGBT patients as barriers to care).

47. *Id.* at 10.

48. *Id.*

49. *Id.*

50. Paula R. DeCola, *Gender Effects on Health and Healthcare*, in *HANDBOOK OF CLINICAL GENDER MEDICINE* 10, 13 (Karin Schenck-Gustafsson et al. eds., 2012).

Elderly LGBT persons also face unique obstacles in accessing certain health care services that their non-LGBT and even non-elderly LGBT counterparts do not.⁵¹ This concern is important, as there were an estimated three million LGBT Americans over the age of sixty-five as of 2006.⁵² Financial concerns for elderly persons are common, but intensify for many LGBT elderly because of the Defense of Marriage Act (DOMA) and because many states have a constitutional or statutory prohibition on same-sex marriages.⁵³ Moreover, many same-sex elderly couples do not get Social Security survivors' benefits, costing these couples \$124 million annually.⁵⁴

Elderly LGBT persons are also subject to unique disparate treatment under government health care programs.⁵⁵ Elderly persons typically need varying forms of long-term care (e.g. in-home care or nursing home facilities), the cost of which Medicare does not cover.⁵⁶ Medicaid can fill in the coverage gap if seniors fall below the income and asset limits of the program.⁵⁷ To meet these limits, most seniors will spend or transfer assets, but a regulation allows exclusion of the value of a jointly owned marital home when determining qualification for Medicaid.⁵⁸ Because the federal government may only recognize valid same-sex marriages under state law, non-married same-sex elderly couples or those couples that marry in states prohibiting such unions must still transfer or sell their marital home in order to obtain essential long-term medical care, which is simply not an option for many couples.⁵⁹ LGBT elders further suffer from decreased access to nursing home facilities due to a fear of bias, harsh treatment, and discrimination, resulting in anxiety over whether such facilities will allow same-sex partners or married couples to share rooms.⁶⁰

51. See Knauer, *supra* note 33, at 47–49 (asserting that LGBT elders do not qualify for Social Security survivors' benefits, which are a primary source of income for seniors, due to DOMA, and that it is more difficult for LGBT elders to meet the income eligibility limits for Medicaid because their relationships are typically not recognized as a "marriage"); see also *supra* text accompanying note 22 (describing how the impact of the Supreme Court's decision to invalidate Section 3 of DOMA is likely to be limited because the decision was confined to lawfully performed same-sex marriages within one of only thirteen current jurisdictions that allow them).

52. Knauer, *supra* note 33, at 8.

53. *Id.* at 47; see also *supra* text accompanying notes 22, 51.

54. Knauer, *supra* note 33, at 47; see also *supra* text accompanying note 51.

55. See *supra* text accompanying note 51.

56. Knauer, *supra* note 33, at 48.

57. *Id.*

58. *Id.*

59. *Id.* at 48–49; see also *supra* text accompanying note 22.

60. Knauer, *supra* note 33, at 54–56.

C. The Effects of Discrimination on the Quality of LGBT Health Care

1. Direct or Intentional Provider Discrimination Against LGBT Patients

Too many same-sex couples share a story similar to that of Lisa Pond and Janice Langbehn, a committed lesbian couple from Washington State.⁶¹ While on vacation in Florida with their children, Lisa collapsed and was taken to a local hospital.⁶² Hospital officials refused to provide Janice with any information on Lisa's condition or to take any medical history from her.⁶³ Janice was continually denied access to her partner, even after presenting a valid power of attorney and advance directive.⁶⁴ Lisa's condition deteriorated over the next eight hours and Janice and their children were unable to access Lisa's room until Lisa's sister arrived.⁶⁵ By the time her partner and children were able to be by her side, Lisa was unconscious and could not communicate with those closest to her; she died a few hours later.⁶⁶ Being able to see loved ones who are hospitalized is a common human desire,⁶⁷ causing President Obama to issue an Executive Memorandum directing the Department of Health & Human Services (HHS) to promulgate rules requiring all providers receiving Medicare and Medicaid funding to extend visitation rights to same-sex couples.⁶⁸

61. Shawna S. Baker, *Where Conscience Meets Desire: Refusal of Health Care Providers to Honor Health Care Proxies for Sexual Minorities*, 31 WOMEN'S RTS. L. REP. 1, 7 (2009).

62. *Id.* at 8.

63. *Id.*

64. *Id.* at 8–9. An advance directive is a legal document that allows an unrelated person to act as a patient's health care "proxy" and to make substantive medical decisions on the patient's behalf. *Id.* at 21–22.

65. *Id.* at 9.

66. *Id.*

67. See Medicare and Medicaid Programs: Changes to the Hospital and Critical Access Hospital Conditions of Participation To Ensure Visitation Rights for All Patients, 75 Fed. Reg. 70,831, 70,833 (Nov. 19, 2010) (codified at 42 C.F.R. §§ 482 and 485) (explaining that most of the comments received in support of the Department of Health & Human Services' proposed rule requiring providers receiving Medicare and Medicaid funding to allow same-sex couples visitation rights recognized the harm caused by keeping loved ones apart and the better health outcomes experienced by patients when they have access to loved ones).

68. President's Memorandum for Secretary of Health and Human Services, Respecting the Rights of Hospital Patients to Receive Visitors and to Designate Surrogate Decision Makers for Medical Emergencies, 75 Fed. Reg. 20,511 (Apr. 20, 2011); see also 42 C.F.R. §§ 482.13(h), 485.635(f) (2011) (codifying the implementation of the policy changes by HHS). While this was certainly an important step towards protecting the rights of LGBT hospital patients, the degree of success of such an order is really a function of the political ideology of the Presidency itself. See Jamie McGonnigal, *Romney May End Hospital Visitation Rights for Many Gay Couples*, HUFFINGTON POST (Oct. 22, 2012), http://www.huffingtonpost.com/jamie-mcgonnigal/romney-may-end-hospital-visitation-rights-for-many-gay-couples_b_1996964.html (citing Mitt Romney's campaign advisor as saying that Romney would leave it to states to decide whether to grant same-sex couples hospital visitation rights, showing that such executive policies are subject to change with any given president).

The plight of Lisa and Janice is indicative of the primary cause of LGBT health disparities in the quality of services received: discrimination.⁶⁹ This discriminatory treatment in health care is premised on American society's own broader homophobia and transphobia and takes many forms, including provider bias, lack of federal protections based upon sexual orientation and gender identity, and discriminatory facility practices and policies.⁷⁰ The root of most of these issues is the persistent, hostile stigma society attaches to the LGBT community.⁷¹ There is no shield to stop this stigma at the door of a doctor's office or hospital and many times it pervades the treatment relationship between a provider and his or her LGBT patients.⁷² For example, in the National Gay and Lesbian Task Force's survey of approximately 7,000 transgender respondents, twenty-eight percent experienced verbal assaults and two percent experienced physical assaults in medical care facilities.⁷³ In another survey of approximately 5,000 LGBT respondents, fifty-six percent had experienced some form of outright discrimination in health care, including complete denials of care based on LGBT status, verbal abuse, physical abuse, refusals to touch the patient, and being blamed for their own medical conditions.⁷⁴

The result of such outright discrimination on the health status of those in the LGBT community has been more than detrimental.⁷⁵ Members of the LGBT community typically feel like outcasts in larger society due to the extensive discrimination they experience during critical stages of their development, discrimination that continues into adulthood in various forms.⁷⁶ As a result of societal discrimination and the direct discrimination they may have experienced in the receipt of health care, LGBT individuals are much less likely to seek preventative care than their non-LGBT counterparts out of fear of further outright

69. See generally Lambda Legal Study, *supra* note 3 (focusing on discriminatory attitudes in its discussion of survey results that describe the quality of LGBT patient care).

