



# Protecting and Advancing Health Care for Transgender Adult Communities

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# Introduction and summary

**Author's note:** *"Transgender" is an umbrella term used to describe people whose gender identity and/or gender expression differ based on the sex they were assigned at birth.<sup>1</sup> The transgender community is not a monolith. Transgender people have diverse sexual orientations, gender expressions, and gender identities, and transgender identities do not depend on physical appearance or medical procedures.*

Discrimination, stigma, and violence, along with other social, political, and economic factors, significantly affect the physical, mental, and behavioral health of transgender adults.<sup>2</sup> Research demonstrates that, compared with the general population, transgender people suffer from more chronic health conditions and experience higher rates of health problems related to HIV/AIDS, substance use, mental illness, and sexual and physical violence, as well as higher prevalence and earlier onset of disabilities that can also lead to health issues.<sup>3</sup> In addition to poorer health outcomes, transgender people also encounter unique challenges and inequalities in their ability to access health insurance and adequate care.<sup>4</sup> The public health and economic crises spurred by the COVID-19 pandemic have only exacerbated existing disparities and barriers to care for transgender people, especially transgender people of color.<sup>5</sup>

While robust laws that protect transgender people from discrimination based on gender identity are essential to providing greater legal safeguards, such tools must be paired with enforcement mechanisms and in-practice policies that are affirming, inclusive, and culturally competent. Adopting both nondiscrimination laws and inclusive policies will be critical for improving health outcomes and the daily lives of the estimated 1.4 million<sup>6</sup> adults identifying as transgender in the United States.

To examine the health conditions that transgender adults face, this report incorporates storytelling to elevate their lived experiences. The following sections highlight:

- The status of the physical, behavioral, and mental health of transgender communities and barriers to accessing general and gender-affirming care
- The contemporary landscape of legal and regulatory nondiscrimination protections in health care
- In-practice policies to promote affirming, inclusive, and culturally competent care

# Health status of and barriers to care for transgender communities<sup>7</sup>

Transgender individuals are a high-risk population for mental and physical health problems and are consistently and systemically underserved by the American medical system. Regular harassment and discrimination contribute to high rates of stress and—combined with adverse social, political, and economic risk factors—make transgender individuals significantly more likely to experience poor health outcomes. Structural, institutional, and individual barriers in access to care, along with a lack of cultural competency from many health care providers, contribute to the large disparities in health between transgender and cisgender populations.

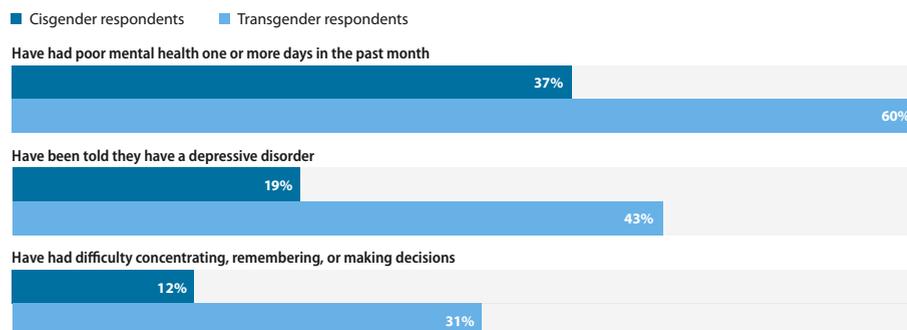
For example, according to 2019 Behavioral Risk Factor Surveillance System (BRFSS) data, 3 in 5 transgender respondents report experiencing poor mental health at least one day in the past month—a rate 23 percentage points higher than that of cisgender respondents. (see Figure 1) Fifty-four percent report poor physical health at least one day in the past month—a rate 18 percentage points higher than that of cisgender respondents. Transgender populations also face an increased likelihood of developing cardiovascular disease<sup>8</sup> as well as a higher likelihood of having asthma,<sup>9</sup> and their rates of chronic depression are more than twice that of cisgender populations.<sup>10</sup> Transgender respondents are significantly more likely to be living with HIV.<sup>11</sup> New research from the Williams Institute at the University of California, Los Angeles School of Law on the first transgender population-based national dataset developed through the TransPop study shows that 7 percent<sup>12</sup> of transgender respondents have at some point been told by a doctor that they have a sexually transmitted infection (STI), compared with 2 percent of heterosexual cisgender respondents. (see Appendix A for more details)

The coronavirus pandemic has exacerbated these existing disparities. Elevated rates of asthma, regular smoking, and HIV among transgender populations make them more prone than the general population to experience a severe case of COVID-19.<sup>13</sup> For example, CAP analysis of 2019 BRFSS data shows that 22 per-

FIGURE 1

## Transgender adults are more than 2 times as likely as cisgender adults to be told they have a depressive disorder

Shares of transgender and cisgender adults who reported facing mental health concerns, 2019

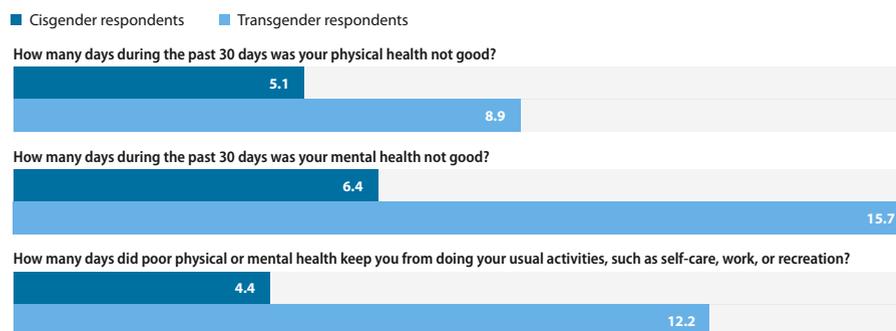


Source: Centers for Disease Control and Prevention, "2019 BRFSS Data and Documentation," available at [https://www.cdc.gov/brfss/annual\\_data/annual\\_2019.html](https://www.cdc.gov/brfss/annual_data/annual_2019.html) (last accessed July 2021).

FIGURE 2

## Transgender adults report more than twice as many days with poor mental health as cisgender heterosexual adults

Average number of days that transgender and cisgender heterosexual adults reported experiencing poor mental and physical health, 2016–2018



Source: Ilan H. Meyer, "TransPop, United States, 2016-2018" (Los Angeles: University of California, Los Angeles, Williams Institute, 2021), available at <https://www.icpsr.umich.edu/web/ICPSR/studies/37938/summary>.

cent of transgender individuals have been told they have asthma, compared with 14 percent of cisgender individuals. One international survey of transgender individuals during the pandemic found that 50 percent of respondents had risk factors for a severe course of a COVID-19 infection.<sup>14</sup> Evidence demonstrates that the economic and social inequalities felt by transgender individuals also make them less able to access quality care<sup>15</sup> and more likely to encounter the coronavirus due to factors such as overrepresentation in industries highly affected by the pandemic, such as restaurants and food services; hospitals; K-12 education; colleges

and universities; and retail.<sup>16</sup> Isolation during the pandemic has also been particularly damaging to the mental health of transgender populations, who already face higher rates of mental health disparities,<sup>17</sup> and 1 in 3 reported having suicidal thoughts during the pandemic.<sup>18</sup> One in 2 reported that their access to gender-affirming health care was curtailed significantly during the pandemic,<sup>19</sup> and this reduced access to necessary care has also been detrimental to mental health.<sup>20</sup>

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## Health effects of minority stress

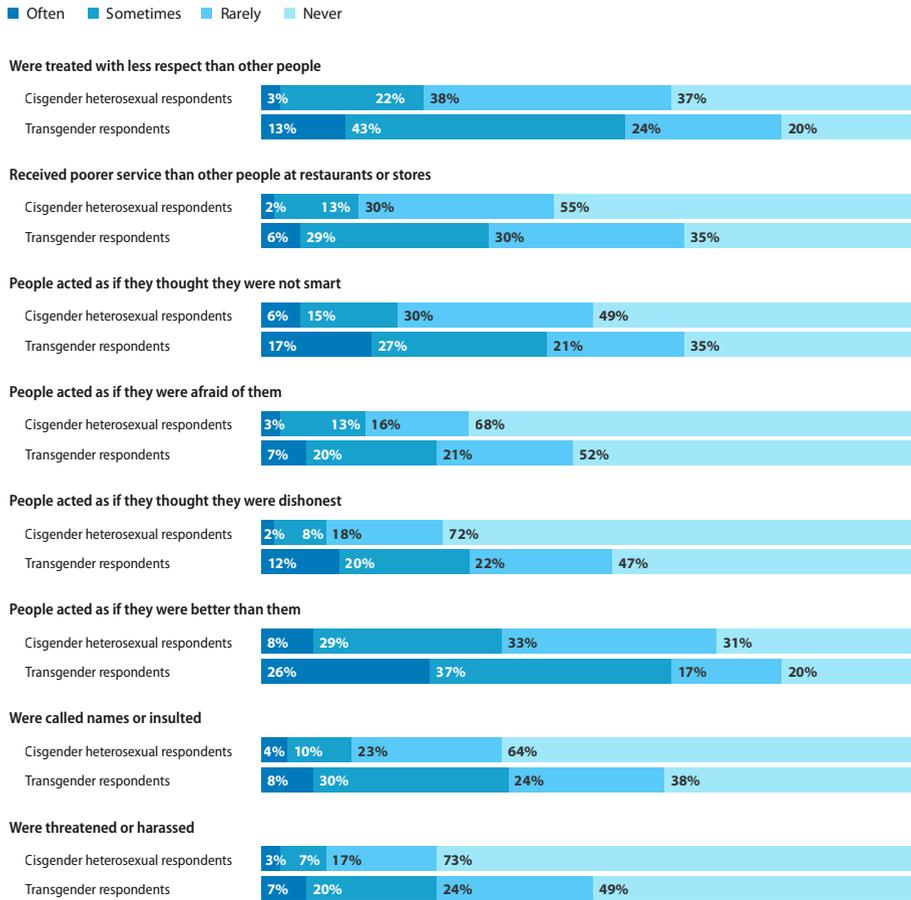
High rates of mental and physical health conditions among transgender people<sup>21</sup> can be partly explained under a “minority stress” model, a well-supported theory<sup>22</sup> that for minorities within a society, stigma, prejudice, and discrimination create a hostile and stressful social environment that can contribute to mental health problems such as depression and anxiety and drive higher prevalence of unhealthy or high-risk behaviors.<sup>23</sup> According to a nationally representative survey of lesbian, gay, bisexual, transgender, queer, intersex, and other sexual and gender-diverse individuals (LGBTQI+) conducted by the Center for American Progress,<sup>24</sup> 2 in 3 transgender individuals have experienced some form of discrimination in the year prior, including 65 percent of transgender people of color.<sup>25</sup> The 2015 U.S. Transgender Survey, conducted by the National Center for Transgender Equality, found that 46 percent of transgender individuals reported verbal harassment due to their gender identity in the past year,<sup>26</sup> while nearly 1 in 10 reported being physically attacked in the past year. Both numbers increase significantly for Black, Middle Eastern, and American Indian transgender populations.<sup>27</sup>

TransPop data<sup>28</sup> show extensive discrimination in the day-to-day lives of transgender respondents. Thirty-eight percent of transgender respondents reported that they were often or sometimes called names or insulted in the past year,<sup>29</sup> compared with 14 percent of cisgender heterosexual respondents. (see Figure 3) Twenty-eight percent<sup>30</sup> also reported that they were often or sometimes threatened or harassed, compared with 10 percent of cisgender heterosexual respondents. These experiences were compounded by disproportionately high rates of mistreatment and disrespect from others: 35 percent reported often or sometimes receiving poorer service at restaurants or stores, and 63 percent reported that people sometimes or often acted as though they were better than them,<sup>31</sup> compared with 15 percent and 37 percent of cisgender heterosexual respondents, respectively.

