State-Level Transgender-Specific Policies, Race/Ethnicity, and Health Care Use among Transgender and Gender Diverse People in the United States

Introduction

Over the past decade, the presence of trans-specific policies in the United States has increased, including policies that both protect and stigmatize transgender and gender diverse populations (i.e., people whose gender identity is not the same as their sex assigned at birth, referred to throughout as TGGD). Policies enacted at federal, state, and local levels can limit or enable access to a variety of resources and can shape experiences of health and health care for TGGD people. Policies can also contribute to the social climate; for example, policies that allow for religious exemptions or policies that limit TGGD access to public accommodations, such as bathrooms, can increase negative representations of TGGD people and allow for experiences of discrimination and victimization to occur. On the other hand, policies such as non-discrimination protections or policies that prohibit the exclusion of TGGD individuals in health insurance coverage can promote resilience, allowing for increased access to social services and health care. In the current political U.S. context, it is important to have a better understanding of how these policies influence experiences of health and health care. However, to date, little research has examined the relationships between state-level trans-specific policies and TGGD people's experiences with health care use. Furthermore, even less is understood about how the relationships between policies and health care may vary depending on other identities, such as race.

Previous research has demonstrated that policies and social climate matter for the health of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people more broadly. Specifically, this research has found that policies such as non-discrimination protections that are inclusive of sexual orientation and anti-bullying policies in schools are associated with improved mental health experiences of sexual minorities in the United States. In addition, research specific to TGGD populations has found that the inclusion of gender identity and/or gender expression in non-discrimination policies as well as more general experiences of state-level structural stigma are associated with perceptions of community prejudice, mental health, and suicide among TGGD people. Taken together, these studies suggest that LGBTQ-related policies and indicators for social climate matter for the health of TGGD people. However, more work is needed to understand how a variety of trans-specific policies and social indicators play a role in TGGD health care use.

It is especially important to understand experiences of health care use among TGGD people. Healthy People 2020 recognizes that access to "comprehensive, quality health care services" is an important goal to achieve health equity across social groups in the United States. However, to achieve equitable access to care, it is important to consider the distinct health care needs and barriers to care that TGGD people may experience. Pervasive transphobic stigma in the United States limits access to health care in multiple ways. For example, many TGGD people report delaying or not using care due to fears of being mistreated. In addition, when TGGD people do try to access care, some have reported being refused care, being refused health insurance coverage, or have reported receiving a poorer quality of care. These negative experiences in health care can have negative consequences for the health of TGGD people; for example, one study found that reporting non-use of health care due to fears of mistreatment was associated with a poorer self-rating of one's own health and an increase in experiences of depression, suicidal ideation, and suicide attempts. This is especially problematic since TGGD people also experience large inequities across a number of poor health outcomes, including psychological distress, suicide, HIV, and substance use disorders. Though some research has examined how policies and social climate influence these health inequities, little is known about how policies may shape access to and use of health care among TGGD people.

Finally, the relationship between state-level trans-specific policies and health care use may not be consistent across all groups of TGGD people. It is important to apply an intersectionality approach and understand how other aspects of identity, such as race or ethnicity, may play a role in the relationship between state-level policies and health care among TGGD people, and especially among TGGD People of Color. Intersectionality theory explains that the experiences of race and gender identity are not additive, but instead, TGGD People of Color have fundamentally different experiences with power and privilege than White TGGD people. In addition to needing to navigate both racist and transphobic stigma, the experiences of transphobic stigma may be different for TGGD People Color than for White TGGD people. This is evident with research demonstrating that TGGD People of Color experience a higher prevalence of transphobic stigma as well as greater consequences to these experiences of stigma, with experiences of structural vulnerability (e.g., homelessness, incarceration, poverty) and health inequities also being largest for TGGD People of Color. Taken together, this research suggests that it is important to consider how experiences of stigma, especially at a policy-level, may have a differential relationship with health care use across TGGD people of different racial/ethnic backgrounds. Therefore, in addition to examining the relationships between state-level trans-specific policies and health care use, this paper will also examine the ways in which these relationships vary by race/ethnicity.

Methods

This study uses multi-level modeling to examine the relationships between state-level trans-specific policies and health care use among TGGD people throughout the United States. Data are from the U.S. Trans Survey (USTS), national survey examining the experiences of 27,715 TGGD people. For this analysis, the USTS is also be supplemented with policy-level data and state-level characteristics taken from other publicly-available sources, including the U.S. Census Bureau, the U.S. Department of Agriculture, and the Movement Advancement Project (a think tank that addresses policy issues related to LGBTQ communities).

Recruitment and Study Sample. Data were collected by the National Center for Transgender Equality (NCTE), using multiple outreach strategies. Outreach efforts occurred prior to data collection and included contacting LGBTQ organizations, support groups, health centers, online communities, etc. The NCTE contacted LGBTQ organizations across the country to assist with outreach for the survey, with nearly 400 organizations providing support for recruitment. In additional, communications promoting the survey were distributed in both English and Spanish through email, social media, print media, and additional promotional campaigns (e.g., a photo booth campaign and USTS Awareness week). Eligibility criteria for this analysis included identifying along a spectrum of TGGD identities (e.g., trans, genderqueer, non-binary, and other identities on the spectrum), being at least age 18, and living in a U.S. state or territory. Additional eligibility criteria excludes individuals who identify as cross-dressers (because these experiences may be fundamentally different) and individuals living in U.S. territories (because there were not enough participants from these regions to include them).