70. See Dean, *supra* note 16, at 103 (describing how providers subscribe to social views and stigmas attached to the LGBT community); see also Lambda Legal Study, *supra* note 3, at 6–7 (concluding that medical facilities should encourage the development of inclusive policies and procedures to protect LGBT patients and that the federal government should implement policies aimed at ending discriminatory provision of health insurance and medical care to LGBT individuals as well as promulgate broad antidiscrimination provisions based upon sexual orientation and gender identity).

71. Lambda Legal Study, *supra* note 3, at 12.

72. *Id.* at 5–6 (documenting the extensive experiences of discriminatory behavior LGBT patients go through at the hands of providers).

73. JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 72 (2011), available at http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf.

74. Lambda Legal Study, *supra* note 3, at 10.

75. See Becky McKay, *Lesbian, Gay, Bisexual, and Transgender Health Issues, Disparities and Information Resources*, 30 MED. REFS. SERVS. Q. 393, 394–95 (2011) (finding that discrimination and prejudice against LGBT persons is linked to higher rates of mental disorders, suicide and sexually transmitted diseases).

76. DeCola, *supra* note 50, at 13.

discrimination or worse, violence.⁷⁷ This in turn causes higher incidences and worse prognoses of certain diseases, whose outcomes are correlated with early detection and screening, such as ovarian and anal cancers.⁷⁸ Distrust of the medical community is even more common for elderly LGBT persons, who have been exposed more frequently and extensively to societal stigma and discrimination than their non-elderly cohorts.⁷⁹ Simply increasing access to care for LGBT persons cannot cure such disparities because those individuals will continue to put off care they perceive as hostile or discriminatory, even if available at a reduced or no cost.⁸⁰

2. Unintentional Provider Discrimination Against LGBT Patients

In addition to outright hostile treatment, LGBT individuals face another barrier to receiving high quality health care: providers' unintentional discrimination.⁸¹ Many health care professionals who consider themselves to be LGBT friendly unknowingly deliver less than adequate care to these patients.⁸² This is primarily because these providers simply do not receive the appropriate training needed to care for the specialized needs of LGBT patients.⁸³ Just as with any other racial or social minority group, the LGBT community has its own cultural identity.⁸⁴ This identity is more complex than those of most other discrete minority groups because members of the LGBT community can also be members of other minority groups and the lines between the cultural identities of each tend to blur.⁸⁵

It is precisely the complexity of the LGBT identity itself, coupled with a lack of provider understanding, that contributes to unintentional provider discrimination.⁸⁶ For example, risks of HIV infection are higher for the gay male

77. *Id.* at 13–14.

78. *Id.* at 12–14.

79. *See supra* note 33 and accompanying text; *see also* GAY & LESBIAN MED. ASS'N, HEALTHY PEOPLE 2010: COMPANION DOCUMENT FOR LGBT HEALTH 18–19 (2010) (classifying LGBT elders as a unique subgroup of LGBT culture due to their past historical experiences of discriminatory treatment).

80. *See* DeCola, *supra* note 50, at 11–12 (intimating that the reason gays and lesbians have been observed to have poor health maintenance habits is a result of avoiding care they expect will be discriminatory).

81. Dean et al., *supra* note 16, at 107–08 (finding that even those providers that are “sympathetic” to LGBT patients have acknowledged that they are typically not aware of the specialized health issues and service needs of that population).

82. *Id.* *See also* DeCola, *supra* note 50, at 11–12.

83. *See generally* Harvey J. Makadon, *Ending LGBT Invisibility in Health Care: The First Step in Ensuring Equitable Care*, 78 CLEV. CLINIC J. MED. 220, 221 (2011) (discussing the special health care needs of the LGBT community that providers should understand and their failure to consistently do so).

84. *See* GAY & LESBIAN MED. ASS'N, *supra* note 79, at 14, 17.

85. *Id.* at 16.

86. *Id.* at 24.

population than their straight counterparts⁸⁷ and lesbians tend to be at higher risk for gynecological cancers than heterosexual women.⁸⁸ Knowing that a given patient is more prone to certain diseases due to his or her sexual orientation is a critical component of providing the quality of care that a particular patient needs, but providers that do not approach the situation appropriately can cause the patient to feel uncomfortable revealing details as personal as one's sexual orientation.⁸⁹ Similarly, providers that are unaware of a transgender patient's gender identity can use incorrect pronouns that contribute to the patient's perception of discriminatory treatment and prevent that patient's full disclosure of all information relevant to obtaining comprehensive, high quality care.⁹⁰ LGBT patients' past experiences of discrimination, caused by the stigma directed at the LGBT community as a whole, reinforce this unintentionally substandard provision of care and can result in worse health outcomes.⁹¹

II. COMBATING ALL FORMS OF DISCRIMINATION IN LGBT HEALTH CARE: THE INADEQUACY OF CURRENT POLICY SUGGESTIONS AND CULTURAL COMPETENCY EDUCATION AS THE REMEDY

The medical field, as well as the federal government, has recognized the disparate health status of LGBT versus non-LGBT persons.⁹² What is less clear is what exactly should be done to close this gap.⁹³ Although the federal government acknowledges that health disparities do in fact exist in the LGBT community,⁹⁴

87. Royal Gee, *Primary Care Health Issues Among Men Who Have Sex with Men*, 18 J. AM. ACAD. NURSE PRACTITIONERS 144, 147 (2005).

88. DeCola, *supra* note 50.

89. See Makadon, *supra* note 83, at 220–21 (discussing the importance of a clinician's approach to collecting medical histories from LGBT patients to ensure comfort in disclosure of that status, allowing for more comprehensive care).

90. Nikki Burrill & Valita Fredland, *The Forgotten Patient: A Health Provider's Guide to Providing Comprehensive Care for Transgender Patients*, 9 IND. HEALTH L. REV. 69, 100–01 (2012).

91. See DeCola, *supra* note 50, at 11–12 (attributing LGBT underutilization of medical treatment to broader social stigma); see also Dean et al., *supra* note 16, at 108 (describing LGBT patients' feelings of discomfort with the thought of defending themselves against negative experiences, whether intentionally or unintentionally caused by providers, because of their past experiences of discrimination based on their LGBT status, resulting in inaccurate diagnoses and ineffective courses of treatment).

92. McKay, *supra* note 75, at 394–95; see also Makadon, *supra* note 83, at 220; U.S. DEP'T HEALTH & HUMAN SERVS., *Lesbian, Gay, Bisexual and Transgender Health*, HEALTHYPEOPLE.GOV (last updated Apr. 10, 2013), <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25>.

93. See *infra* Part II.A–C (spelling out a diverse set of policy suggestions aimed at improving LGBT health disparities).