On a psychological level, stress from such experiences leads to the dysregulation of cortisol, which affects a wide range of bodily functions, including one’s metabolism, mood, cardiovascular health, and immune system health.<sup>32</sup> Experiences of discrimination have been linked to high rates of post-traumatic stress disorder,<sup>33</sup> lack of body satisfaction,<sup>34</sup> depression,<sup>35</sup> anxiety, and psychological distress.<sup>36</sup>

**FIGURE 3**  
**4 in 5 transgender adults report being treated with less courtesy or respect than their cisgender heterosexual counterparts**

Shares of transgender and cisgender heterosexual adults who reported poor treatment in various spaces, 2016–2018



Note: Totals may be larger than 100 due to rounding.  
 Source: Ilan H. Meyer, "TransPop, United States, 2016-2018" (Los Angeles: University of California, Los Angeles, Williams Institute, 2021), available at <https://www.icpsr.umich.edu/web/ICPSR/studies/37938/summary>.

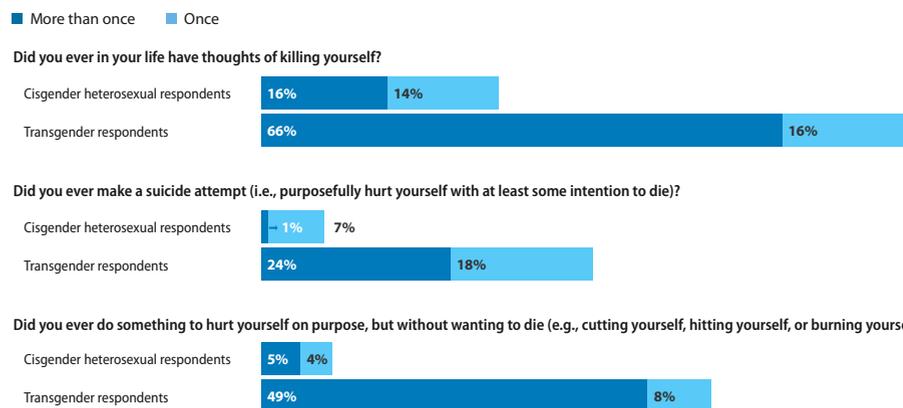
Most alarmingly, such experiences have been connected to both nonsuicidal self-injury<sup>37</sup> and attempted suicide: 42 percent of transgender individuals reported attempting suicide to cope with transgender-related discrimination.<sup>38</sup> Data from

the TransPop survey reveal disparities in suicidal behavior between transgender and cisgender heterosexual individuals in terms of contemplating suicide during their lifetime (81 percent<sup>39</sup> versus 30 percent); attempting suicide in their lifetime (42 percent<sup>40</sup> versus 8 percent); and engaging in nonsuicidal self-injury (56 percent<sup>41</sup> versus 9 percent). (see Figure 4)

In addition to physical ailments and psychological harms, experiences of discrimination have been extensively linked to high rates of substance use. Transgender individuals who report experiencing high levels of discrimination are 3.59 times more likely to engage in binge drinking<sup>42</sup> than transgender individuals who report

**FIGURE 4**  
**Transgender adults are 4 times as likely as cisgender heterosexual adults to report making at least 1 suicide attempt in their life**

Shares of transgender and cisgender heterosexual adults who reported suicidal ideation, suicide attempts, and self-harm during their lifetime, 2016–2018



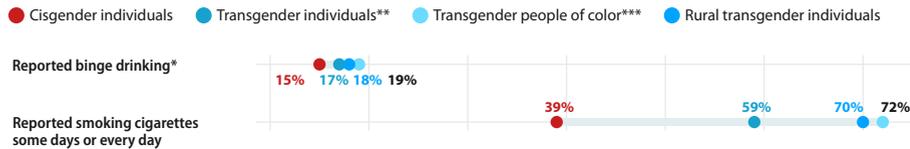
Source: Ilan H. Meyer, "TransPop, United States, 2016-2018" (Los Angeles: University of California, Los Angeles, Williams Institute, 2021), available at <https://www.icpsr.umich.edu/web/ICPSR/studies/37938/summary>.

low levels of discrimination.<sup>43</sup> CAP analysis of data from the BRFSS shows that 59 percent of transgender individuals report smoking tobacco some days or every day, compared with 39 percent of cisgender individuals.<sup>44</sup> (see Figure 5) TransPop data also show large disparities in drug use: 25 percent of transgender respondents report using drugs other than alcohol at least twice a month, compared with 10 percent of cisgender heterosexual respondents. Discriminatory experiences have also been linked to difficulty engaging in healthy life practices, which is compounded by economic difficulties.<sup>45</sup> BRFSS data reveal that transgender adults reported exercising in the past month at a rate of 8 percent lower than cisgender respondents; were 9 percent less likely to consume at least one fruit a day; and were 11 percent less likely to consume at least one vegetable a day. (see Figure 6)

## Gender-based violence and hate violence

**FIGURE 5**  
**3 in 5 transgender adults smoke cigarettes**

Shares of transgender and cisgender adults who reported engaging in high-risk behaviors, 2019



\* In this instance, the CDC define binge drinking as having five or more (males) or four or more (females) drinks on one occasion in the past 30 days.

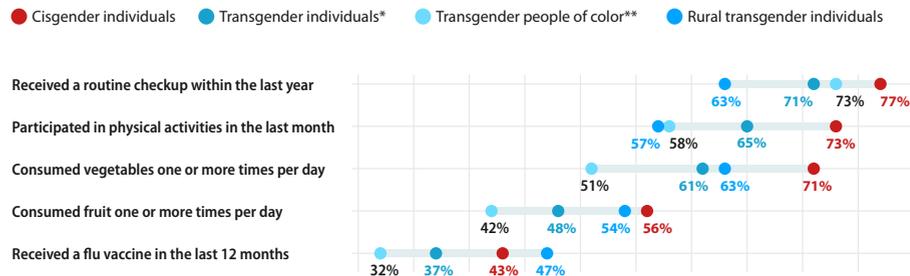
\*\* Consisting of male, female, and gender-nonconforming respondents.

\*\*\* Consisting of Black, Asian, American Indian/Alaskan Native, Hispanic, and "Other race, Non-Hispanic" respondents.

Source: Centers for Disease Control and Prevention, "2019 BRFSS Data and Documentation," available at [https://www.cdc.gov/brfss/annual\\_data/annual\\_2019.html](https://www.cdc.gov/brfss/annual_data/annual_2019.html) (last accessed July 2021).

**FIGURE 6**  
**Transgender adults are significantly less likely than cisgender adults to have flu shots and routine doctor's visits**

Shares of transgender and cisgender adults who reported engaging in selected positive health-related behaviors, 2019



\* Consisting of male, female, and gender-nonconforming respondents.

\*\* Consisting of Black, Asian, American Indian/Alaskan Native, Hispanic, and "Other race, Non-Hispanic" respondents.

Source: Centers for Disease Control and Prevention, "2019 BRFSS Data and Documentation," available at [https://www.cdc.gov/brfss/annual\\_data/annual\\_2019.html](https://www.cdc.gov/brfss/annual_data/annual_2019.html) (last accessed July 2021).

The threat or presence of violence represents an additional determinant of health for many transgender people. In addition to causing physical injuries, the presence of violence against transgender people in many environments contributes to minority stress and mental health consequences.

Lethal violence is widespread, and reported killings are increasing annually: In

the United States, 29 transgender or gender-nonconforming people have been reported killed in 2021 so far, and 44 were killed in 2020.<sup>46</sup> The true number is likely higher, as law enforcement and media often do not accurately identify victims.<sup>47</sup> Black and Latina transgender women are consistently and drastically overrepresented among victims. Awareness and fear of potential victimization contribute to the many stresses that transgender people already face. This fear is justified by not only the possibility of lethal violence but also the ubiquity of non-lethal violence. The TransPop survey found that 48 percent of transgender adults in the United States have been beaten, physically attacked, or sexually assaulted at least once since the age of 18<sup>48</sup>—a rate 12 percentage points higher than that of cisgender heterosexual people. (see Figure 7) Nearly half of those transgender respondents experienced such violence three or more times. Sixty-one percent of transgender people reported being threatened with violence, and 76 percent reported verbal insults or abuse.<sup>49</sup>

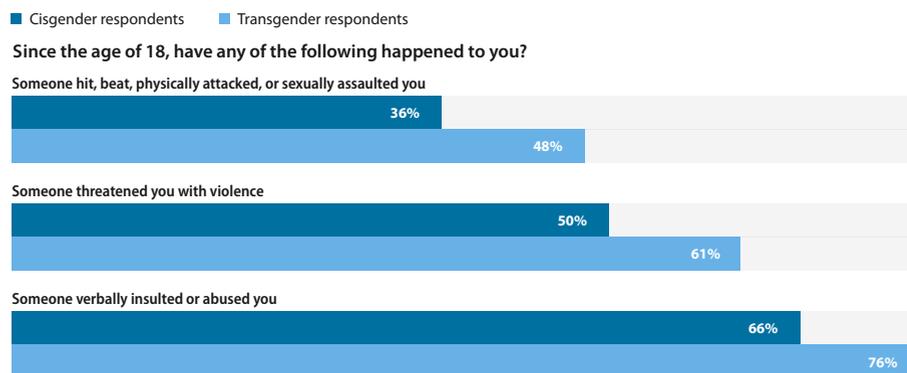
Violence takes many forms. According to the TransPop survey, 32 percent of transgender people report experiencing intimate partner violence,<sup>50</sup> a rate 7 percentage points higher than that of cisgender heterosexual people. Among cases of transgender women killed in the U.S. between 2015 and 2020, almost half of identified suspects were intimate partners, a category taken to include romantic partners, sex work clients, and other relationships.<sup>51</sup> Even with less than 15 percent of law enforcement departments nationwide reporting hate crime data, 227 crimes motivated at least in part by gender identity bias were recorded by the FBI in 2019, including intimidation, vandalism, and simple and aggravated assault.<sup>52</sup> Violence also occurs in many settings: A Washington, D.C., survey found that perpetrators of physical assault against transgender people include co-workers, students and school staff, police, incarcerated people and prison staff, and shelter residents or staff.<sup>53</sup>

Violence has serious health consequences, both physical and mental. Estimates of the prevalence of post-traumatic stress disorder in transgender population samples range from 18 percent to 61 percent, compared with 6.8 percent among the general adult population.<sup>54</sup>

FIGURE 7

## Half of transgender adults report being physically attacked or sexually assaulted at some point in their lives

Shares of transgender and cisgender heterosexual adults who reported verbal or physical abuse in their lifetimes, 2016–2018



Source: Ilan H. Meyer, "TransPop, United States, 2016-2018" (Los Angeles: University of California, Los Angeles, Williams Institute, 2021), available at <https://www.icpsr.umich.edu/web/ICPSR/studies/37938/summary>.