Procedures. The survey was comprised of 32 sections and a total of 324 possible questions that covered a broad range of topics, including, for example, experiences with health, health care, employment, housing, education, identity documents, families, etc. Survey questions were designed through collaborations with a team of researchers and advocates and individuals with a range of expertise that were important for the development of the survey (e.g., research experience, lived experience). The majority of respondents completed the survey online; however, some participants (approximately 200) completed the survey during in-person events occurring at 71 different LGBTQ organizations across the United States. All data were collected anonymously. IRB approval to collect the data was attained by the NCTE from the University of California-Los Angeles North General IRB. Permission to use the USTS dataset was acquired and additional IRB approval specifically for the analysis of the was not needed, since no identifying information was included in the dataset.

Measures include health care use (the outcome variable), policy variables (the primary independent variables), and both individual-level and state-level control variables. In addition, state is included as the random intercept and race will be measured as a random slope.

Health care use is a dichotomous variables measured with one yes/no question asking: "Was there a time in the past 12 months when you needed to see a doctor but did not because you thought you would be disrespected or mistreated as a trans person?" This is aligned with previous studies that have measured TGGD health care utilization through delays in care and, more specifically, though delays or non-use of health care due to fear of mistreatment.

Policy variables include six separate state-level trans-specific policies covering three domains (laws allowing or protecting against discrimination, policies specific to health insurance, and policies specific to changing legal documents). The specific policies include: non-discrimination policies, religious exemption laws, private health insurance protections, inclusion/exclusion in Medicaid, requirements for changing the gender marker on a driver's license or state ID, and requirements for a legal name change. All of these policies are measured as categorical variables, with the number of categories depending on the nuances in laws across states. For example, non-discrimination laws are examined as a dichotomous variable based on whether or not non-discrimination protections include gender identity and/or expression. However, Medicaid policies are measured using three possible categories: 1) No Medicaid policy exists excluding or including the coverage of TGGD-specific health care; 2) The state Medicaid policy explicitly covers TGGD-specific health care; and 3) The state Medicaid policy explicitly excludes the coverage of TGGD-specific health care. Classification of state policies are based on the existence of the policy in 2015, at the time data were collected.

Sensitivity analyses will examine two possible ways for measuring these policies. The first option is to include all policy variables in the model separately; this method has the benefit of capturing the nuances in policies through an examination of the relationship between each policy and health care use. The second option is to create an index, combining all policies, with a state getting a negative point for each harmful policy (e.g., a Medicaid exclusion, a religious exemption law) and a positive point for each protective policy (e.g., a Medicaid inclusion, an inclusive non-discrimination protection policy).

Control variables include individual-level and state-level control variables. Individual-level control variables include sociodemographic characteristics (including age, gender identity, sexual orientation, race/ethnicity, U.S. citizenship status, education level, and employment status), individual experiences of transphobic discrimination and victimization, outness about gender identity, social support, structural vulnerability (including experiences of poverty, homelessness, incarceration, and sex work), health status (including measures of psychological distress, suicidal ideation, HIV status, and substance use), and whether or not an individual made changes to identity documents. Race/ethnicity as a control variable is measured as a multi-category variable (including White; American Indian or Alaska Native; Asian, Native Hawaiian, or Pacific Islander;

Black; Latino/Hispanic; Multiracial; or another race). However, as the random slope, race will be included as a binary variable, based on whether or not and individual has a White race. State-level control variables include the racial makeup of each state, the state's population density, the rural vs. urban makeup of the state, the political climate (measured by who won the 2016 presidential election in each state), and aggregate variables describing state-level experiences of transphobic discrimination and victimization.

Analysis. Data will be analyzed using the STATA 14 software package (College Station, Texas). Multilevel logistic regression will be used to understand the relationships between state-level trans-specific policies and health care use, with two separate models being fit: one with and one without race as the random slope. This analysis will be able to account for clustering within states, since state-level trans-specific policies will vary across state. In addition, including race as a random slope will allow for an examination of how much the relationships between race and health care use vary across U.S. states. The sigma-mu will measure unobserved heterogeneity that exists after controlling for all of the variables in the model.

Results

After applying additional eligibility criteria and dropping all data from the sample that had missing data, the total sample includes 23,368 TGGD people. It is hypothesized that protective policies will be associated with increased health care use, while harmful policies will be associated with decreased health care use. In addition, it is expected that the ways in which policies shape health care use will vary by race/ethnicity, with protective policies being expected to have a stronger positive association with health care use among White TGGD people, while harmful policies are expected to have a stronger negative association with health care use among TGGD People of Color. The sensitivity analyses for conceptualizing policies will determine which matters more for health care use: the nuanced differences in each individual policy or the larger social and political climate measured by an index of all of the policies.

Innovation

This study adds to the existing literature on TGGD health by examining how state-level trans-specific policies play a role in health care use. Policies have been found to matter for the health experiences of sexual minorities, and stigmatizing social climates and individual policies have been found to play a role in the health experiences of TGGD people. However, to our knowledge, this is the first study examining how multiple TGGD-specific policies are associated with health care use among TGGD people. In addition, this study is unique because it applies an intersectionality framework and examines how the relationship between state-level TGGD-specific policies and TGGD health care use may vary by race.

Findings from this study may have implications for improving the health care experiences of TGGD people. Results may offer clear and specific policy recommendations. If results suggest that policies are associated with health care use across states, findings may be useful for advocating for improving state-level and even federal policies. Understanding the wide health implications of policy decisions can be useful as an advocacy tool with policy makers across all levels of government. It is possible that policies that aim to reduce stigma and increase resilience may help to increase access to health care and improve the health care experiences of TGGD people.