94. See U.S. DEP'T HEALTH & HUMAN SERVS., *supra* note 92. The Department of Health and Human Services states that “LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights,” but seems to qualify this by citing a “need for more research to document, understand, and address the environmental factors” that may contribute to observed disparities. *Id.* It is unclear if the federal government is poised to implement policy changes to combat LGBT health disparities or would prefer to first engage in more research to determine the “root”

policy suggestions are varied. Proposed solutions include calls for utilization of the ACA's health exchanges,⁹⁵ using state public accommodations statutes as a vehicle to prohibit discrimination in health care,⁹⁶ and adoption of stricter federal employment non-discrimination laws.⁹⁷ Since the root of LGBT health disparities is provider discrimination based upon broader social stigma,⁹⁸ and these suggestions focus mainly on combating discrimination in access to health services,⁹⁹ they fall short of the goal of improving the health status of LGBT Americans. Each of these three suggestions, and the reasons they will fail to accomplish this objective, will be discussed below and an alternative will be presented using an amended ACA as the vehicle for delivery and implementation.

A. The ACA's Affordable Insurance Exchanges

The ACA provides for the establishment of Affordable Insurance Exchanges (AIEs),¹⁰⁰ through which uninsured consumers can directly compare competing private insurers' benefits in a user-friendly manner.¹⁰¹ This method can also be used to determine which insurance providers extend benefits to domestic partners.¹⁰² It has been suggested that LGBT consumers' utilization of AIEs will help to close the health care gap in that community.¹⁰³

It is true that using AIEs will assist in closing the *coverage* gap in the LGBT community, since they are projected to help increase access to health insurance coverage in the general population due to allowing collective bargaining power to achieve competitively low prices.¹⁰⁴ However, it does not follow that increasing *access* to health care for LGBT consumers will likewise increase the *quality* of care they will receive from that access.¹⁰⁵ On the contrary, there is nothing to safeguard against the persistence of bias in the health care industry against these

of these disparities. *Id.* However, multiple organizations have identified discriminatory attitudes and behaviors as the main cause of LGBT health disparities. *See supra* Part I. Thus, the federal government may simply be acting insouciantly rather than making proactive, comprehensive efforts to combat all LGBT health disparities.

95. *See, e.g.,* Pizer et al., *supra* note 25, at 767; U.S. DEPT. OF HEALTH & HUMAN SERVS., *supra* note 2.

96. *See generally* Elizabeth R. Cayton, *Equal Access to Health Care: Sexual Orientation and State Public Accommodation Antidiscrimination Statutes*, 19 LAW & SEXUALITY 193 (2010).

97. *See generally*, Pizer et al., *supra* note 25.

98. *See supra* Part I.

99. *See infra* Part II.A–C.

100. 18 U.S.C. § 18003 (2011).

101. U.S. DEP'T HEALTH & HUMAN SERVS., *Health Care Reform and HIV/AIDS*, AIDS.GOV (last updated Mar. 29, 2013), <http://aids.gov/federal-resources/policies/health-care-reform/>.

102. *See* U.S. DEPT. OF HEALTH & HUMAN SERVS., *supra* note 2.

103. Pizer et al., *supra* note 25, at 767.

104. Laurence H. Tribe, *The Constitutionality of the Patient Protection and Affordable Care Act: Swimming in the Stream of Commerce*, 35 HARV. J. L. & PUB. POL'Y 873, 874 (2012).

105. *See supra* Part I.C (describing the extensive discrimination LGBT individuals experience while accessing health care services).

individuals.¹⁰⁶ The AIEs will allow LGBT persons to locate an insurance plan that will cover their specific needs, but providers will continue to engage in the intentional and unintentional discriminatory behaviors described above without interventions aimed at curbing those behaviors.¹⁰⁷ As a result, the AIEs themselves are unlikely to result in any meaningful positive change in the health status of the LGBT community.

B. State Public Accommodations Antidiscrimination Statutes

It has been suggested that state public accommodations antidiscrimination (PAA) statutes could be applied to health care providers to prohibit discriminatory practices on the basis of sexual orientation or gender identity.¹⁰⁸ Most state PAA laws that include sexual orientation as a protected class have similar language.¹⁰⁹ For example, California's PAA law provides that "all persons . . . are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business[es]" regardless of their status as a member of certain particular protected classes, including sexual orientation.¹¹⁰ In one sense, PAA laws can certainly remedy some of the problems associated with LGBT health disparities. For instance, as stated above, many LGBT persons have been completely denied care on the basis of their LGBT status and PAA laws explicitly prohibit such denials.¹¹¹ However, while PAA laws may help to end outright denials of care (which can be accurately associated more with discrimination in terms of accessing care rather than with discrimination in the quality of care received),¹¹² they will do little to correct provider bias and hostile treatment of LGBT patients. Providers can be prohibited from refusing a patient treatment due to some particular trait, but such regulations do not necessarily prohibit adverse treatment of those patients based on that characteristic once they are being treated.¹¹³

It could also be said that, broadly construed, the statutory language of PAA laws entitling every individual to "full and equal. . . services"¹¹⁴ would in fact

106. See *supra* Part I.C.

107. See *infra* Part II.D (discussing how cultural competency can curb discriminatory behaviors in which providers engage).

108. See generally Cayton, *supra* note 96, at 200 n.15.

109. *Id.* at 200 (comparing the provisions of Colorado's PAA law to those of other states that include sexual orientation as a protected class).

110. CAL. CIV. CODE § 51(b) (West 2007).

111. Cayton, *supra* note 96, at 203–04.

112. Denials of care are more associated with accessing health care services because no actual services are given when providers refuse treatment based on LGBT status. See generally Lambda Legal Study, *supra* note 3, at 10 (finding that one form of discriminatory provider behavior was refusing to treat patients whatsoever due to that patient being part of the LGBT community).

113. See *id.* (providing survey results of LGBT respondents, which reveal that in addition to denying treatment altogether, providers also engage in verbal abuse, physical abuse, refusing to touch the patient, and blaming the patient for his or her own medical conditions).

114. See, e.g., CAL. CIV. CODE § 51(b) (West 2007).

prohibit purposeful discriminatory treatment based upon LGBT status. Indeed, some state courts have so interpreted PAA statutes.¹¹⁵ This, however, will do nothing to cure indirect or unintentional discriminatory treatment. Providers that are unknowledgeable or unaware of the specialized needs of LGBT patients will consistently provide substandard care to those patients, independently of whether they intend to discriminate in the treatment provided.¹¹⁶ Because of this, using PAA 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.

*C. Federal Employment Nondiscrimination Statutes:
The Employment Non-Discrimination Act*

There have long been calls for a national non-discrimination act that includes sexual orientation and gender identity in its protected classes.¹¹⁷ The major fruit of those efforts has been borne out in the Employment Non-Discrimination Act (the ENDA), which has been introduced in all but one Congress since 1994.¹¹⁸ In its current form, the ENDA does not prohibit discrimination against LGBT employees in provision of employer-sponsored health insurance to their spouses or partners.¹¹⁹ Some have argued that because providing equality in benefits is not cost prohibitive and can result in real, positive outcomes for both LGBT employees and employers, the ENDA should be revised to prohibit provision of unequal benefits.¹²⁰

While one cannot overlook the immense positive benefits and the real need for LGBT employment antidiscrimination statutes at the federal level so that national health care equality can be further realized, the reality is that these advancements stop short of actually curing the problem discussed herein.