## The context of transgender health disparities: Social determinants of health and minority stress

Disparities in health status, health care access, and health outcomes often arise from conditions that are not explicitly associated with the medical system or the nature of transgender identity but are driven by broader social determinants of health. These determinants include factors such as socioeconomic status, education, and physical environments.<sup>55</sup> Oppressive structures such as racism, sexism, and transphobia influence where transgender people live, how they work, what food they can access, and how they are treated in their environments.

For transgender people, social determinants have concrete effects on health. High rates of poverty make medical care unaffordable. High rates of housing instability disrupt the continuity of care. Discrimination by medical providers leads to mistreatment and avoidance of care. Discrimination by employers leads to unemployment and consequent uninsurance. Criminalization and incarceration disrupt the continuity of care and expose transgender people to violence and trauma. Addressing the health disparities faced by transgender people requires addressing the many structural forms of exclusion, discrimination, and violence they endure.

Additionally, it is impossible to ignore the health effects of minority stress. The persistent experience of living in an unsafe, degrading environment where one must change behaviors and hide one's identity to avoid stigma and discrimination<sup>56</sup> is itself a public health problem that generates unique and pronounced disparities between transgender people and others.

In context, then, transgender health is a multifaceted social, economic, and political issue. Furthermore, many transgender people are people of color, people with disabilities, sex workers, or immigrants; their experiences of stigma, discrimination, and socially determined health conditions are distinctive and intersectional. Efforts to address transgender health disparities therefore run the risk of leaving many behind if they do not center the effects of racism, misogyny, criminalization, ableism, and xenophobia on transgender people's health.

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## Social determinants of health and adverse health outcomes

### Family rejection

High rates of rejection from family members are a major contributor to poor health outcomes among transgender people. According to TransPop data, 44 percent of transgender individuals had a parent physically hurt them at least once during childhood,<sup>57</sup> compared with 25 percent of cisgender heterosexual respondents. Many transgender people report having a more strained or conflicted relationship with their parents than their cisgender heterosexual counterparts (57 percent<sup>58</sup> compared with 22 percent), and many more report being bullied as a minor (46 percent<sup>59</sup> compared with 17 percent). According to the U.S. Transgender Survey, 8 percent of transgender individuals report being kicked out of their home for being transgender, and 10 percent report running away from home.<sup>60</sup> This contributes to the fact that 30 percent of transgender individuals have experienced homelessness at some point in their lifetime—a number that increases to 51 percent among Black transgender women.<sup>61</sup> Family rejection is also associated with both the misuse of drugs and alcohol and attempted suicide.<sup>62</sup>

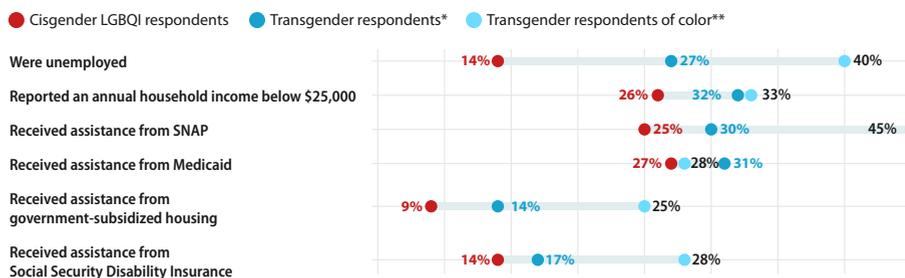
### Barriers to economic security

Broadly, transgender individuals encounter systemic and institutional discrimination and barriers to economic security. According to TransPop data, 62 percent of respondents report a personal income of below \$25,000 annually, compared with 40 percent of cisgender heterosexual respondents. More than 1 in 4 transgender respondents from CAP's 2020 survey reported a household income of less than \$25,000 annually.<sup>63</sup> (see Figure 8) Staggeringly, a survey of transgender and gender-nonconforming individuals in the southeastern United States found that 79 percent were food insecure.<sup>64</sup> Disparities in economic security and access to food have been proven to affect health status; one survey of transgender individuals in New York state found that those with incomes below the poverty line were almost twice as likely to report fair or poor health.<sup>65</sup> These obstacles not only exacerbate stress, leading to mental and physical ailments, but also make it more difficult for transgender individuals to afford quality care. More than half of transgender individuals reported postponing or not receiving necessary medical care in the year prior to CAP's survey because they could not afford it, including 60 percent of transgender respondents of color. And 40 percent avoided preventive screenings in the year prior to CAP's survey due to cost, including 31 percent of transgender respondents of color.<sup>66</sup>

FIGURE 8

## 1 in 3 transgender adults report an annual household income below \$25,000

Shares of transgender and cisgender LGBTQI adults facing unemployment or receiving benefits assistance, 2020



\* The statistics for transgender individuals include nonbinary, gender-nonconforming, genderqueer, and agender respondents.

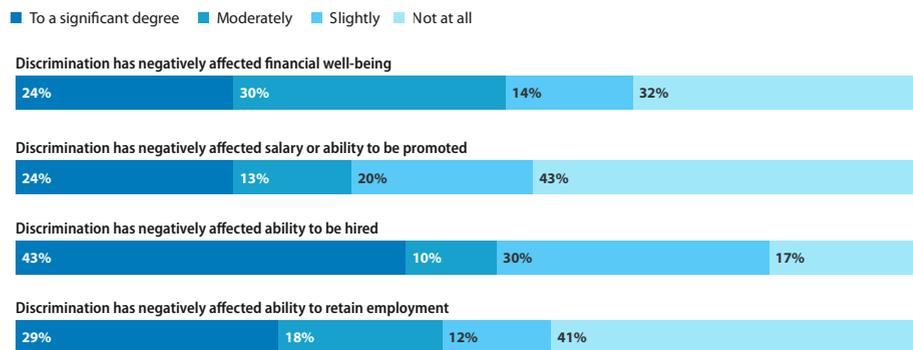
\*\* For the purposes of this survey, people of color include Black, Hispanic, Asian, and multiracial individuals as well as those identifying as "other, non-Hispanic."

Source: Center for American Progress and NORC at the University of Chicago nationally representative online survey of 1,528 LGBTQI+-identifying individuals, June 2020, on file with the authors.

FIGURE 9

## 4 in 5 transgender adults report that discrimination negatively affects their ability to be hired

Shares of transgender adults\* who reported various effects of employment discrimination in the year prior, 2020



\* The statistics for transgender individuals include nonbinary, gender-nonconforming, genderqueer, and agender respondents.

Source: Center for American Progress and NORC at the University of Chicago nationally representative online survey of 1,528 LGBTQI+-identifying individuals, June 2020, on file with the authors.

The reliance of the U.S. health insurance system on employer-provided coverage creates barriers to care for populations that are vulnerable to unemployment and employment discrimination.<sup>67</sup> In a 2020 CAP survey, 27 percent of transgender respondents reported that they were currently unemployed.<sup>68</sup> More than half of transgender individuals reported that discrimination moderately or significantly affected their capacity to be hired in the year prior to CAP's survey, while nearly

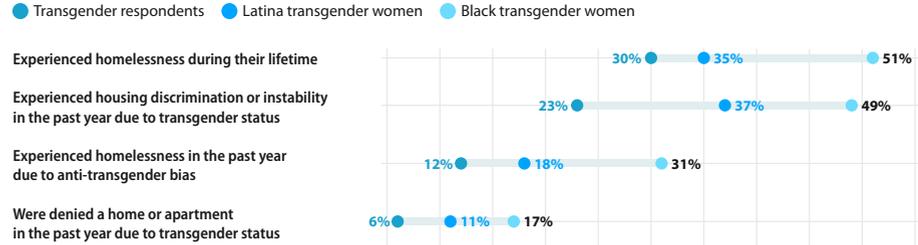
half reported that discrimination had a moderate or significant effect on their ability to retain employment in the year prior to CAP’s survey—with rates of reported discrimination significantly increasing for transgender people of color.<sup>69</sup> (see Figure 9) This discrimination leads to labor market exclusion and lower rates of insurance through employers, with transgender individuals reporting receiving employer-based insurance at a rate 7 percentage points lower than cisgender LGBTQI+ individuals.<sup>70</sup> Overall, transgender adults report uninsurance rates that are 7 percentage points higher than those of cisgender individuals.<sup>71</sup>

**Housing insecurity and experiences of homelessness**

Barriers to economic opportunities, labor and housing market discrimination and exclusion, lack of legal protections, and family rejection are main contributors to transgender people experiencing disproportionately high rates of homelessness. Nearly one-third of transgender individuals report living in poverty—compared with just 12 percent of the U.S. population<sup>72</sup>—limiting their capacity to afford rent or mortgage payments. A majority of states lack legal protections in housing based on gender identity,<sup>73</sup> and 23 percent of transgender individuals—including 49 percent of Black transgender individuals—have reported experiencing some form of housing discrimination, including eviction and the denial of a home or apartment.<sup>74</sup> (see Figure 10) For example, CAP survey data show that 52 percent of transgender individuals reported that discrimination negatively affected their ability to rent or buy a home to some degree in the year prior to the survey, compared with 36 percent of cisgender LGBTQI+ respondents. On a basic level, housing is essential to physical and mental health. Safe and stable housing means access to clean water, significantly reduced likelihood of contracting diseases and physical ailments, the proper storage of medications, improved mental health, and reduced health care costs.<sup>75</sup>

**FIGURE 10**  
**Nearly 1 in 3 transgender adults have experienced homelessness during their lifetime**

Shares of respondents to U.S. Transgender Survey who reported experiences of housing discrimination and homelessness, 2015

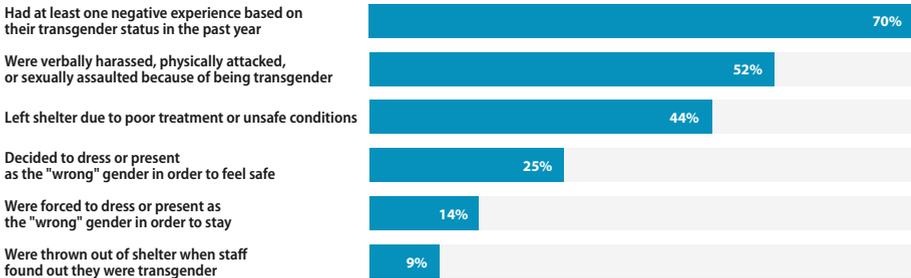


Source: Sandy E. James and others, “The Report of the 2015 U.S. Transgender Survey” (Washington: National Center for Transgender Equality, 2016), available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

High rates of homelessness have detrimental effects on mental and physical health and are associated with high rates of drug use, depression, anxiety, and suicide.<sup>76</sup> These effects are worsened due to the lack of safe shelter access. Among transgender individuals who have stayed in shelters, 70 percent have reported experiencing harassment, physical assault, or removal.<sup>77</sup> (see Figure 11) One in 4 transgender individuals experiencing homelessness report avoiding homeless shelters for fear of harassment, and an additional 6 percent have been denied access to shelter,<sup>78</sup> contributing to 63 percent of transgender people experiencing homelessness also being unsheltered.<sup>79</sup> Among unsheltered transgender populations, 60 percent are trimorbid, facing co-occurring physical, mental, and substance use disorders.<sup>80</sup> Unsheltered transgender people are more than seven times as likely to have police interactions and more than eight times as likely to be sent to jail or prison than transgender individuals who are sheltered. Those numbers increase among Black unsheltered transgender individuals.<sup>81</sup>