115. Cases interpreting PAA statutes emphasize that an element of intentional discrimination is generally required for a successful claim. *See, e.g., Harris v. Capital Growth Investors XIV*, 805 P.2d 873, 893 (Cal. 1991) (holding that a plaintiff seeking liability under California's PAA statute must establish and prove intentional discrimination that violates the terms of the act), *overruled by statute on other grounds, Munson v. Del Taco, Inc.*, 208 P.3d 623, 628 (finding that a plaintiff alleging public accommodations discrimination under CAL. CIV. CODE § 51(f), which prohibits violations of the rights of a disabled individual under the federal Americans with Disabilities Act, need not prove intentional discrimination). Thus, unintentional, indirect discrimination by medical providers on the basis of sexual orientation would not be protected under such statutes.

116. *See, e.g., Julia Higgins Foresman, Health Care Reform: Seeking the Cure for Tax and Social Justice on the Landscape of Changing Familial Norms*, 36 SETON HALL LEGIS. J. 344, 365–66 (2012) (discussing the fact that bias and a lack of knowledge of LGBT persons' specialized health care needs, whether unintentional or intentional, results in lower health outcomes for LGBT individuals).

117. Pizer et al., *supra* note 25, at 760–61. Since 1973, there have been Congressional efforts to include homosexuals as a protected class in federal employment laws. *Id.*

118. *Id.*

119. *Id.* at 761–62.

120. *See, e.g., id.* at 772–79 (describing, *inter alia*, increased productivity and retention rates for companies who provide same-sex partner benefits as well as LGBT employees' decreased reliance on public health initiatives to access health care).

Extending employer-sponsored health insurance to LGBT employees and their families is, unsurprisingly, focused upon expanding access to care for LGBT individuals through prohibiting employers' discriminatory provision of benefits to LGBT employees and their families.¹²¹ Like the ACA's expansion of insurance coverage to previously uninsured LGBT Americans, providing equal access to employer insurance plans would simply provide greater access to health care services.¹²² It will not prevent provider-based discriminatory practices or work to promote inclusive and knowledgeable health care procedures and policies for LGBT patients.¹²³ Thus, the ENDA's enactment (if it ever is, in fact, enacted) is not a comprehensive solution, because it would combat only the access element of the discrimination LGBT persons experience in their health care.

D. LGBT-Specific Cultural Competency Education: A Holistic Solution to Discrimination in LGBT Health Care

Studies have recognized that cultural differences between patient and provider backgrounds can contribute to positive or negative health care outcomes.¹²⁴ As a result of these findings, the concept of cultural competency was suggested to combat health care disparities resulting from a lack of provider awareness and training as to the specific needs of different cultural groups in receiving health care.¹²⁵ Cultural competence is the "capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."¹²⁶

It has been shown that cultural competency education can reduce significant health disparities because it educates providers about how, among other things, their behaviors and attitudes can impact the treatment relationship.¹²⁷ Such education results in the improvement of the overall quality of care that minority classes of patients receive because it increases their utilization of health care

121. See *id.* at 767 (characterizing the issue of unequal provision of health benefits to partners of LGBT employees as primarily affecting those individuals' access to health care services, rather than the quality of services received).

122. See *supra* Part I.C (describing the extensive discrimination LGBT individuals experience while accessing health care services).

123. Cf. Pizer et al., *supra* note 25, at 767 (stating that homosexuals are less likely to be insured—an access to care issue—than heterosexuals to show that a federal law prohibiting discrimination on the basis of sexual orientation in providing employee benefits would provide equal access to care).

124. Sunil Kripalani et al., *A Prescription for Cultural Competence in Medical Education*, 21 J. GEN. INTERN. MED. 1116, 1116 (2006).

125. *Id.*

126. U.S. DEP'T HEALTH & HUMAN SERVS., *What is Cultural Competency?*, OFFICE OF MINORITY HEALTH (Oct. 19, 2005, 11:29 AM), <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>.

127. See Leon McDougale, et al., *Evaluation of a New Cultural Competency Training Program: CARE Columbus*, 102 J. NAT'L MED. ASSOC. 756, 756 (2010) (noting, in the context of foreign-born patients, that providers' culturally discriminatory attitudes and inadequate ability to use interpreters can be remedied with "cross-cultural education" or cultural competency training).

services and adherence to plans of treatment.¹²⁸ As discussed above, other proposals to close the gap in LGBT health care will not be enough because they primarily remedy discriminatory provision of *access* to care.¹²⁹ On the other hand, cultural competency training focuses precisely on the quality of care provided because it centers on decreasing discriminatory provider attitudes and behaviors.¹³⁰ Thus, providing health professionals with LGBT-specific cultural competency training is a better method for improving the state of LGBT health care overall than merely providing greater access, and the ACA can be used as the vehicle for delivery of this training.¹³¹

III. THE ACA: UNITED STATES HEALTH REFORM, THE ACA'S GOALS, AND ITS SHORTCOMINGS IN THE CONTEXT OF THE LGBT COMMUNITY

A. *An Overview of United States Health Reform*

Health care reform in the United States is no creature of modern politics; its roots date at least to the beginning of the twentieth century.¹³² As early as the 1910s, progressives advocated for comprehensive reforms, based upon European models, to prevent illness from causing poverty and to increase utilization of preventive care.¹³³ By the time the Great Depression struck in the 1930s, medical technologies, and therefore costs of treatment, had significantly increased.¹³⁴ At the same time, few people were able to afford the costs of health care, including middle class Americans.¹³⁵ It was during this period that the idea of compulsory medical insurance gained momentum, but this was eventually abandoned in favor of the now well-known Social Security program, primarily due to extreme resistance from the American Medical Association.¹³⁶

The policy of expanding access to health care continued over the next thirty years, focusing on target populations of concern and culminating in the enactment

128. Kripalani et al., *supra* note 124.

129. *See supra* Part II.

130. *See supra* text accompanying note 127.

131. *See infra* Part IV.

132. *See generally* Joseph S. Ross, *The Committee on the Costs of Medical Care and the History of Health Insurance in the United States*, 19 EINSTEIN Q.J. BIOLOGY & MED. 129 (2002) (providing a comprehensive discussion of health care reform efforts in the United States from the late nineteenth century through the Great Depression).