**FIGURE 11**  
**More than half of transgender adults who have stayed at a shelter have experienced verbal, physical, or sexual harassment**

Shares of respondents to U.S. Transgender Survey who reported discrimination and abuse at homeless shelters, 2015



Source: Sandy E. James and others, "The Report of the 2015 U.S. Transgender Survey" (Washington: National Center for Transgender Equality, 2016), available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

Interactions with the criminal legal system

Transgender individuals are much more likely than their cisgender counterparts both to have negative encounters with law enforcement and to face mental and physical health concerns due to incarceration. Data from the 2015 U.S. Transgender Survey show that of respondents who had a police encounter in the year prior, 58 percent experienced some form of mistreatment, including 61 percent of Black respondents and 71 percent of Latino/a respondents.<sup>82</sup> Police often target transgender people in discretionary interactions. One study of Latina transgender women in Los Angeles found that 60 percent of those who had been stopped by the police had not violated any laws.<sup>83</sup> Most prominently, police often

use the pretext that transgender individuals—particularly transgender women, and especially transgender women of color—are sex workers to create grounds to accost or detain them.<sup>84</sup> This practice is made easier by state statutes criminalizing loitering and practices allowing the possession of condoms to be used as justification for arrest and evidence of prostitution. These policies are so often used to target transgender people that they are referred to as “walking while trans” laws.<sup>85</sup> Staggeringly, 22 percent of individuals from the U.S. Transgender Survey who were arrested believe that they were arrested as a result of their gender identity,<sup>86</sup> likely contributing to CAP survey data showing that 50 percent of transgender individuals report avoiding police to avoid experiencing discrimination, compared with 29 percent of cisgender LGBTQI+ respondents.

Higher rates of contact with the criminal legal system mean that transgender individuals are incarcerated at a rate two times that of cisgender individuals.<sup>87</sup> These rates are even higher among transgender people of color; for example, Black transgender women are incarcerated at a rate 10 times that of the cisgender population. Incarcerated transgender people are often placed in housing in accordance with their gender assigned at birth; are nearly 10 times as likely to be assaulted than the general prison population; and face constant harassment from staff and other incarcerated persons.<sup>88</sup> Many are also disallowed from continuing necessary transition care. One in 3 incarcerated transgender people who had been taking hormones prior to their incarceration were prohibited from taking them.<sup>89</sup>

### Detention settings

Immigrants in detention centers face similar difficulties. Transgender individuals being held by U.S. Immigration and Customs Enforcement (ICE) in 2017 were detained more than twice as long as the general population.<sup>90</sup> One in 8 reported being held in solitary confinement,<sup>91</sup> and many have reported experiences of physical abuse and denial of gender-appropriate clothing.<sup>92</sup> Twelve percent of LGBT individuals overall report experiencing sexual abuse and assault, making them 97 times as likely to be sexually victimized than non-LGBT people in custody.<sup>93</sup> There are many reports of transgender individuals being denied access to basic health care, including hormone therapy and necessary care for those living with HIV.<sup>94</sup>

### Inaccurate identity documents

Barriers to obtaining accurate identity documents present additional challenges. State-level restrictions on gender marker and legal name changes vary,<sup>95</sup> with many states requiring approval by a medical provider or court order. These restrictions make identification changes dependent on health care access and therefore inacces-

sible to many, especially when specific medical procedures are required. Even more barriers to identification changes exist for transgender people with criminal records, who already face unique risks associated with discrimination and law enforcement interactions.<sup>96</sup> CAP's survey shows that 66 percent of transgender respondents reported discrimination having an impact on their ability to obtain accurate identification documents in the year prior to the survey, compared with 23 percent of cisgender LGB respondents. TransPop data show that 1 in 2 transgender respondents have no identification with their authentic name, and just 1 in 3 have any identification with their authentic pronouns. In practice, this may expose transgender people to harassment, violence, and administrative barriers when engaging with health care providers, the legal system, law enforcement, stores, and banks. Among those whose identifications do not reflect their current name or gender, 25 percent of transgender people have been verbally harassed and 16 percent have been denied services or benefits.<sup>97</sup> Incongruence between identification documents and gender identity has also been associated with worsened mental health, including higher levels of anxiety, depression, and adverse responses to gender-based mistreatment.<sup>98</sup>

## The context of barriers to care for transgender people: Medical system hostility

Hospitals, clinics, and doctors' offices should be safe environments where people are given the medical care they need. For many transgender people, this is not the case. Even when providers do not outright refuse to treat transgender people, they may verbally abuse or physically harm their transgender patients.<sup>99</sup> Refusal and abuse of transgender people of color is even more common.<sup>100</sup>

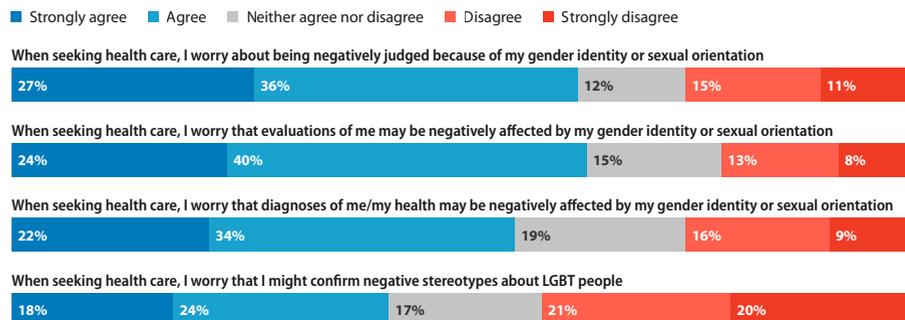
For transgender people who use drugs, have disabilities, or experience mental illness, medical system involvement also carries the risk of institutionalization or contact with the criminal legal system. Medical systems can be hostile and discriminatory due to racism and sexism as well,<sup>101</sup> and this hostility is often inseparable from transphobia. Medical system hostility has led to a long-standing reliance by transgender communities on black markets and informal networks to obtain gender-affirming care—practices that have resurfaced as the COVID-19 pandemic erects new barriers. For many, the risks of unregulated substance distribution and potential legal consequences feel safer than having to engage with health care providers.<sup>102</sup>

Supporting transgender people through the medical system can only be achieved with the trust of transgender patients. This trust has been violated repeatedly, violently, and fatally—from the long-standing classification of transgender identity as a mental disorder<sup>103</sup> to the psychologically abusive use of pseudoscientific conversion therapy<sup>104</sup> to the historical and continued failure of public health responses to the HIV epidemic.<sup>105</sup> Medical systems must earn transgender people's trust if they hope to effectively address health disparities.

FIGURE 12

## 2 in 3 transgender adults worry their health evaluations are affected by their sexual orientation or gender identity

Shares of transgender adults who reported concerns of bias in their health care treatment, 2016–2018



Source: Ilan H. Meyer, "TransPop, United States, 2016-2018" (Los Angeles: University of California, Los Angeles, Williams Institute, 2021), available at <https://www.icpsr.umich.edu/web/ICPSR/studies/37938/summary>.

### Receiving adequate care

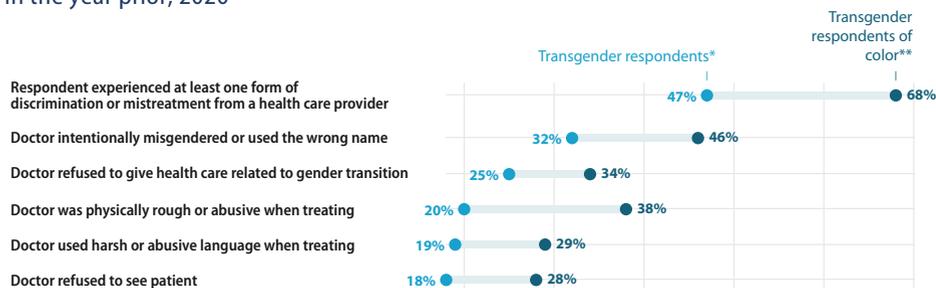
Transgender individuals face additional barriers due to a lack of cultural competency in how to provide treatment for transgender and gender-diverse populations. One in 3 transgender people reported having to teach their doctor about transgender people in order to receive appropriate care in the year prior to the survey.<sup>106</sup> And 15 percent report being asked “invasive or unnecessary questions about being transgender” not related to their reason for visiting.<sup>107</sup> Sixty-two percent of transgender respondents from the TransPop survey reported worrying about being judged because of their sexual orientation or gender identity when seeking health care,<sup>108</sup> with 63 percent agreeing that they worry evaluations of them will be negatively affected by these factors. (see Figure 12) More than half of medical school curricula lack information about the unique health issues and treatment of LGBT people beyond work related to HIV, likely contributing to transgender people’s inability to access affirming care.<sup>109</sup> Notably, just 20 percent of transgender respondents to TransPop report being very satisfied with the health care they receive, compared with 45 percent of cisgender heterosexual respondents. And 20 percent of transgender respondents report having no place to go when sick or need advice about health,<sup>110</sup> compared with 10 percent of cisgender heterosexual respondents.

Discrimination also affects the ability to access services, as TransPop data show that 61 percent of transgender respondents report having a personal doctor or health care provider,<sup>111</sup> compared with 76 percent of cisgender heterosexual respondents. Transgender individuals are less likely to have access to reproductive health services,<sup>112</sup> and 37 percent have to travel more than 10 miles in order to receive routine health care.<sup>113</sup>

FIGURE 13

## Nearly half of transgender adults report having negative or discriminatory experiences with a health care provider

Shares of transgender adults who reported discrimination in the health care industry in the year prior, 2020



\* The statistics for transgender individuals include nonbinary, gender-nonconforming, genderqueer, and agender respondents.

\*\* For the purposes of this survey, people of color include Black, Hispanic, Asian, and multiracial individuals as well as those identifying as "other, non-Hispanic."

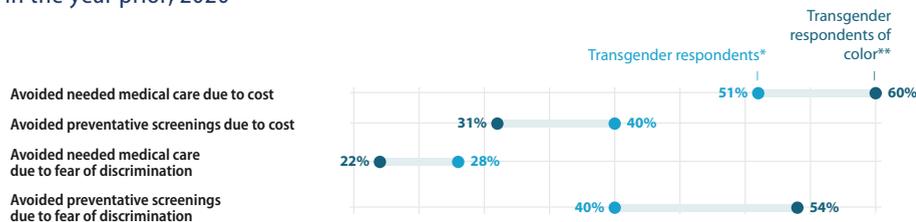
Source: Center for American Progress and NORC at the University of Chicago nationally representative online survey of 1,528 LGBTQ+-identifying individuals, June 2020, on file with the authors.

Further damaging are the high rates at which health care providers mistreat and abuse transgender adults. Nearly 1 in 2 transgender individuals, including 68 percent of transgender people of color, reported experiencing mistreatment at the hands of a provider in the year prior to CAP’s survey, including care refusal as well as verbal or physical abuse.<sup>114</sup> (see Figure 13) Twenty-eight percent of transgender individuals reported postponing or not receiving necessary medical care in the year prior to CAP’s survey for fear of experiencing discrimination, including 22 percent of transgender people of color. (see Figure 14) Stigma and discrimination from health care providers has also been explicitly linked to increased levels of substance use among transgender individuals.<sup>115</sup>

FIGURE 14

## More than half of transgender adults have avoided needed medical care due to cost

Shares of transgender adults who reported avoiding care due to cost or discrimination in the year prior, 2020



\* The statistics for transgender individuals include nonbinary, gender-nonconforming, genderqueer, and agender respondents.

\*\* For the purposes of this survey, people of color include Black, Hispanic, Asian, and multiracial individuals, as well as those identifying as "other, non-Hispanic."

Source: Center for American Progress and NORC at the University of Chicago nationally representative online survey of 1,528 LGBTQ+-identifying individuals, June 2020, on file with the authors.

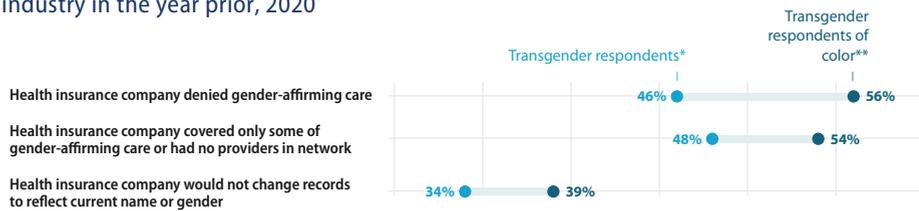
“[My doctors] treat me as if I had no rights. As if I weren’t human. Many times my doctors have refused to treat my asthma and diabetes. They allege my problems are mental, they dismiss the symptoms I describe to them and mock me because I am trans.”

—Emperatris, a community member quoted in Sylvia Rivera Law Project’s comment on the Trump administration’s rule on Section 1557 of the Affordable Care Act (ACA)<sup>116</sup>

Existing barriers to accessing medically necessary gender-affirming care create additional obstacles. Forty-six percent of transgender individuals had a health insurer deny them gender-affirming care in the year prior to CAP’s survey.<sup>117</sup> Fifty-five percent of transgender individuals report needing to travel at least 10 miles in order to receive gender-affirming care,<sup>118</sup> which can make it inaccessible for many. Notably, while 78 percent of respondents to the U.S. Transgender Survey reported wanting hormone therapy at some point in their life, only 49 percent of respondents have ever received it, and just 25 percent of respondents have had some form of transition-related surgery.<sup>119</sup> (see Figure 15)

**FIGURE 15**  
**Nearly 1 in 2 transgender adults have had insurers deny them coverage for gender-affirming care**

Shares of transgender adults who reported discrimination in the health insurance industry in the year prior, 2020



\* The statistics for transgender individuals include nonbinary, gender-nonconforming, genderqueer, and agender respondents.

\*\* For the purposes of this survey, people of color include Black, Hispanic, Asian, and multiracial individuals, as well as those identifying as "other, non-Hispanic."

Source: Center for American Progress and NORC at the University of Chicago nationally representative online survey of 1,528 LGBTQ+–identifying individuals, June 2020, on file with the authors.

# Current landscape of legal and regulatory nondiscrimination protections in health care

The landscape of legal protections in health care that prohibit discrimination based on sexual orientation and gender identity (SOGI) has evolved drastically in recent years. The sections below highlight notable legal and regulatory developments and recommendations for further action under the Biden administration. These recommendations are essential to building a more transgender-inclusive legal apparatus but should also be paired with in-practice policies set out below that promote affirming, quality care.

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## The *Bostock* decision and President Joe Biden's executive order

On June 15, 2020, the U.S. Supreme Court affirmed in *Bostock v. Clayton County*<sup>120</sup> that Title VII of the Civil Rights Act of 1964's prohibition on sex discrimination in employment encompasses discrimination based on SOGI. Prior to the high court's landmark decision, courts across the country were already interpreting sex discrimination to also prohibit SOGI discrimination, not just in Title VII but also in other statutes that prohibit sex discrimination,<sup>121</sup> such as Title IX, Section 1557 of the ACA, and the Fair Housing Act.<sup>122</sup> On day one of his presidency, President Biden signed a groundbreaking executive order<sup>123</sup> (EO) directing all agencies to enforce federal laws prohibiting sex discrimination to also prohibit discrimination based on SOGI in areas including but not limited to employment, housing, health care, education, and credit. The EO implements the *Bostock* decision throughout the country's major civil rights laws to consistently protect LGBTQ people from discrimination<sup>124</sup> and ensure equal protection under the law.

## Recommendations

- **Federal agencies should fully implement EO 13988 across the government.** Implementation of the EO on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation<sup>125</sup> throughout the government, including in the realms of health care, health insurance, and provision of services is essential. Doing so not only accurately reflects the current state of the law but is

also supported by the large<sup>126</sup> majority<sup>127</sup> of Americans who oppose discrimination against transgender people. EO 13988 granted each agency head 100 days to develop plans in consultation with the U.S. attorney general to carry out actions to revise, suspend, rescind previous agency actions or to promulgate new agency actions as necessary to fully implement statutes that prohibit sex discrimination to also prohibit discrimination based on SOGI. As explained below, the U.S. Department of Health and Human Services (HHS) has started announcing actions to better enforce SOGI nondiscrimination protections. However, it has not yet released its plan and should do so as soon as possible. Fully implementing these nondiscrimination protections throughout the country's health care system is vital, especially given the current wave of discriminatory, dangerous, and harmful state bills that aim to strip transgender people of their rights and ability to access to health care. As highlighted in the previous section, discrimination affects transgender communities across multiple, intersecting areas of life, including health care, employment, and housing. It is therefore imperative that all federal agencies release their plans detailing how they will use their authority to implement SOGI nondiscrimination practices. Congress' passage of the Equality Act will also be imperative to combating discrimination in multiple key areas of life that jeopardize the ability of transgender people to access health care and maintain economic security. And it would provide legal recourse from discrimination in public spaces and services as well as federally funded programs.<sup>128</sup>

- **Reverse the Trump administration's overly broad religious exemptions.** In implementing this historic EO, the Biden administration should also act across agencies to reverse the Trump administration's expansion of overly broad religious exemptions in health care with the aim of instituting a transparent and effective process for determining religious exemptions and third-party burdens. Doing so is particularly important given the increased rate of consolidation among hospitals to those affiliated with Catholic systems and the fact that more than 1 in 6 hospital beds are in Catholic hospitals, many of which follow transgender-exclusive ethical and religious directives from the U.S. Conference of Catholic Bishops.<sup>129</sup>

“When Tyler decided to pursue gender-affirming surgery, St. Joseph’s Santa Rosa Memorial Hospital near Tyler’s home and community was the natural hospital choice. After her doctor had trouble scheduling the surgery, Tyler drove to the hospital to schedule the surgery in person. The hospital staff misgendered Tyler and denied her gender-affirming surgery, citing their religious directives. She felt humiliated and dehumanized.”

– The American Civil Liberties Union Foundations of California’s comment on the Trump administration’s rule on Section 1557 of the ACA<sup>130</sup>

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## Discrimination in health care settings

Section 1557 is the primary nondiscrimination provision of the ACA, which prohibits health programs or facilities that receive federal funding from discriminating based on race, color, national origin, age, disability, or sex. Notably, Section 1557 incorporates the grounds and enforcement of mechanisms of various civil rights statutes, including Title IX of the Education Amendments of 1972’s prohibition on sex discrimination in health care programs and activities, a statute which many courts have consistently found applies to discrimination on the basis of SOGI.<sup>131</sup> Overall, the Section 1557 statute incorporates the grounds of existing federal civil rights laws and prohibits discrimination by federally funded health programs such that an individual cannot be excluded from participation in, be denied the benefits of, or be subjected to discrimination on these bases by any health program or activity that receives federal financial assistance.<sup>132</sup>

In 2016, the HHS Office for Civil Rights (OCR) issued a historic<sup>133</sup> rule codifying nondiscrimination protections for transgender people in health facilities, programs, and activities that receive federal funding. The rule clarified<sup>134</sup> that the sex nondiscrimination protections in Section 1557 explicitly protect transgender individuals on the basis of gender identity and confirmed that individuals must have access to health care facilities and programs that are in accordance with their gender identity. Regrettably, in 2020, the Trump administration promulgated a final rule creating numerous harms by attempting to erase specific nondiscrimination protections based on gender identity and sex stereotyping.<sup>135</sup> Litigation over the final rule is ongoing,<sup>136</sup> but courts have affirmed that gender identity discrimination is prohibited under the statute itself as well as under the 2016 rule’s protections based on “sex stereotyping,” and some parts of the 2020 final rule related to LGBT people are currently enjoined.<sup>137</sup> In light of the Supreme Court’s ruling in *Bostock* and subsequent court decisions, on May 10, 2021, the HHS announced that the OCR will interpret and enforce Section 1557 of the ACA

and Title IX’s prohibition on discrimination based on sex to include discrimination on the basis of SOGI.<sup>138</sup> The OCR simultaneously issued a notice of this new interpretation and its intent to accept, investigate, and resolve complaints of health care discrimination on the basis of SOGI under Section 1557.<sup>139</sup>

## Recommendation

- **Engage in rule-making to strengthen nondiscrimination protections in Section 1557 and Centers for Medicare and Medicaid Services (CMS) regulations.** While the interpretation helps to clarify explicit protections for LGBTQ people in federally funded health programs under Section 1557, numerous questions remain. For example, the announcement does not provide additional guidance or examples on what it means for covered entities not to discriminate based on SOGI and behaviors that could trigger review by the OCR; it does not resolve any of the pending litigation over the 2020 rule; it does not restore protection eliminated by the conforming amendments to CMS regulations that were implemented with the 2020 rule; and it remains unclear how the OCR will approach questions surrounding the Religious Freedom Restoration Act,<sup>140</sup> which protects the free exercise of religious belief, and how it interacts with Section 1557, if at all, as well as prior court orders in its enforcement of Section 1557, as stated in the announcement.<sup>141</sup> Future rule-making and litigation should be expected. The administration should engage in notice-and-comment rule-making at the HHS to strengthen Section 1557’s nondiscrimination protections by explicitly prohibiting discrimination based on sexual orientation, gender identity, gender expression, gender transition, transgender status, sex stereotypes, and sex characteristics (including intersex traits) and clarify the same scope of claims and remedies exist under Section 1557 regardless of the type of discrimination; reverse the CMS conforming amendments and clarify the scope of coverage and nondiscrimination in CMS rules for the Marketplace, Medicaid, and Medicare; and clarify protections for transgender and gender-diverse patients in health care and coverage by adopting regulatory and preamble language, guidance, technical assistance and enforcement efforts that underscore the wide range of scenarios in which discrimination against transgender patients can occur and is prohibited under federal law. Finally, the HHS should publish the 2016 proposed rule<sup>142</sup> establishing explicit nondiscrimination protections on the basis of SOGI within the Medicare and Medicaid conditions of participation for health care organizations. These conditions apply to facilities and providers and should include strong language about inpatient treatment prohibiting discrimination and harassment based on gender identity. The HHS’s OCR should also publish a yearly report with information about complaints and resolutions and disaggregate data by bases of complaints and numbers of investigations and complaints closed.

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## Discrimination in health insurance coverage

“I have a transgender son. My son needs hormone blockers, but we are at a standstill right now because our insurance company does not want to pay due to Trump’s proposal to take away protections for the transgender community. This is a life and death matter. Without hormone blockers, my son’s anxiety and anger will be out of control and his mental health will deteriorate.”