133. *Id.* at 128. These efforts were subsequently defeated when Woodrow Wilson assumed the presidency. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* at 132–33; *see also* President Franklin Delano Roosevelt, State of the Union Address to Congress (Jan. 11, 1944), *available at* http://www.fdrheritage.org/bill_of_rights.htm (proposing a “Second Bill of Rights” that included a right to health care for all).

of the Medicare and Medicaid programs in 1965.¹³⁷ Subsequently, several calls were made for further comprehensive reforms and in 1974, President Richard Nixon communicated to Congress that comprehensive health care was needed for all.¹³⁸ While this call went unheeded, hugely rising costs of health care in the late 1970s shifted the focus to cost containment rather than access to care.¹³⁹ This resulted in Bill Clinton's creation of the Clinton Health Care Task Force upon assuming the presidency in 1992.¹⁴⁰ This committee eventually produced a Health Security bill, but it remained highly unpopular with citizen groups and providers, the former dissatisfied with the degree of employers' and commercial insurance companies' control and the latter dissatisfied with the lack of measures tailored to cost containment.¹⁴¹

The historical context of health care reform in the United States frames the landscape immediately preceding the ACA. Before its passage, the American health care system was the most expensive in the world, and yet delivered lower quality results than the systems of other industrialized nations.¹⁴² High rates of uninsured, exorbitant health care costs, and the ability of insurance companies to deny or drop coverage based on health status as a result of little competition in the market plagued the American system.¹⁴³ As a result of these market forces, many Americans were forced to either continue paying premiums they could not afford or go without insurance and risk becoming destitute if a catastrophic medical condition struck.¹⁴⁴ The overall goals of the ACA were a direct response to these concerns and are essentially threefold: (1) to increase access to health care for all Americans; (2) to increase the overall quality of care received; and (3) to assert control over uncontrolled health care prices and costs.¹⁴⁵ While cost-containment is highly important given the exorbitant costs in the American health system, this

137. I.S. Falk, *Medical Care in the USA—1932-1972. Problems, Proposals and Programs from the Committee on the Costs of Medical Care to the Committee for National Health Insurance*, 51 MILBANK MEMORIAL FUND Q: HEALTH AND SOCIETY 1, 17 (1973).

138. Special Message from President Richard Nixon to the Congress Proposing a Comprehensive Health Insurance Plan (Feb. 6, 1974), available at <http://www.presidency.ucsb.edu/ws/index.php?pid=4337>.

139. Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 78 (2003).

140. *Id.*

141. *Id.*

142. Michael Saul, *Expensive Without the Results: Health Care in the U.S. Costs the Most, Not the Best in the World*, N.Y. DAILY NEWS (Aug. 23, 2009), http://articles.nydailynews.com/2009-08-23/news/17930526_1_health-care-universal-coverage-primary-care.

143. President Barack Obama, *Fighting for Health Insurance Reform*, (Mar. 8, 2010), available at <http://www.whitehouse.gov/photos-and-video/video/fighting-for-health-insurance-reform#transcript>.

144. *Id.* (describing personal stories of having to cancel health insurance plans due to disproportionately high premium costs versus health care bills paid and risking having to mortgage or sell a home in order to cover future medical bills).

145. GEYMAN, *supra* note 6, at 2. The goal of controlling increasingly high health care costs is outside the scope of this comment and will not be discussed further.

comment focuses on the first two pillars of access to and quality of care, because they mirror the areas in which discrimination in LGBT health care manifests, as discussed above.¹⁴⁶

B. The ACA's Expansion of Access to Health Care

The ACA has many provisions aimed at increasing access to health care.¹⁴⁷ The major sections devoted to increasing access to care can essentially be reduced to four main categories with regard to their regulatory focus: (1) regulations affecting insurance companies; (2) regulations affecting businesses; (3) reforms of the Medicare and Medicaid systems; and (4) other regulations or reforms.¹⁴⁸

The provisions of the ACA aimed at increasing access to care that focus on regulation of insurance companies are pervasive.¹⁴⁹ Insurance companies will be required to cover the dependent adult children of customers up to the age of twenty-six.¹⁵⁰ Providers are also prohibited from unilaterally cancelling insurance plans, protecting consumers that develop serious and expensive-to-treat conditions.¹⁵¹ They will also be prohibited from denying coverage based upon pre-existing conditions.¹⁵² Lifetime limits on amounts paid out for medical bills will also be eliminated for plans established after December 31, 2013.¹⁵³

The ACA also has regulations applicable to businesses that provide insurance plans to their employees. Qualifying small businesses will receive tax credits based on a percentage of the amounts they contribute to employee health plans.¹⁵⁴ It also authorizes a temporary program to reimburse employers for the cost of “reinsuring” their qualifying early retirees.¹⁵⁵ Furthermore, businesses with over fifty employees will be subject to a fine if any of their employees qualify for federal health insurance subsidies (in other words, if any of their employees go uninsured by the employer’s plan).¹⁵⁶

146. See *supra* Part I (detailing how discrimination against LGBT patients affects their access to health care services and also impacts the quality of services they do receive).

147. See Laxmaiah Manchikanti et al., *Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade*, 14 J. AM. SOC’Y INTERVENTIONAL PAIN PHYSICIANS E35, E39–40 (2011) (providing a table with major ACA provisions and dates of implementation for each, where each provision can be reduced to one of these four categories).

148. *Id.*

149. *Id.* at E35 (characterizing the new insurance industry regulations as “extensive”).

150. 42 U.S.C. § 300gg-14 (2011).

151. § 300gg-12.

152. § 18001.

153. § 300gg-11.

154. 26 U.S.C. § 45R (2011).

155. 42 U.S.C. § 18002.

156. Manchikanti, *supra* note 147, at E40.

The ACA proposes to significantly expand the Medicaid and Medicare programs.¹⁵⁷ One of the shining stars of, and a major point of contention in challenges to,¹⁵⁸ the ACA is its widespread increase of the income eligibility for Medicaid to 133% of the poverty level.¹⁵⁹ Medicare patients also received a one-time rebate of \$250 in 2010 to help with gaps in prescription drug coverage, providing access to more medicines.¹⁶⁰ Drug companies will also be required to subsidize branded prescription drugs for seniors receiving Medicare, starting with fifty percent discounts and increasing thereafter.¹⁶¹ Lastly, Medicare income taxes will also be increased and a new tax will be imposed on unearned income in order to finance the expanded access to Medicare.¹⁶²

Finally, the remaining major provisions of the ACA have various regulatory impacts. The most famous regulation (or infamous, depending on one's perspective) in the ACA is its individual mandate, requiring most Americans to enroll in an insurance program or pay a tax.¹⁶³ The federal government will likewise provide subsidies for indigent persons who cannot afford to purchase health insurance on their own.¹⁶⁴ A temporary high-risk insurance pool will also be created to provide access to qualifying individuals denied coverage due to pre-existing conditions.¹⁶⁵ Community health center funding will additionally be increased by eleven billion dollars to help provide access to underserved and indigent populations.¹⁶⁶ It is estimated that once the majority of the ACA's provisions are implemented, approximately thirty million Americans will have access to health care that previously did not.¹⁶⁷

157. Under the recent Supreme Court decision in *Nat'l Fed'n Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2607 (2012), the ACA's provision requiring states to participate in the Medicaid expansion or lose all federal Medicaid funds, found at 42 U.S.C. § 1396(c) (2011), is unconstitutional. Thus, states may opt out of the Medicaid expansion without risking loss of all federal Medicaid funds.

158. See, e.g., *Nat'l Fed'n Indep. Bus.*, 132 S. Ct. at 2607 (2012) (involving two primary challenges to the ACA, one of which is that the ACA's requiring states to expand Medicaid eligibility is unconstitutional).

159. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2011).

160. § 1395w-152.