– Colorado parent’s comment on the Trump administration’s rule on Section 1557 of the ACA<sup>143</sup>

There is a growing consensus among expert and medical organizations that gender-affirming health care, including surgical procedures, is medically necessary.<sup>144</sup> Historically, however, transgender-specific exclusions have been deployed by public and private health insurers to deny transgender people coverage for medically necessary care, including for care unrelated to gender affirmation.<sup>145</sup> For example, insurers would regularly deny transgender people services and procedures such as hormone therapy, mental health counseling, preventive screenings, and surgeries that are regularly covered for cisgender people. The 2016 Section 1557 rule—and many states’ changes before that<sup>146</sup>—prohibited insurers from categorically excluding services related to gender-affirming health care, including gender-affirming surgeries, and from imposing discriminatory restrictions based on gender identity. Notably, numerous court decisions have found that these categorical exclusions violate Section 1557 or Title VII of the Civil Rights Act in employer-provided insurance plans.<sup>147</sup> Prior to the 2020 final rule, the number of private companies that were eliminating exclusions in their employee coverage appeared to be rapidly increasing,<sup>148</sup> and many insurers in the individual market removed transgender-specific exclusions, even after this part of the rule was enjoined in court.<sup>149</sup> However, the Trump administration’s final rule eliminated these explicit regulatory protections, resulting in a lack of clarity and life-threatening<sup>150</sup> consequences for transgender people across the country.

### Recommendations

- **Clarify that transgender exclusions do not comply with federal law.** The HHS should issue guidance to state Medicaid directors stating that transgender-specific exclusions are out of compliance with federal law. This guidance should suggest enforcement mechanisms, enumerate the ways in which medical necessity determinations can be applied in a discriminatory manner, and urge insurers to

affirmatively state their plans cover medically necessary care for gender dysphoria.<sup>151</sup> State Medicaid programs should immediately remove any exclusions and promulgate coverage protocols for gender-affirming care that are grounded in the most up-to-date medical standards of care in the field of transgender medicine.<sup>152</sup>

- **Encourage state and federal regulatory bodies to adopt similar affirmative coverage language.** These measures should include efforts to improve the Center for Consumer Information and Insurance Oversight’s (CCIIO) review process of plans to ensure compliance with state- and federal-level gender identity nondiscrimination requirements.<sup>153</sup> Because transgender consumers continue to find it challenging to obtain information from insurers regarding whether gender-affirming care will be covered,<sup>154</sup> the federal government should also invest additional funding in LGBTQI-specific outreach and enrollment support for transgender consumers in the individual health insurance market and Medicaid.
- **Improve Medicare coverage.** Absent a national coverage determination,<sup>155</sup> coverage decisions fall on the Medicare Administrative Contractors and Medicare Advantage plans,<sup>156</sup> where restrictive and discriminatory policies persist. To help address this issue, the CMS should add a provision to the Medicare Benefit Policy Manual that explicitly prohibits discrimination on the basis of SOGI when making coverage determinations.
- **Eliminate exclusions and expand care for federal employees.** Operated by the Office of Personnel Management (OPM), the Federal Employees Health Benefits (FEHB) Program offers health insurance coverage for which most federal employees are eligible.<sup>157</sup> Unfortunately, program members continue to be denied gender-affirming care and services regarded as medically necessary by the World Professional Association for Transgender Health’s Standards of Care.<sup>158</sup> Partly or wholly excluding transgender health care from employer insurance plans constitutes discrimination under federal law.<sup>159</sup> In compliance with the recently announced EO on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce and Section 1557, the OPM should take action to remove existing exclusions or other restrictions and direct carriers to cover comprehensive gender-affirming care through the FEHB to transgender employees, including beneficiaries and eligible dependents.<sup>160</sup> Furthermore, in light of its recent announcement,<sup>161</sup> the U.S. Department of Veterans Affairs (VA) should act to remove the existing discriminatory exclusion for gender-affirming surgical care,<sup>162</sup> as well as any other restrictions that limit the ability of transgender veterans to access gender-affirming care.<sup>163</sup>

- **Explicitly clarify protections for transgender patients in health care.** Any notice-and-comment rule-making related to Section 1557 should clarify protections for transgender and gender-diverse patients in health care and coverage. Through the rule, enforcement mechanisms, and technical assistance to insurers and providers, the HHS should provide clear guidance on what it means for covered entities and providers not to discriminate against transgender patients and the wide range of scenarios in which discrimination can occur. At a minimum, the CMS should issue a letter to state Medicaid directors notifying them of these actions and clarifying protections.
- **Improve enforcement and accountability through technical assistance and oversight.** While studies show that insurers have largely moved away from transgender-specific categorical exclusions in plans, insurers continue to discriminatorily reject coverage.<sup>164</sup> As such, to promote enforcement and accountability among insurers, the above actions should be paired with technical assistance and oversight mechanisms through the CCIIO. To ensure HHS enforcement of these nondiscrimination protections will require a strong Section 1557 rule and an OCR that is adequately funded to meet its caseload and investigate complaints thoroughly. Filing lawsuits against entities violating nondiscrimination protections in health care places labor and a fiscal burden on patients, while proactive civil rights enforcement mechanisms will institute systemic accountability and lessen that burden. The OCR should simultaneously implement awareness campaigns to ensure that transgender people are aware of their right to nondiscrimination and lift up highly valuable community-based legal resources. (see Appendix B)

“Despite having employer health care coverage, a transgender woman from Boulder County, Colorado, with a significant family history of breast cancer had to struggle with her insurance provider at length, on multiple occasions to obtain a covered breast cancer screening.”

– Boulder County Public Health’s comment on the Trump administration’s rule on Section 1557 of the ACA<sup>165</sup>

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## HHS grants regulation

Grants issued by the HHS total more than \$500 billion annually<sup>166</sup> and fund a wide array of programs and services that transgender people rely on—including those addressing substance use and mental health, homelessness, intimate partner violence, anti-bullying efforts, aging care, and people living with HIV/AIDS.<sup>167</sup>

These programs and services are critical to addressing the various physical, mental, and behavioral health disparities highlighted throughout this report. The HHS's central nondiscrimination regulation for federal awards required HHS-funded service providers not to discriminate based on nonmerit factors such as sex, sexual orientation, and gender identity, among others.<sup>168</sup> In November 2019, however, the Trump administration released a notice of nonenforcement for key nondiscrimination provisions for many HHS programs,<sup>169</sup> and in January 2021 it finalized a rule<sup>170</sup> that strips beneficiaries of HHS-funded services of these explicit comprehensive nondiscrimination protections and attempts to permit service providers to discriminate based on nonmerit factors including sex, sexual orientation, and gender identity.<sup>171</sup> There are lawsuits currently pending against both the notice of nonenforcement and the grants rule.<sup>172</sup>

### Recommendation

- **Immediately rescind the 2019 notice of nonenforcement and restore nondiscrimination protections.** In addition to rescinding the notice of nonenforcement issued in 2019, the Biden administration should work to restore protections by engaging in notice-and-comment rule-making to rescind the final grants rule, which has yet to go into effect but is set to go into effect in August 2021.<sup>173</sup> The HHS should also clearly require nondiscrimination as a condition of issuing grants and avoid overly broad religious exemptions that remove crucial safeguards designed to protect people accessing government-funded services at faith-based providers from discrimination.

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### COVID-19 administrative actions

Transgender communities have been hit especially hard by the health, economic, and social effects of the COVID-19 pandemic.<sup>174</sup> In addition to being at greater risk of suffering severe illness from the coronavirus,<sup>175</sup> transgender people reported experiencing disproportionately high rates of serious financial hardship and employment disruption during the pandemic, undermining their economic security, housing stability, and ability to afford and access care.<sup>176</sup>

### Recommendations

- **Integrate targeted relief for transgender communities into coronavirus testing, vaccine, and recovery efforts.** During the first days of his presidency, President Biden signed various EOs to promote a strategic, data-driven, and equity-centered approach to addressing the pandemic.<sup>177</sup> These actions should be used as

an opportunity to integrate targeted relief to support transgender communities. For example, federal and state governments should partner with and financially support community-based organizations to issue vaccine distribution plans and outreach campaigns targeting transgender communities; share information about accessing testing, vaccines, and the right to receive services free from discrimination under the law; and dispel misinformation about how vaccines may interfere with transition-related care.<sup>178</sup> The pandemic has also highlighted the need for a national paid sick leave policy. The administration should continue to support efforts to expand paid medical and family leave for transgender people by adopting an inclusive definition of chosen-family caregiving relationships<sup>179</sup>—a provision included in the president’s proposed American Families Plan, which Congress should act to adopt.<sup>180</sup>

- **Enhance data collection to shed light on the experiences of transgender people during the COVID-19 pandemic.** There are numerous steps that the HHS, with the support of the COVID-19 Health Equity Task Force, should take to support data collection that will provide greater clarity on the experiences of transgender people during the pandemic.<sup>181</sup> The existing COVID-19 laboratory data guidance from the HHS<sup>182</sup> should be revised to require voluntary data collection and reporting on SOGI in COVID-19 testing, care, and vaccination uptake in a manner that protects privacy and confidentiality for individuals. Moreover, the Centers for Disease Control and Prevention (CDC) case report form<sup>183</sup> should add SOGI questions and alter its sex question response options to be more inclusive. Additionally, the National COVID Cohort Collaborative and Office should add SOGI to its COVID-19 Clinical Data Warehouse Data Dictionary, and the national coordinator of health information technology should require the HL7 electronic health record to add SOGI measures to foster better data exchanges between clinical and reporting systems. Finally, the HHS should ensure the CDC’s Data Modernization Initiative<sup>184</sup> directs funding to and prioritizes expanding and enhancing SOGI data collection in public health surveillance. Taking these steps is essential to collect more accurate information on transgender peoples’ health needs, bring visibility to their experiences throughout the pandemic, and help federal, state, and local programs reduce disparities and improve access to care during the pandemic and beyond.

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## Data collection

Persistent lack of routine data collection on gender identity, as well as sexual orientation and intersex status, remains a significant barrier for researchers, advocates, and policymakers alike.<sup>185</sup> Data collection mechanisms often conflate sex and gender or rely solely on a binary model of sex and gender that fails to capture health outcomes for transgender and other gender-diverse populations.<sup>186</sup> To better understand and address health disparities that transgender communities face, it is imperative that federal agencies, including the HHS, the U.S. Department of Commerce, and the U.S. Department of Labor, expand and enhance data collection efforts to add measures for SOGI and to test and implement intersex status measures. Doing so is crucial to advancing research agendas, evaluating population trends, equitably distributing funding resources, tracking and addressing discrimination, and designing evidence-based policy solutions to promote equity and reduce existing disparities that transgender communities face across key areas of life.<sup>187</sup>

## Recommendations

- **Expand and enhance data collection efforts under the HHS.** For example, the CDC should prioritize adding SOGI measures to the standardized demographic core questionnaire of the BRFSS and the National Violent Death Reporting System as well as adding gender identity questions to the National Health Interview Survey. Expansion of data collection should be paired with funding, technical assistance, and training to facilitate implementation and ensure high standards for collection, storage, sharing, and use that promote security and confidentiality. These actions should include efforts to meaningfully engage directly with transgender communities and organizations for the purposes of qualitative and quantitative research.