161. Manchikanti, *supra* note 147, at E39.

162. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

163. 26 U.S.C. § 5000A (2011).

164. § 36B.

165. 42 U.S.C. § 18001 (2011).

166. Manchikanti, *supra* note 147, at E39.

167. CONGRESSIONAL BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 13 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

C. The ACA's Goal of Increasing Quality of Care

As compared to provisions directly relating to expanding access to care, ACA provisions focusing on increasing quality of care are few.¹⁶⁸ The most obvious statute relating to increased quality of care is the requirement that insurance companies cover preventative care services with no co-payments, including immunizations and women's cancer screenings.¹⁶⁹ Prohibiting denials of coverage based upon pre-existing conditions also relates to quality of care in that patients will be able to receive needed services from physicians with which they have established an ongoing treatment relationship who can provide them with a more complete understanding of their medical history and needs.¹⁷⁰ Closing Medicare's prescription drug coverage gap will likewise tend to improve the quality of health care received because this will provide more comprehensive treatment.¹⁷¹

D. How the Current ACA Will Fail to Improve the Health Status of the LGBT Community

It would be inaccurate to say that the ACA is completely unconcerned with improving quality of care because there are, in fact, important provisions that will impact the quality of care all Americans receive.¹⁷² What is clear, however, is that the primary regulatory focus of the ACA is access to health care; simply weighing the number of provisions directly influencing access to care and those directly influencing quality of care illustrates this result.¹⁷³ Examining governmental documents concerning the ACA, most if not all of which prominently feature initiatives improving access to health care, leads to the same conclusion.¹⁷⁴ Further, the scope of the major provisions relating to health care access is much broader than that relating to health care quality.¹⁷⁵ On this basis, it is fair to conclude that

168. See Manchikanti, *supra* note 147. By the author's count, roughly fifteen of the major provisions in Table 1 relate directly to expanding access to care, whereas perhaps four major provisions relate to quality of care.

169. 42 U.S.C. § 300gg-13 (2011).

170. § 18001.

171. Manchikanti, *supra* note 147, at E39; see also U.S. DEPT. OF HEALTH & HUMAN SERVS., *Medicare Drug Discounts*, HealthCare.gov (last updated July 6, 2012), <http://www.healthcare.gov/law/features/65-older/drug-discounts/> (explaining the practical effects of the ACA on Medicare drug coverage).

172. The best example of this is the requirement of covering preventative services at no cost. 42 U.S.C. § 300gg-13 (2011).

173. See *supra* text accompanying note 168.

174. See, e.g., U.S. DEP'T HEALTH & HUMAN SERVS., *supra* note 101 (devoting an extensive discussion, when compared to the section devoted to increased quality of care, to how the ACA will provide increased access to care); U.S. DEPT. OF HEALTH & HUMAN SERVS., *supra* note 2 (highlighting the pre-existing conditions prohibitions, ending lifetime dollar limits on key benefits, the expansion of the Medicaid program, and the Affordable Insurance Exchanges as ACA provisions that will benefit the LGBT community).

175. Compare 26 U.S.C. § 5000A (2011) (requiring most citizens to obtain health insurance or pay a fine), with 42 U.S.C. § 300gg-13 (2011) (requiring coverage of certain preventative services for those

the ACA focuses more on increasing access to care rather than improving the quality of care received and that it will work toward remediating the *coverage* gap in the LGBT community caused by discrimination, rather than the discrimination against LGBT individuals in the health care they do receive.¹⁷⁶

Although the ACA's primary focus is on increasing access to health care for all Americans, it does contain some important provisions that will impact the quality of health care received.¹⁷⁷ As related to the LGBT community, however, these provisions miss the mark. Government documents focus on the fact that the ACA requires all insurance plans to cover pre-existing medical conditions, chronic disease management, and preventive services, such as HIV testing.¹⁷⁸ While these provisions are certainly important, they do nothing to combat the extensive stigma targeting LGBT patients that is present in American health care services.

A major cause of the disparate health care status of the LGBT community is provider discrimination and bias against the very patients they are to serve.¹⁷⁹ Even with all the expanded access that will presumably result from the ACA, there is no reason to think that LGBT Americans will change their longstanding practices of delaying medical care as long as possible to avoid being subjected to what they see as unnecessary discrimination.¹⁸⁰ On this basis, the ACA is not a holistic solution to the LGBT community's health care troubles. Furthermore, although other racial minority groups experience low quality health care, medical schools have begun to recognize this and incorporate cultural competency training for those populations to make providers aware of the specific needs of these communities. Unfortunately, that training rarely, if ever, includes LGBT-specific subjects.¹⁸¹ Using the ACA to encourage LGBT-specific cultural competency education can remedy this oversight.¹⁸²

who choose to offer or issue group health plans, improving the quality of the health care the covered individuals receive). The former affects the entire citizenry as a whole, while the latter affects only those with need of the specified services, which will apply primarily to women and children by its own terms.

176. See *supra* Part II.A (explaining that the ACA's affordable insurance exchanges will likely provide access to care for previously uninsured LGBT Americans and how the exchanges won't prevent persons from continuing to experience discrimination in the provision of health care services).

177. See *supra* Parts III.B–C.

178. See, e.g., U.S. DEP'T HEALTH & HUMAN SERVS., *supra* note 101.

179. See *supra* Part I.C.

180. See DeCola, *supra* note 50, at 12 (finding underutilization of health care by LGBT persons to be primarily attributable to discrimination or a perceived lack of understanding of their specialized needs).

181. See Juno Obedin-Maliver et al., *Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education*, 306 JAMA 971, 973 (2011) (finding that out of 150 survey respondent medical schools, their cultural competency curricula offered a median of five hours of LGBT cultural competency training); see also *infra* Part IV.A (describing the current state of LGBT cultural competency curricula in United States medical schools).

182. See *infra* Part IV.B. (providing a more detailed explanation).

IV. CURING THE ACA'S ILLS: AN AMENDMENT TO PROVIDE CULTURAL COMPETENCY TRAINING

In light of LGBT persons' needs for better care in the face of societal stigma, the ACA's complete dearth of provisions working to counteract provider discrimination in provision of services and seeking to educate them on LGBT needs will cause it to fail to improve the existing health disparity in the LGBT community.¹⁸³ Amending the ACA to require provision of LGBT-specific cultural competency training will help cure this deficiency.¹⁸⁴ Provisions of the ACA do, in fact, address cultural competency training in health professional education.¹⁸⁵ However, these provisions suffer from two flaws that still leave LGBT health disparities resulting from discriminatory provision of care unaddressed. First, they are permissive rather than compulsory, merely authorizing the Secretary of Health and Human Services (HHS) to issue grants for the development of model cultural competency curricula.¹⁸⁶ Second, they do not require development of these model curricula for any specific populations but rather authorize grants to "reduce health disparities" in general.¹⁸⁷

Given the fact that the LGBT population has essentially been ignored in current cultural competency curricula, it is speculative that these permissive and overly vague provisions will do anything to combat discrimination that results in the substandard provision of care to LGBT patients.¹⁸⁸ The ACA is particularly well-suited as a vehicle for educating providers on the needs of LGBT patients since it already recognizes a general need for cultural competency training¹⁸⁹ and because it is intended to be a major overhaul of the American health care system as a whole.¹⁹⁰ To provide LGBT patients with effective health care, any proposal to amend the ACA to improve the health status of LGBT Americans should focus on

183. As it currently stands, the ACA will likely combat discrimination in LGBT *access* to care to some degree. *See supra* Part II.A; *see also supra* text accompanying note 172. However, it should be amended to combat all discrimination, whether in terms of access to or quality of health care services.

184. *See supra* Part II.D (describing how cultural competency can curb discriminatory provider behaviors directed toward LGBT patients).

185. 42 U.S.C. § 293e(a)(1) (2011).

186. *Id.* (stating that the Secretary of the Department of Health and Human Services "*may* make awards of grants, contracts, or cooperative agreements . . . for the development [of] model curricula for cultural competency [and] reducing health disparities . . . for use in health professions schools and continuing education programs") (emphasis added).

187. *Id.*

188. *See* Obedin-Maliver, et. al., *supra* note 181 and accompanying text.

189. 42 U.S.C. § 293e(a)(1) (2011) (authorizing HHS to make grants for programs aimed at establishing model cultural competency curricula).

190. *See supra* Part III.A–C. (describing the problems with the American health care system prior to the ACA's enactment and the ACA's broad regulatory sweep aimed at eliminating those problems).

provisions aimed at the discrimination that causes substandard provision of care to LGBT persons; cultural competency training is just such a focus.¹⁹¹

A. The Current Status of LGBT Cultural Competency Training in American Medical Schools

Health disparities have long been documented in racial minority groups.¹⁹² As a result of these disparities and the fact that accrediting bodies typically require sensitivity training,¹⁹³ many medical schools incorporate some form of cultural competency into their current curricula.¹⁹⁴ These programs, however, suffer from shortcomings in the context of the LGBT community because many focus only on the care of racial and ethnic minority groups.¹⁹⁵ Further, those programs that do specifically address the needs of the LGBT community typically spend minimal time doing so.¹⁹⁶ Thus, the overall status of LGBT cultural competence training in medical schools is inadequate and will not combat the LGBT health disparity the ACA leaves unaddressed.

B. Training Competent Providers for LGBT Patients: A National Legislative and Regulatory Effort

Currently, medical schools are left to choose for themselves which populations will be introduced in cultural competency curricula.¹⁹⁷ This has resulted in few, if any, medical schools devoting sufficient time to training physicians to provide high quality care to LGBT patients.¹⁹⁸ It is clear that to curtail discrimination in provision of care to LGBT patients, a more comprehensive approach is needed, and a national, uniform requirement can accomplish this. Although already enacted, simply amending the ACA to include provisions requiring applicable agencies to issue rules aimed at increasing implementation and

191. See *supra* Part II.D (concluding that cultural competency would be an effective solution to combat overall discrimination in health care directed at LGBT person).

192. Betancourt et. al., *supra* note 1.

193. LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE 10 (2012), available at <http://www.lcme.org/functions.pdf>.

194. Nisha Dogra et al., *Teaching Cultural Diversity: Current Status in U.K., U.S., and Canadian Medical Schools*, 25 Suppl. 2 J GEN. INTERN. MED. S164, S165 (2010).

195. If these programs incorporated aspects of LGBT sensitivity training, it would be expected that health disparities based on providers' discriminatory behaviors in that community would have been observed to be narrowing, but this does not seem to be the case. See, e.g., Lambda Legal Study, *supra* note 3 (detailing LGBT patients' accounts of experiencing discrimination at the hands of medical service providers); see also *supra* text accompanying note 181.

196. See *supra* text accompanying note 188.

197. Accrediting bodies may require such programs to be present for accreditation purposes, but they do not give much, if any, guidance as to what must be presented or which minority populations must be covered. Dogra, *supra* note 194, at S166.

198. See *supra* text accompanying note 188.

utilization of LGBT-specific cultural competence training provides a convenient vehicle for such reform.¹⁹⁹

1. Providing Cultural Competency Training to Medical Students

As previously described, most medical schools do provide cultural competency training for students, but these curricula are severely deficient in training future providers to provide high quality care for members of the LGBT community.²⁰⁰ Two main methods are proposed to improve the presence and amount of LGBT-specific cultural competency in medical schools. First, Congress should amend the ACA to require HHS to promulgate new rules governing participation in the Medicare and Medicaid programs. Most hospitals participate in the Medicare and Medicaid programs²⁰¹ and most medical schools are associated with their own individual hospitals.²⁰² HHS promulgates many different rules that serve as conditions of participation in these programs²⁰³ and can use this ability to promulgate new rules requiring the medical schools with which any recipient hospital is affiliated to include substantive,²⁰⁴ LGBT-specific cultural competency training in their curricula.²⁰⁵

Secondly, Congress could amend the ACA to require the agencies that administer research funding to place new conditions on receipt of those funds. Most

199. See *supra* Part IV (explaining that the ACA is a convenient vehicle for amendments aimed at reducing LGBT health care disparities by providing cultural competency training because it would further the its overall reformatory purpose and because it recognizes the need for such training).

200. See *supra* Part IV.A.

201. For example, as of 2010, there were 6,169 hospitals participating in Medicare alone. U.S. SOC. SEC. ADMIN. OFFICE OF RET. AND DISABILITY POLICY, ANNUAL STATISTICAL SUPPLEMENT TO THE SOCIAL SECURITY BULLETIN, 2011 8.42 (2012), available at <http://www.ssa.gov/policy/docs/statcomps/supplement/2011/8c.pdf>.

202. Both the Liaison Committee on Medical Education (the national accrediting body for M.D. degrees) and the Commission on Osteopathic College Accreditation (the national accrediting body for D.O. degrees) require that schools provide appropriate resources for hands-on clinical instruction of students, and school-affiliated hospitals provide an ideal venue for this. LIAISON COMM. ON MED. EDUC., *supra* note 193, at 25; AM. OSTEOPATHIC ASS'N, ACCREDITATION OF COLLEGES OF OSTEOPATHIC MEDICINE: COM ACCREDITATION STANDARDS AND PROCEDURES 23 (2012), available at <http://www.osteopathic.org/inside-aoa/accreditation/predoctoral%20accreditation/Documents/COM-Accreditation-Standards-Effective-7-1-2012.pdf>.

203. See, e.g., 42 C.F.R. § 482.1 (2011) (outlining conditions for hospitals' participation in the Medicare and Medicaid programs).

204. The meaning and parameters of a "substantive" LGBT-specific cultural competency curriculum are beyond the scope of this comment, but they should at minimum include experiences and materials allowing practitioners to develop the tactics discussed by Makadon, *supra* note 83.