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## Access to identification documents

Gender-incongruent forms of identification expose transgender people to a range of adverse outcomes and pose a significant barrier to accessing a wide range of services, including those related to health care. Unfortunately, many states<sup>188</sup> still impose intrusive and burdensome requirements<sup>189</sup> for transgender people to update their IDs—such as providing proof of surgery or court orders—to amend driver’s licenses or birth certificates. In June 2021, President Biden signed an EO on Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce,<sup>190</sup> directing relevant agencies to take steps to facilitate access to identity credentials that meet the needs

of transgender, gender-nonconforming, and nonbinary employees and to reduce unnecessary administrative burden for updating employee identity credentials. Also in June 2021, the U.S. Department of State announced it will be updating procedures for issuance of U.S. passports and consular reports of birth abroad to allow applicants to “self-select their gender as ‘M’ or ‘F’ and will no longer require medical certification if an applicant’s self-selected gender does not match the gender on their other citizenship or identity documents.”<sup>191</sup>

## Recommendation

- **Facilitate the process through which transgender people acquire accurate IDs.** As part of the EO on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,<sup>192</sup> all relevant federal agencies ensure that wherever federal ID documents or administrative records list gender, individuals can select a designation for M, F, or X, and remove medical certification. Gender-incongruent identification increases the risk of exposing transgender people to discrimination, harassment, violence, and administrative barriers when engaging in a variety of settings. As such, states should also modernize their policies or processes for transgender people to access identification—such as driver’s licenses, birth certificates, and legal name changes—that matches their gender identity.<sup>193</sup>

# In-practice policies to promote affirming, inclusive, and culturally competent care

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## Beyond nondiscrimination legal protections

Nondiscrimination protections alone cannot rectify the health consequences of the long-standing structural exclusion that transgender people face. Access to legal recourse in instances of discrimination in health care does not address many of the social determinants contributing to inadequate health care, such as persistent poverty, criminalization, and unemployment. Furthermore, many harmful actions by providers may not constitute or be recognized as formal discrimination—even with protections, mistreatment and consequent avoidance will continue. Proactive efforts to promote access to health care, including through targeted support for affirming health care programs and increasing cultural competence among health care providers, are also needed.

Needs beyond nondiscrimination protections are visible in locations such as Washington, D.C. Despite the district having some of the most transgender-inclusive health care protections in the country,<sup>194</sup> a DC Trans Coalition survey found that transgender people in Washington, D.C., were much more likely to be uninsured, HIV positive, use illicit substances, or experience suicidality, with transgender people of color reporting higher rates in all these categories.<sup>195</sup> The organization's community needs assessment found that access to “trans-sensitive health care” was the community's top priority.<sup>196</sup> A further study of sex workers in Washington, D.C., most of whom were transgender, identified sex work criminalization and housing insecurity as the primary barriers to their health and well-being.<sup>197</sup>

Trans-sensitive health care is not simply access to medical transition through hormones and surgeries. While medical transition is widely recognized as holistically beneficial to those who seek it out,<sup>198</sup> the pressing health care needs of many transgender people include care for chronic conditions,<sup>199</sup> care associated with disability, and mental health treatment<sup>200</sup>—and not all transgender people would choose to medically transition even if this care were available.

Meanwhile, many health providers lack basic knowledge of the health experiences of transgender people and must increase their cultural competence to effectively serve their transgender patients. According to CAP’s nationally representative survey, in the year prior, 33 percent of transgender respondents reported having to teach their doctor or provider about transgender people in order to receive appropriate care; 32 percent of respondents reported misgendering by doctors or providers; and 38 percent reported providers being visibly uncomfortable due to actual or perceived gender identity. Transgender people of color faced even higher rates of mistreatment in all these categories.<sup>201</sup>

“I broke my foot and I went to physical therapy and they wouldn’t respect my pronouns at all [...] They would change me a lot [to new/different physical therapists]. They would switch me around because they were tired of me telling them to use the right pronouns. They would change me to different people because they didn’t want to deal with respecting my pronouns. So, I stopped and now my foot is hurt really badly. Walking hurts.”

– Participant in the 2018 Southern Trans Health Focus Group Project<sup>202</sup>

Resources for training insurers, providers, and administrative staff in cultural competence are already available.<sup>203</sup> Adding funding and guidance from federal and state governments would aid in ensuring their widespread implementation, as would increased emphasis on cultural competence in the standard education of health care providers.

Evidence demonstrates the multifaceted harms of unsupportive, stigmatizing, and discriminatory care and highlights the benefits of culturally competent, inclusive, and gender-affirming care.<sup>204</sup> The below sections offer recommendations for in-practice policies and procedures that should be adopted by health providers.<sup>205</sup> Notably, these policies are interconnected and should be implemented together to foster a holistically inclusive and supporting health care environment for transgender and gender-nonconforming patients.

Increase funding for programs that advance the health of transgender communities

The data and findings presented throughout this report highlight the significant and intersectional impacts that discrimination, minority stress, violence, and various social determinants of health have on the physical, mental, and behavioral health of transgender adults. In addition to the nondiscrimination regulatory and in-practice policies recommended here, there are multiple broad-based policies and investments

beyond the scope of this report that will also help to address the myriad harms, barriers to care, and disparities that transgender communities face. For example,<sup>206</sup> the Biden administration, Congress, and state and local governments should increase funding and support for entities providing LGBTQI+ family acceptance models; integrated and culturally competent mental and behavioral health services that take a trauma-informed, harm-reduction approach; LGBTQI+ community health centers; affordable housing models that are explicitly designed for transgender communities; efforts to combat violence and improve attitudes toward transgender people;<sup>207</sup> collaborative, restorative justice, and community-centered organizations providing LGBTQI+ survivors of violence with support services; and LGBTQI+ and HIV-targeted reentry services.<sup>208</sup> Furthermore, the administration should continue to incentivize Medicaid expansion in states that have failed to do so; encourage states to expand reimbursement and utilization of telemedicine services through Medicaid and the Children’s Health Insurance Program; and work with Congress to permanently expand the American Rescue Plan Act’s provision of lower health insurance premiums for people purchasing coverage on the ACA exchanges, as recently proposed in the American Families Plan. Improving access to these kinds of crucial programs and services is a cross-cutting endeavor that requires strategic coordination among different federal and state actors.

#### Adopt LGBTQI-inclusive administrative data systems

Many health care-related forms fail to include informational options that reflect the diversity of sexual and gender identities, and family types. Health care providers should review their current documentation policies and protocols, as well as intake forms, to ensure inclusive<sup>209</sup> language<sup>210</sup> and form options related to SOGI and intersex demographic questions, authentic names and pronouns, relationship status and definitions of family, as well as questions related to sexual history, family planning, and gynecological history. Adopting these kinds of inclusive forms must also be paired with administrative procedures and training to ensure patients are not misgendered or subject to other kinds of violence and abuse. Health care institutions should also adopt existing best practices for collecting gender identity data in electronic health records.<sup>211</sup>

#### Foster affirming environments in health care settings

Given the widespread discrimination and negative experiences that transgender people encounter in health settings, as well as the historic pathologizing of transgender people by the medical community, it is crucial for health care providers to communicate to transgender patients that they are entering an inclusive and affirming environment where they will be treated with respect. In addition to staff

training, it is important that the physical space and materials available to patients are inclusive of LGBTQI+ people. At minimum, for example, the terms “sexual orientation,” “gender identity,” “gender expression,” and “sex characteristics” should be added to providers’ nondiscrimination policy—and placed in areas of high visibility—as well as added to patient handouts and providers’ websites.<sup>212</sup> Additionally, materials specific to the needs of transgender patients related to general care and gender-affirming care should be available and visible. Where possible, patient navigation services for transgender patients seeking gender-affirming care should be provided.

#### Provide regular staff training on cultural competency and readiness

It is imperative that both administrative staff and clinical providers receive annual cultural competency training related to transgender and gender-diverse identities and terminology, as well as how to avoid stereotyping or making assumptions about a patient’s gender identity.<sup>213</sup> Mandatory training<sup>214</sup> for front-line staff should also include materials on best practices related to addressing patients, using names and pronouns, obtaining information related to insurance or medical records, and generally creating an affirming environment for transgender and nonbinary patients.<sup>215</sup> To ensure implementation, the government should include high-quality LGBTQI+ cultural competency as a mandatory component in all federally conducted or supported training programs for grantees, including federally employed health care providers such as those at the VA. The CMS could also encourage cultural competency by reinstating the former policy of requiring that managed care plans include information in the provider directory on whether the Medicare and Medicaid participating providers have completed cultural competency training, which should include LGBTQI+ cultural competency training.<sup>216</sup> The Health Resources and Services Administration should receive additional funding to support the dissemination and implementation of trainings for health center staff, and LGBTQI+ cultural competency training could be incorporated as a prerequisite for certification as a community health center.<sup>217</sup>

#### Adopt clinical standards and education on the health experiences and needs of transgender communities

Presently, among many clinical providers there exists a lack of knowledge and cultural competence concerning the experiences and health care needs of transgender people; a lack of mental and behavioral health specialist services; and a lack of awareness regarding health professionals’ own biases resulting in unequal and discriminatory treatment that deter people from seeking care and ultimately exacerbate disparities.<sup>218</sup> In addition to cultural competency training, clinical

providers should receive robust medical training and learn education curricula about the health care risks and needs of transgender populations located within a deeper understanding of the social, political, and economic forces that shape existing disparities and challenges. It is imperative that providers adopt the most recent standards of clinical care from expert bodies, such as the World Professional Association for Transgender Health, and that medical education institutions explicitly adopt these materials into their curricula through bodies such as the Association of American Medical Colleges. For example, the Substance Abuse and Mental Health Services Administration should develop and disseminate cultural competency curricula on LGBTQI+ patients in federally funded medical facilities, medical training programs, and providers participating in Medicaid. Moreover, the government should incentivize training and education related to these clinical standards of care in federally conducted or supported training programs for grantees, including federally employed health care providers such as those at the VA. States could also work to adopt National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, which should be continuously modified to be inclusive of and better aligned with meeting the needs of transgender and gender-diverse patients.<sup>219</sup>

#### Increase funding for community health centers and other safety net providers

The historical and continued hostility of insurers and providers has led many transgender people to rely on community health centers, which were often created by LGBTQI+ communities themselves. While these services remain uncommon outside of urban areas and coastal states, they provide urgently needed and affordable care targeted to LGBTQI+ populations.<sup>220</sup> In these areas, support for existing, trusted services is essential to transgender health. Federal funding for community health centers can be increased through the Health Resources and Services Administration designating LGBTQ people as a Medically Underserved Population and a Health Professional Shortage Area population.<sup>221</sup> Existing health disparities and a shortage of culturally competent providers clearly justify these designations, which would increase community health centers' access to funding streams.<sup>222</sup> The HHS has proposed regulations to restore access to Title X funding to many providers and ensure equity for underserved populations in the provision of Title X funds.<sup>223</sup> Programs qualify for Title X funds due to their provision of family planning services, and Title X programs have historically been crucial for transgender people due to their low-barrier provision of STI treatment and prevention services, basic health maintenance, and gender-affirming care.<sup>224</sup> In 2018, for example, 100 Planned Parenthood affiliates provided hormone therapy for transgender people,<sup>225</sup> and many Title X providers offer comprehensive and targeted

care for LGBTQ populations.<sup>226</sup> The Trump-era domestic gag rule<sup>227</sup> imposed onerous requirements on Title X grantees offering abortion-related care or referrals, decimating funding for this essential network of providers.<sup>228</sup> In addition to rescinding the domestic gag rule, the HHS's efforts to repair Title X should create a pathway for reentry to evidence-based Title X grantees excluded due to the gag rule, including reissuing the funding opportunity announcement and ensuring protections from adverse action by state governments against Title X programs.