205. The legality of such conditions would be governed by the Administrative Procedure Act, 5 U.S.C. 500 (2011) and would likely be found valid as long as they comply with the HHS' enabling statute (here, the hypothetically amended ACA), any other applicable limiting statutes (here, the Medicare and Medicaid provisions of the Social Security Amendments of 1965) and the provisions of the Administrative Procedure Act itself. See generally CHARLES H. KOCH, WEST'S FEDERAL ADMINISTRATIVE PRACTICE § 7323 (Westlaw ed., 3d ed. 2012) (describing the interplay between the Administrative Procedure Act, other federal statutes and promulgated rules).

medical schools conduct research²⁰⁶ and, as a result, are recipients of various federal agency research funds.²⁰⁷ To comply with an amended ACA, those agencies could attach new conditions to the receipt of medical research funds by medical schools that require them to provide substantive, LGBT-specific cultural competency training to their students. However, because the issuance of and compliance with the rules of participation in the Medicare and Medicaid programs is relatively simple and those rules are pervasive,²⁰⁸ issuance of new rules of participation as outlined above is probably a better method than attaching conditions to research funding. This is particularly true given that most hospitals participate in Medicare and Medicaid programs.²⁰⁹

2. *Providing Cultural Competency Training to Existing Practitioners*

The benefits to the quality of patient care of cultural competency education having been shown,²¹⁰ efforts to provide such education should not be limited solely to medical students. The most obvious way to achieve this for existing providers would be for Congress to require HHS to again promulgate new conditions. This time, the conditions would attach to individual providers' receipt of Medicare and Medicaid payments, like those previously outlined for medical school-associated hospitals. Such conditions should require participating providers to undergo a certain number of hours of continuing education courses that focus on LGBT populations and LGBT-specific issues.²¹¹

LGBT-specific cultural competence can also be achieved for existing providers at the state level.²¹² Although not directly related to the ACA, state

206. Both the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation require that schools provide basic education in clinical research or experiential efforts. LIAISON COMM. ON MED. EDUC., *supra* note 193, at 9; AM. OSTEOPATHIC ASS'N, *supra* note 202, at 23.

207. For example, the National Institutes of Health alone provided federal funding to 137 medical schools in 2012. BLUE RIDGE INST. FOR MED. RESEARCH, *Ranking Tables of NIH Funding to US Medical Schools in 2012*, BRIMR.ORG, tbl.3, http://www.brimr.org/NIH_Awards/2012/NIH_Awards_2012.htm (last updated Feb. 19, 2013).

208. *See, e.g.*, 42 C.F.R. §§ 482.23–482.28 (2011) (requiring participating hospitals to have a plethora of basic functions, such as nursing, medical records, pharmacy, radiology, laboratory, and dietary services affecting almost every aspect of a hospital's operation).

209. *See supra* text accompanying note 201.

210. Kripalani et al., *supra* note 124.

211. The Fenway Center's National LGBT Health Education Center provides excellent resources on the specific quality of care needs of the LGBT community, including CME courses (some of which are free). FENWAY CTR'S. NAT'L LGBT HEALTH EDUC. CTR., *About Continuing Education—National LGBT Health Education Center*, LGBTHEALTHEDUCATION.ORG, <http://www.lgbthealtheducation.org/training/about-continuing-education/> (last visited June 5, 2013).

212. At least one state, New Jersey, has already implemented a similar regime, requiring all applicants for a new or renewed medical license to have completed a requisite number of hours in cultural competence training (albeit the training required does not specifically state it must include LGBT health care subject matter). N.J. STAT. ANN. § 45:9-7.1 (West 2012).

licensing boards should require a certain number of hours of LGBT cultural competence training as a condition of renewed licensure, either during medical school or through continuing education.²¹³ This method can also help to ensure LGBT cultural competence in graduating medical students who are obtaining a license for the first time.

V. CONCLUSION

Considering the history and controversy surrounding health care reform in the United States, the passage of the ACA is certainly monumental in and of itself.²¹⁴ The ACA will expand access to care across the board, and greatly increase the number of Americans having health insurance who would otherwise go uninsured.²¹⁵ At the same time, health care disparities are evident in the LGBT community.²¹⁶ The disparities that exist within the LGBT community's health care are directly related to the discrimination LGBT individuals experience generally.²¹⁷ The substandard care provided to LGBT patients is in turn directly related to provider bias based upon a broader social stigma associated with LGBT individuals.²¹⁸

Because expanding access to health care, as opposed to improving the quality of care received, is the major theme running throughout the ACA, its provisions will ultimately fail to improve the health status of LGBT individuals that the ACA otherwise covers because they do not combat broader provider-based LGBT discrimination.²¹⁹ Moreover, policy suggestions for improving LGBT health disparities are also directly aimed at achieving equal access to health insurance and treatment, rather than improving LGBT health outcomes.²²⁰ As a result, a more comprehensive approach is needed. Physician cultural competency training has been shown to improve the overall quality of care and to increase target populations' utilization of health care services, in turn resulting in a reduction in

213. Continuing education is a conference-like process that assists physicians to remain current on new technologies, diseases and the like in their field and allows them to improve the care they provide to their patients. *Why Accredited CME is Important*, ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., <http://www.accme.org/for-public/why-accredited-cme-is-important> (last visited June 5, 2013). Continuing education is also a requirement to maintain a license to practice medicine. *Id.*

214. *See supra* text accompanying note 5.

215. *See* CONGRESSIONAL BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 13 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf> (estimating that the ACA will grant insurance coverage to approximately thirty million previously uninsured Americans).

216. Kane-Lee & Bayer, *supra* note 15.

217. *See supra* Part I.

218. *See generally supra* note 24 and accompanying text.

219. *See supra* Part III.D.

220. *See supra* Part II.A–C (describing how these policy suggestions fail to directly impact the treatment relationship and thus fail to address the low quality of health care received by the LGBT).

health care disparities.²²¹ This occurs because cultural competency training exposes providers to the unique needs of certain groups of patients and allows them to care for those needs in a manner sensitive to that specific population.²²²

Currently, most medical schools incorporate cultural competency training into their curriculum.²²³ Unfortunately, most of these curricula emphasize only racial and ethnic minority health competencies.²²⁴ Medical schools that do actually incorporate LGBT health needs into their cultural competency training usually spend very minimal amounts of time on the training provided.²²⁵ Because of the varied status of LGBT cultural competency training, a national, uniform regulatory effort is needed to ensure that LGBT-specific health needs are being adequately addressed during provider education.²²⁶ Amending the ACA to require HHS to promulgate new rules compelling cultural competency training as a condition of participating in the Medicare and Medicaid programs, both for hospitals and individual providers, can accomplish this goal. Since most medical schools also conduct medical research, the ACA could also be amended to require agencies administering federal research funds to place these same conditions on those funds given to medical schools.

Amending the ACA to include provisions for compulsory cultural competency training will make existing and future health care providers not only aware of the health care needs of the LGBT community but will also make them knowledgeable. Using the ACA is particularly appropriate in light of the fact that it recognizes a need for cultural competency generally and because doing so will further its goal of being a comprehensive reform of American health care.²²⁷ Exposing providers to LGBT individuals will help to break down socially-enforced stigmas and stereotypes, reducing instances of discrimination against those persons and helping to provide a meaningful change in the overall quality of health care that population receives. Providing meaningful access to care—that is, providing access to high quality health care rather than simply providing basic access—is an important part of achieving substantive equality for the LGBT community.

221. Kripalani et al., *supra* note 124.

222. *Id.*

223. Dogra et al., *supra* note 194.

224. Obedin-Maliver et al., *supra* note 181.

225. *Id.*

226. *See supra* Part IV.B.

227. *See supra* text accompanying note 199.