"I have argued with pharmacists who refuse to dispense my testosterone because the way I use it is 'off label use.' I have been asked invasive questions about my body including details about my genitals, surgical history, and sexual history that were irrelevant to the circumstances which led me to seek medical care.

– **Comment from Matthew Gray Brush, a health educator, on the Trump administration's rule on Section 1557 of the ACA**<sup>229</sup>

Develop policies to prevent violence against transgender people

The Biden administration has created an Interagency Working Group on Safety, Inclusion, and Opportunity for Transgender Americans, which is intended in part to address violence against transgender people and the factors contributing to it.<sup>230</sup> The establishment of this group presents a unique opportunity to coordinate federal policymaking to proactively address poverty, housing insecurity, criminalization, and resulting outcomes in victimization. Such policies must be developed with reliance on the input and expertise of affected people and advocates.

In 2019, only 13.9 percent of law enforcement agencies submitted data on hate crimes to the FBI.<sup>231</sup> This drastic underreporting prevents research into the scale and nature of gender identity-based violence and hampers the development of evidence-based policies to combat it.

The administration should develop accountability measures for noncompliance with hate crime reporting standards, including audits and conditioning of federal grants to law enforcement agencies. It should also work to establish processes for hate violence reporting outside of law enforcement channels, such as through hotlines and local 211 lines that may be more trusted by communities vulnerable to negative law enforcement interactions.

Intimate partner violence presents a complex problem for transgender people—and one which law enforcement agencies are not equipped to address. Economic inse-

curity can exacerbate intimate partner violence, creating special vulnerabilities to financial abuse.<sup>232</sup> Comprehensive efforts to improve the economic security of transgender people would begin to address these factors. Expanded funding for affirming services for survivors of violence and implementation of nondiscrimination protections in emergency services such as shelters would mitigate the immediate effects of these issues by increasing transgender survivors' access to support systems.

Addressing violence against transgender sex workers is complicated by the effects of sex work criminalization on survivors' access to support systems and health care.<sup>233</sup> Improved economic security and funding for affirming services must be complemented by efforts to advance the decriminalization of sex work.

Policies to prevent violence against transgender people must also address the direct role of law enforcement and carceral systems in perpetrating this violence. Transgender people are seven times more likely than cisgender people to experience physical violence when interacting with the police<sup>234</sup> and five times more likely than the general population to be sexually assaulted by facility staff in jails, prisons, and juvenile detention.<sup>235</sup> These dangers must be addressed through broader efforts to decrease law enforcement interactions and criminal legal system involvement among transgender people, including policies advancing the decriminalization of sex work, rather than increased funding for law enforcement training.

Efforts to address the HIV epidemic and support people living with HIV

CDC data reveal that transgender communities, particularly Black/African American transgender people, Hispanic/Latino transgender people, and transgender women in general, are disproportionately affected by HIV. In 2018, 2 percent of all new HIV diagnoses in the United States and dependent areas were among transgender people, with disproportionate new HIV diagnoses among Black/African American transgender women and Black/African American transgender men, as well as among transgender people aged 25 to 34.<sup>236</sup> HIV prevalence is roughly 20 times higher among transgender people, and roughly 30 times higher among transgender women, than among the general population.<sup>237</sup> To address existing disparities and continue working toward the HHS's goal of ending HIV by 2030<sup>238</sup> requires that biomedical prevention and treatment options for HIV only be adopted as part of a more holistic approach that recognizes the structural and systemic barriers that lead to disproportionate effects among transgender communities of color. These barriers include the criminalization of sex work, drug use, and HIV status, which prevent many transgender people from safely engaging with public health initiatives.<sup>239</sup> The administration must adopt an approach

that meaningfully involves and centers the experiences of people living with HIV and the policy recommendations generated by and for communities marginalized by HIV.<sup>240</sup> As part of the CDC’s efforts to realize the Ending the HIV Epidemic (EHE) plan,<sup>241</sup> the authors recommend the following actions.

#### Increase funding for a range of HIV-related programs and initiatives

For example, budgetary funding increases for all domestic HIV and viral hepatitis programs—including Housing Opportunities for People With AIDS, the CDC’s Division of Viral Hepatitis, and the Ryan White HIV/AIDS Program—to provide services and supports for low-income people with HIV are critical to getting the nation on track to end HIV by 2030. The HHS should also work with HIV leaders to modernize the Ryan White HIV/AIDS Program and continue to increase access to essential services for program recipients, thereby reducing barriers to access. More broadly, the HHS should fund and scale programs providing biomedical prevention and treatment options for HIV such as HIV testing, preexposure and postexposure prophylaxis (PrEP and PEP), treatment-as-prevention strategies, and long-acting HIV treatment options. These actions must be complemented by investments to fund and bring to scale innovative messaging and stigma reduction strategies for priority HIV populations advanced by the communities of people living with HIV, such as Undetectable Equals Untransmittable.

#### Continue to support strategies for prevention, treatment, and harm reduction

Strategies to prevent new HIV transmissions should include adequately funded collaboration with municipalities and nongovernmental organizations able to engage sex workers and people who use drugs<sup>242</sup> as well as the adoption of evidence-based harm reduction strategies, including syringe service programs, medication-assisted treatment, and the institution of overdose prevention sites. Syringe exchanges reduce the risk of transmission among at-risk populations<sup>243</sup> and must be supported, including through a congressional allocation of appropriations funds through opioid epidemic initiatives and the removal of restrictions on syringe purchases by these programs. This would reduce the harms associated with hormone injection, substance use, HIV, and hepatitis C among transgender people who cannot easily access safe supplies.<sup>244</sup>

#### Revise U.S. Department of Justice (DOJ) positions criminalizing overdose prevention sites

The DOJ has prevented the development of overdose prevention sites through an interpretation of 21 USC § 856, the so-called “crack house statute” of the Controlled Substance Act.<sup>245</sup> Decades of research have consistently shown the

health and safety benefits of overdose prevention sites, which provide supervision and safer environments and supplies for injection drug use.<sup>246</sup> The DOJ must drop pending cases challenging overdose prevention sites and institute policies de-prioritizing future prosecution of sites under the Controlled Substances Act.

#### Adopt HIV surveillance and research safeguards

A key pillar of the EHE, the molecular HIV surveillance (MHS) collects and tracks people's biological data with the aim of allowing public health systems to trace networks of HIV transmission and identify transmission clusters to offer prevention and health care services.<sup>247</sup> Unfortunately, these surveillance systems utilize and share data without the consent of people living with HIV and lack meaningful accountability mechanisms, exacerbating mistrust among people living with HIV and concerns about whether data will be used to criminalize these communities.<sup>248</sup> More than 30 states have laws criminalizing HIV transmission, exposure, or nondisclosure that state legislatures should repeal.<sup>249</sup> The CDC should issue a moratorium on MHS until adequate safeguards are created and implemented to protect the privacy and autonomy of people living with HIV, bolster community trust, and eliminate opportunities for criminalization and other unintended consequences. Implementation of surveillance systems must be responsive to the input of networks of people living with HIV.

# Conclusion

Discrimination, stigma, poverty, and violence significantly affect the physical, mental, and behavioral health of transgender adults and drive disparities in access to health insurance and adequate care. To improve these outcomes and the experiences of transgender patients in health care settings, it is critical to adopt both robust nondiscrimination laws and in-practice policies that are affirming, inclusive, and culturally competent throughout all areas of the U.S. health care system. Given the current slate of discriminatory and harmful state-level bills that seek to strip transgender youth and adults of their rights and access to health care, fully implementing these protections is vital and will have life-saving consequences. The current administration's executive actions to combat discrimination on the basis of SOGI<sup>250</sup> and to advance support for underserved communities<sup>251</sup> offer opportunities to facilitate these changes. The time for the federal agencies and health providers to act is now.

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# Appendix A

This report draws from original CAP analyses of three data sources, outlined below.

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CAP's nationally representative survey of LGBTQI+ Americans, conducted in June 2020

This sample includes data from 1,528 LGBTQI+-identifying individuals, including 121 transgender individuals, collected with assistance from NORC at the University of Chicago using their AmeriSpeak panel. A sample of U.S. adults ages 18 and older who self-identified as LGBTQI+ was selected for this study, and this sample has been weighted to account for both U.S. population characteristics and survey nonresponse. The full results of the study, along with a detailed overview of the methodology, are on file with the authors. For additional information on survey results, please see CAP's related report<sup>252</sup> and interactive.<sup>253</sup> All statistics from CAP's survey comparing transgender respondents with cisgender LGBTQI+ respondents are significant at the 0.05 level.

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The 2019 edition of the CDC's Behavioral Risk Factor Surveillance System

This survey is a collaborative project between the CDC, U.S. states, and participating territories. It is conducted by phone among U.S. adults ages 18 years and older and asks a series of questions regarding health-related risk behaviors, diseases, and chronic conditions. The survey is comprised of a core set of questions as well as additional modules that states have the option of including. Currently, 31 states and one territory have opted to include questions to ascertain an individual's gender identity, creating a sample of 232,088 cisgender individuals and 955 transgender individuals. This data is weighted to account for probability of selection, nonresponse bias, and U.S. population characteristics. All statistics comparing transgender respondents with cisgender respondents are significant at the 0.05 level. Data and a detailed methodology are on file with the authors and available publicly via the CDC.<sup>254</sup>

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The TransPop study, conducted by the Williams Institute, Columbia University, Harvard University, and the Fenway Institute at Fenway Health

TransPop is the first nationally representative survey of transgender individuals in the United States. Conducted over the phone and mail by Gallup from 2016 to 2018, the TransPop study was a national probability sample of 1,436 adults over the age of 18, including 274 transgender individuals and 1,040 cisgender heterosexual individuals. The sample has been weighted to account for both survey nonresponse and U.S. population characteristics. For a full overview of the methodology behind TransPop, please see the Methodology section of the Williams Institute’s overview report on TransPop.<sup>255</sup>

The Williams Institute released a comprehensive overview of results from its TransPop and Generations surveys in June 2021.<sup>256</sup> This overview included the vast majority of statistics for transgender respondents to TransPop cited in this report. Where a statistic cited here was taken from this overview, an endnote is included to account for it. In addition, Feldman and others recently released a study comparing health and health care access of transgender and cisgender individuals, also cited in this report and an important resource for providing a thorough overview of differences in health outcomes.<sup>257</sup> Where TransPop statistics have no corresponding endnote, as is the case with statistics for cisgender heterosexual respondents to TransPop, the statistic comes from original CAP data analysis. All comparisons between transgender and cisgender heterosexual individuals from TransPop are significant at the 0.1 level.

# Appendix B

The following resources offer more information and legal guidance on the right to nondiscrimination in health care and filing complaints.

- National Center for Transgender Equality: Know Your Rights | Health Care<sup>258</sup>
- Lambda Legal: Know Your Rights<sup>259</sup>
- Transgender Legal Defense and Education Fund: Trans Health Project<sup>260</sup>
- Human Rights Campaign: Know Your Healthcare Rights<sup>261</sup>

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## Endnotes

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